General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 22-24 High Street, CHATTERIS, Cambridgeshire, PE16 6BG

Pharmacy reference: 1029250

Type of pharmacy: Community

Date of inspection: 05/02/2020

Pharmacy context

This community pharmacy is in the centre of the small town of Chatteris, alongside a range of other independent retail and food outlets on the high street. Its main activity is dispensing NHS prescriptions and providing advice on healthcare matters over the counter. It also offers seasonal flu vaccinations, delivers medicines, and supplies instalment doses to people on substance misuse programmes. It has a needle exchange service. And it supplies medicines in multi-compartment compliance packs to quite a few people who need help in taking their medicines at the right time. The pharmacy team provides blood pressure checks and blood glucose checks.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.2	Good practice	The pharmacy proactively reviews and monitors the safety of its services and makes improvements where needed.
2. Staff	Good practice	2.2	Good practice	Pharmacy team members receive good support, through training materials and practical experience, so they keep their skills and knowledge up to date.
		2.4	Good practice	Team members are encouraged to learn from mistakes in an open and honest way. And they can contribute their ideas to make the pharmacy safer.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy takes particular care when supplying medicines which could be higher-risk. And the team does regular training to refresh their knowledge about these medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team works in a safe and effective manner and it identifies and manages the risks associated with its services well. The team members proactively learn from their mistakes and make improvements to reduce risks in the pharmacy. And they understand and work within their roles and competencies. The pharmacy keeps accurate records about its services. It makes sure people's personal information is held safely. And the team members understand their role in making sure vulnerable people are protected.

Inspector's evidence

The pharmacy had a comprehensive range of standard operating procedures (SOPs) which were issued by head office and had been last reviewed in July 2019. There was evidence that staff members had read and signed SOPs relevant to their roles and had been deemed competent in the procedures by the pharmacist. Internal audits were completed to check that the pharmacy complied with the written procedures and to make sure other routine tasks which could impact on patient safety were done. For example, fridge temperature checks.

The pharmacy used baskets to keep people's prescriptions separate. The pharmacist used a designated area of dispensary to complete the final accuracy check of prescriptions. And this area was kept clear of other items to reduce distractions. Computer-generated labels contained relevant warnings and were initialled by the dispenser and checker to produce an audit trail. The pharmacy used stickers to highlight higher-risk medicines so that staff members could make appropriate checks when handing out these medicines. This included checks about the expiry dates of prescriptions for all controlled drugs, so these medicines weren't supplied when the prescription was no longer valid.

Mistakes which reached people were recorded and reported to head office. There was a process to review these to understand how the incident had happened and to put in place improvement actions to prevent the same thing happening again. The way methadone doses were now prepared meant there were fewer doses made up at a time to reduce the possibility of errors such as supplying sugar-free mixture when the sugared version was required. Mistakes which had happened in other pharmacies were also shared with the team members so they could learn from them. A stamp highlighting medicines which looked or sounded alike (LASA) was applied to prescriptions so that dispensers and checkers were particularly careful when dispensing these medicines. There was a current focus on amlodipine and amitriptyline and these items had been moved well-apart to prevent selection errors. 'LASA' stickers had been applied to the storage locations.

Mistakes made during the dispensing process which were corrected before being handed out, known as near misses, were recorded. Members of staff were handed back incorrectly dispensed items to spot and rectify their own mistakes where possible. And they were encouraged to record their own mistakes. Records about near misses included some information about why the mistake had been made or other contributing factors. There was a process to review these alongside other incidents as part of the company's 'Safer Care' process every four weeks. Any patterns or trends were identified, and improvement actions were cascaded to the team.

Staff had a clear understanding of what they could and couldn't do if there was no pharmacist present. Members of staff wore uniforms and their job titles were included on their name badges to help people know who they were talking to. The team members were asking the necessary questions when handing out prescriptions and referred queries to the pharmacist throughout the visit. When asked, staff understood about sales restrictions for medicines containing co-codamol or pseudoephedrine. And they said they would refer queries about footcare to the pharmacist if the patient had diabetes.

The pharmacy had the appropriate insurances in place for its services. It asked customers for their views about its services through an annual survey. Responses to a survey from 2019 were displayed in the shop and were very positive about the pharmacy. During the inspection, a member of the public gave very positive feedback to staff about the service they provided. The pharmacy provided information to people about how they could raise concerns or complaints in one of the leaflets it displayed.

The pharmacy had policies to protect people's information and staff received regular training on this topic. There was a poster displayed telling people about the General Data Protection regulation and how their information would be used but this was a little obscured. Computer screens carrying people's information could not be viewed by the public. Confidential waste was separated from other waste and disposed of securely. The electronic patient medication record system was password protected and people used their own NHS smartcards to access electronic prescriptions and summary care records. Staff used the consultation room for more sensitive conversations with people. Prescriptions were stored out of sight and reach of the public.

To protect more vulnerable people, the pharmacy team members had read and signed procedures about safeguarding and this training was refreshed regularly. The pharmacist had completed level 2 safeguarding training. Information about safeguarding support agencies was available to staff in the event they had a concern. In most cases, concerns would be discussed with the superintendent's office first to make sure the appropriate next steps were taken. The pharmacy had recorded an incident where additional support for a person had been sought. The team also contacted patients' families if medicines couldn't be delivered to their homes as expected.

A notice giving details about the responsible pharmacist (RP) on duty was displayed where people in the shop could see it. The record kept about the RP was complete. Controlled drug (CD) registers were available and entries were up to date. Running balances were kept and were checked regularly. The recorded balance of an items chosen at random agreed with the physical stock. CDs returned by people for disposal were recorded on receipt and destroyed by the pharmacist in the presence of a witness soon after receipt. Private prescription records were made in a book reserved for this purpose and the records viewed were complete. Emergency supplies were made very infrequently but the records seen contained a good level of information to show why a supply had been made.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy team members work very closely together, and they are well-trained. There are enough of them to manage the workload safely and they receive good support in keeping their skills and knowledge up to date. They share and can implement ideas to make the pharmacy safer. And they learn from mistakes in an open and honest way. The team members have appropriate support in place should they need to raise any concerns about the pharmacy.

Inspector's evidence

The pharmacy team members were observed working closely together and communicating well with each other throughout the inspection. There was an obvious rapport amongst the staff and with the regular customers. And the staff appeared to manage their workload in a safe and competent manner.

A full-time, employed pharmacist provided the vast majority of responsible pharmacist cover at the pharmacy. She was supported by a full-time, non-pharmacist pharmacy manager. There were also three full-time healthcare partners (dispensers), two part-time dispensers, and a part-time medicines counter assistant. One of the dispensers was training to become a pharmacy technician and the rest of the team members had completed the required accredited training for their roles. The company provided various training resources to the pharmacy team to help the staff keep their skills and knowledge up to date. Most of this training was web-based; a recent topic was about CBD oil. There were also case studies shared with the team as part of the Safer Care process; a recent case study had been about medicines in pregnancy. The staff each had training records and the pharmacy manager tracked any training that was considered mandatory by the company to make sure it was completed. Time at work was set aside so that the staff could complete training during working hours.

The pharmacist explained that there was a process to swap tasks so that members of the team were fully competent in a variety of activities. An example given was that a recently qualified dispenser was given more time in the dispensary to practice her dispensing skills and other dispensers covered the counter at these times.

The team members had regular performance appraisals with their line manager. There was a whistleblowing policy in place and a confidential helpline if staff felt they needed to raise any concerns about the pharmacy. The team members said they would feel comfortable raising any issues with the pharmacist or manager in-branch and during regular staff huddles. They said they could also approach either the area team or superintendent’s office if needed. Staff explained about changes that they had suggested to make services safer and which had been adopted. These included preparing multi-compartment compliance packs one week ahead of time so the workload was more manageable and would allow for unplanned absences. The team was also making better use of the store diary to improve handover between team members. Staff said that suggestions were always welcomed.

The pharmacist appeared able to use her professional judgement when providing services. She explained that she could get support and advice from other pharmacists in the company if she had professional queries.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are suitable for the services it offers, and they are adequately maintained. The pharmacy has a consultation room which offers people more privacy for services and sensitive conversations.

Inspector's evidence

The registered premises comprised of a relatively large retail area at the front and a dispensary and staff area to the rear. The shop's fixtures and fittings were in good condition and the floor was clean and free of any obstruction or trip hazards. Customer seating was available in the retail area. There was also a well-screened and good-sized consultation room for people who wanted to have private conversations and for services including flu vaccinations. This room was signposted and was clean and bright. There was no confidential information displayed in this room and a chaperone policy for the use of this room was displayed.

There were two parts to the dispensary; one part was reserved for preparing multi-compartment compliance packs and was set away from shop so there were fewer distractions. Other prescriptions were assembled in an area of the dispensary just behind the medicines counter from where there was good visibility of the shop so the pharmacist could supervise sales.

The pharmacy was reasonably clean and tidy throughout and could be protected against unauthorised access. Fire doors were kept free of obstructions. Space in the parts of the dispensary close to the medicines counter was very limited. However, the dispensing workbenches were kept as clear as possible to reduce risks when dispensing.

There was adequate heating and lighting throughout the main premises and air-conditioning to control the room temperature. The pharmacy had sinks with hot and cold running water and handwashing equipment. A separate brick building to the side of the pharmacy was used to store sundries, non-prescription medicines, baby milk and waste awaiting collection. The building was secure but temperatures in this building were not monitored and there was no heating. It was very cold at the time of the inspection. The pharmacy was advised to monitor the temperatures to make sure they remained suitable for storing medicines and baby milk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team works together in an organised way to make sure the pharmacy's services are safe and are generally accessible to people. Members of the pharmacy team know about the checks they should make when supplying medicines which are higher-risk so people get the right advice about their medicines. The team checks its medicines regularly to make sure they are in-date. And they take the right action if there are safety concerns about medicines so these are not supplied to people.

Inspector's evidence

The entrance to the pharmacy was via two small steps making it more difficult for people with mobility problems. A ramp was considered unsuitable due to the proximity to a busy road. However, there was a bell at the entrance to attract the attention of staff if assistance was needed. The pharmacy's opening hours were clearly displayed. Leaflets and notices in the retail area provided information about the pharmacy and its services. Additional leaflets provided information to people about minor ailments. There was also a poster giving advice to people about coronavirus.

The pharmacist could offer the Community Pharmacist Consultation Service (CPCS), and people used this mainly at weekends when GP practices were closed. The pharmacist had prepared a folder which was kept in the dispensary so other locum pharmacists had information about the service readily to hand. The team members knew to check their emails for any referrals made to the pharmacy. For services offered under a patient group direction, including the flu vaccination service, the pharmacy had the current documents available and signed. And the pharmacist had completed the relevant training to provide the service safely.

The pharmacy delivered some people's medicines to their homes. It kept records about deliveries which included recipient signatures. This helped it show that the medicines had been delivered safely.

Some people who needed help managing their medicines were provided with multi-compartment compliance packs. People were usually assessed ahead of starting on this system by a lead person working for Cambridgeshire Community Service. The referral was then made to the pharmacy. This service was well-organised, with enough lead time to make sure the packs could be prepared safely and supplied on time. The pharmacy kept records about medicines, changes to medicines and administration times, hospital admissions and discharge notes. The team had focussed on keeping better records about these recently. Assembled packs included descriptions which allowed individual medicines to be identified. Patient information leaflets were supplied to people every four weeks. Staff preparing the packs understood the types of medicines that weren't suitable for inclusion in the packs, such as warfarin or hygroscopic medicines. There was a process to deal with mid-cycle changes so that obsolete packs were retrieved from patients. The packs were checked promptly by the pharmacist so weren't left unsealed for extended periods of time.

The pharmacy highlighted prescriptions for higher-risk medicines so checks could be made, and advice provided when these were handed out. Dedicated CD stickers were applied to prescriptions for these items so the date on the prescription was checked before handing out. The pharmacy's team members were aware about pregnancy prevention advice to be given to people in the at-risk group when they

were supplied with valproates. The pharmacy had the relevant educational materials and safety stickers to apply to dispensed medicines readily available. Checks had been made to make sure that the appropriate patient declarations were in place. The pharmacist explained that the team carried out audits about valproates every 13 weeks to keep their knowledge refreshed.

Pharmacy-only medicines were stored so they couldn't be self-selected by customers. Stock requiring cold storage was stored in a medicine's fridge. The pharmacy kept temperature records to make sure fridges stayed at the right temperature. The pharmacy stored CDs appropriately. Expired and returned CDs were separated from other stock and there were denaturing kits available for their safe disposal.

Medicines were obtained from licensed wholesalers or specials manufacturers. Medicines were stored in appropriately labelled containers. The pharmacy regularly checked its medicines' expiry dates. It kept records about completed checks and highlighted medicines if they were approaching their expiry dates. The date of opening was added to liquid medicines so dispensers could assess if these were fit for purpose in the future. Expired and returned medicines were segregated and placed in pharmaceutical waste bins. The medicines waste bins were kept safely away from other medicines.

The pharmacy had the equipment it needed to authenticate medicines as part of the Falsified Medicines Directive. The pharmacist explained that the staff needed refresher training before starting to use it. The pharmacy received messages from its head office about medicine recalls. It kept records about the actions it had taken. For example, recent alerts about ranitidine products had been received, stock had been checked, and an audit trail kept showing what the pharmacy had done about these.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities to provide its services safely. It carries out checks to make sure its equipment is working properly.

Inspector's evidence

Electrical equipment in the pharmacy was regularly safety tested and stickers used to track when testing was next due. The blood pressure meter was replaced every two years. And the blood glucose meter was checked using a control solution to make sure the results it provided were reliable. However, the control solution tests weren't carried out as frequently as the company suggested.

The pharmacy had multiple glass measures of a suitable standard to accurately measure liquids and these were all clean. Some were reserved for specific medicines to prevent cross-contamination. Equipment for counting tablets was also available and was clean. The pharmacy had up-to-date reference sources available on paper and on the internet. There was adequate fridge storage space for medicines which required refrigeration. The fridge temperatures were checked and recorded daily, and records showed the temperature ranges remained between 2 and 8 degrees Celsius.

Confidential information stored on computers could not be seen by people using the pharmacy. Computers were password protected to prevent unauthorised access to people's medication records. And the pharmacy had cordless phones, so staff could hold phone calls out of earshot of the public.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.