General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, George Clove Surgery, Swan Drive, CHATTERIS, Cambridgeshire, PE16 6EX

Pharmacy reference: 1029251

Type of pharmacy: Community

Date of inspection: 06/02/2020

Pharmacy context

This busy community pharmacy is located next to a doctors' surgery close to the centre of Chatteris. Most of the prescriptions it dispenses are issued by this surgery. It provides a range of other services including seasonal flu vaccinations, medicines deliveries, Medicines Use Reviews, emergency hormonal contraception, instalment supplies for people on substance misuse treatment, blood pressure checks and blood glucose testing. It also sells a range of medicines over the counter. The pharmacy is open 9am to 7pm Monday to Friday and does not open at weekends.

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	1.1	Good practice	The pharmacy is proactive about managing and identifying risks in the pharmacy to make sure its services are safe. It carries out regular audits to check procedures are being followed correctly. And it makes improvements to reduce risks during the dispensing process.
		1.2	Good practice	The pharmacy has good processes in place to review and monitor its services to make sure they are safe for people.
2. Staff	Good practice	2.2	Good practice	The pharmacy team members receive good support from the company to help keep their skills and knowledge up to date.
		2.4	Good practice	The pharmacy has an embedded culture of openness, honesty and learning. Its team members pro-actively review their dispensing processes when things go wrong so they can improve.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy provides its services safely. And it can show how its services have improved people's health.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy is proactive about managing and identifying risks in the pharmacy to make sure its services are safe. Its team members are encouraged to learn from their mistakes. And they review and monitor how the pharmacy is working, to continually improve. The pharmacy protects people's information well. It keeps the records it needs to by law. And its team members take the right actions to protect vulnerable people if they have concerns about people's welfare.

Inspector's evidence

The pharmacy used a range of approaches to manage risks associated with its activities. Pharmacy services were supported by written procedures and these were last reviewed in July 2019. The procedures included management of controlled drugs (CDs), responsible pharmacist (RP) procedures, dispensing higher-risk medicines, and sales of over-the-counter medicines. There was an audit trail to show that staff had read procedures relevant to their roles and were considered competent in these by the pharmacy manager. There were also internal audits to check that the team was complying with the company's procedures and good practice. These included checks that routines such as fridge temperature checks and controlled drugs (CD) balance checks were being done regularly.

Prescriptions were dispensed using baskets to prevent the inadvertent transfer of items between different people. Baskets of different colours were used to prioritise the workload and identify those items which could be accuracy checked by the accuracy checking technician (ACT). The pharmacist also marked prescriptions when he had clinically checked them which provided further assurance to the ACT that those prescriptions were suitable for her to check. Other staff, when asked, also had a clear understanding of their roles and responsibilities. Members of the team could explain what they could and couldn't do when the pharmacist was not present. They also knew the types of medicines that could be liable to abuse and under what circumstances they needed to refuse to supply or refer requests for these medicines to the pharmacist for further advice. The pharmacy displayed a notice showing who the responsible pharmacist (RP) on duty was and it kept a record showing who the RP had been.

Prescription labels were initialled at the dispensing and checking stages to create an audit trail showing who had been involved in these tasks. Areas of the pharmacy were used for separate tasks such as dispensing and checking prescriptions to reduce the risk of distractions. The pharmacy manager was aware of the potential risk presented by the size of the premises. Because of the limited space, this pharmacy did not prepare multi-compartment compliance packs. However, people needing this service were signposted to a sister branch in the same town.

Dispensing mistakes on medicines which were handed out were recorded and reported to the pharmacy's head office. Evidence was seen of recent reports. The pharmacy manager described how such events were managed, making sure people's care was prioritised and improvements made to reduce similar incidents happening again. He felt it was important for staff to record their own mistakes so they could reflect on how it had happened and what changes they should make in future to improve.

Staff said that any dispensing mistakes they made that were spotted before the medicines were handed

out (referred to as near misses) were pointed out to them. They were asked to rectify these themselves whenever possible and make records about these. There was evidence of near misses being recorded and reviewed regularly. The pharmacy followed the company's monthly 'Safer Care' process; incidents and learning points were shared with the team to reduce similar mistakes happening. Preventative actions included restarting the dispensing process if distracted part-way through. The storage locations of some medicines had been altered to reduce selection errors, particularly for medicines with similar names or packaging. The pharmacy also received case studies from their head office which highlighted particular risks to raise awareness. A recent case study had highlighted that amlodipine and amitriptyline had similar names and had been involved in dispensing errors elsewhere; this pharmacy had moved these items further apart as a result of this.

The pharmacy gathered customer feedback though an annual patient satisfaction survey; results of the survey conducted in 2019 were displayed and the 2020 survey was underway. The pharmacy had a complaints procedure and information about this was included in the pharmacy's practice leaflet. However, because of recent changes to the location of the leaflets, members of the public would have to ask for a leaflet rather than be able to self-select. This might deter some people from raising a concern.

There was a consultation room available for people who wanted to have a private conversation with the pharmacy staff and this facility was signposted. There were written procedures and staff training about protecting confidentiality. And there was a poster giving people information about the General Data Protection Regulation and how the pharmacy protected their information. But this was in the dispensary and was not visible to people using the pharmacy's services. Sensitive information was stored out of the reach and sight of the public and confidential waste was disposed of securely. The IT system was password protected. Staff used their own NHS smartcards and passwords to access electronic prescriptions and did not disclose passwords to each other.

The pharmacy had procedures to help make sure it took appropriate action to protect vulnerable people. A new policy had been sent to the pharmacy in October 2019 by their head office and this had been read by staff. Registrants had completed level 2 training about safeguarding. There was a chaperone policy for using the consultation room and a poster about this was displayed. Staff gave examples of how they had intervened when they had concerns about people who were confused about their medicines and the extra support that people had then received.

The pharmacy had current professional liability and public indemnity insurance. Records for private prescriptions, emergency supplies (rare), and CDs were available and complied with legal requirements. CD running balances were kept and checked regularly for accuracy. The pharmacy had a separate register for patient-returned CDs. These were recorded as soon as received and destroyed as soon as possible.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy's team members work well together, and they are suitably trained or are undertaking appropriate training for the roles they undertake. They are given good support by their company to help keep their skills and knowledge up to date. Pharmacy professionals use their judgement to make sure services are safe and effective. And team members are encouraged to learn from their mistakes to reduce risks in the pharmacy and make services safer.

Inspector's evidence

The pharmacy team had experienced quite a few changes over the past year as a result of extended leave and resignations, but this was starting to settle down. The pharmacy manager and ACT were very experienced and had been in post for quite a few years. The ACT explained how other members of staff were encouraged to take on new tasks, so responsibilities were shared across the team. It was busy throughout the visit. The pharmacy's team members were coping with the workload. They discussed queries with each other and referred to the pharmacist where needed.

The pharmacy team consisted of the pharmacy manager (the RP during the inspection), an ACT, three full-time trained dispensers, one trainee dispenser, two trained medicine counter assistants, and a trainee medicines counter assistant. Certificates for the accredited training and other courses completed by staff were displayed in the consultation room. The company provided ongoing training to staff to help them keep their skills and knowledge current. These included updated SOPs, and eLearning modules which were issued to the team every month. Some of this training was considered mandatory by the company. There were quizzes at the end of some of the training to check that staff had understood the training. And completion of mandatory training was tracked to make sure it was done. Staff said they got time at work to do training.

When asked, the team members said they had regular discussions about any issues or incidents in the pharmacy, so they could share learnings. One of the dispensers explained how she and a colleague had started to use a new way of making sure they had selected the right medicine for a prescription, and they were finding this helpful. There were regular morning huddles to pass on information and a staff notice board to convey messages to people who couldn't attend the meetings. The team said they could make suggestions about how to improve the pharmacy and these would be acted on where appropriate. They also felt comfortable about raising any concerns with the pharmacy manager and area managers who visited the branch. Members of staff had appraisals every year to check on their progress and performance in addition to regular informal discussions with the pharmacy manager.

The pharmacy manager was able to exercise his professional judgement and act in the best interests of his patients. The pharmacy sent a small proportion of prescriptions to an offsite dispensing hub. People were informed about this in advance and the pharmacy sought their consent before doing so. The pharmacy manager said that prescriptions were only sent on certain days of the week so the pharmacy could be sure of receiving the items back in time for people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are safe, secure, and suitable for the services it provides. The premises are accessible to people with mobility problems.

Inspector's evidence

The premises were relatively small for the volume of prescriptions dispensed and this meant that storage space for medicines was quite cramped in places. The pharmacy was reasonably clean and maintained to a suitable standard. The premises could be secured outside of opening hours and were accessible to people with mobility issues or those with prams or wheelchairs. There were two seats for people waiting for services. However, the waiting area was very small and could get quite congested at busy times. This also made it harder for staff to protect people's privacy.

The dispensary was clearly separated from the shop area and access by the public was suitably restricted. Dispensed medicines were protected from public view. Sections of the dispensary were reserved for specific activities to reduce risks in the dispensing process. The dispensary, benches and prescription storage areas were reasonably well-organised.

Room temperatures in the premises were controllable, and levels of ventilation and lighting were appropriate for the activities undertaken. The dispensary sink used for preparing medicines was clean and had hot and cold running water. There were handwashing facilities available for staff. A well-screened consultation room was available and signposted. There was no patient identifiable information on display in the room. Equipment used for services was stored securely.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people with different needs. Overall, it provides its services safely. It takes particular care with medicines that may be higher-risk so people get the advice they need. And it refers people to other healthcare providers when this is needed. To ensure its medicines are fit for purpose, the pharmacy gets them from reputable sources and generally stores them correctly. But it doesn't always keep a record of when it date checks its stock. So, it may be harder to know that all stock is checked regularly.

Inspector's evidence

The pharmacy's opening hours were displayed at the entrance. The main entrance door was power assisted and level with the pavement. There was onsite parking for patients. The pharmacy offered a prescription delivery service to help housebound and elderly people get their medicines. There were records kept for the prescription delivery service and these included signatures from recipients. Other services were advertised to people through posters and leaflets on display but some of the leaflets were behind the counter so could not be self-selected by people visiting the pharmacy. There were also some posters giving information about other healthcare support services or services not provided by the pharmacy. A poster about coronavirus was displayed. The pharmacy was equipped with an induction hearing loop to help people who had hearing aids. The team members also described other ways they tried to help people, for example, by using a language dictionary to translate advice.

Dispensing was carried out in an orderly way. Prescriptions for higher-risk medicines were flagged using alert stickers so staff could make appropriate checks when handing these out. The pharmacy manager also kept a record sheet to show that the staff were making these checks in practice. There was evidence that the correct alert stickers were used. And, when asked, the team members knew how long prescriptions for Schedules 2, 3 and 4 CDs were valid for and the questions to ask when handing out warfarin. The pharmacy manager knew about the advice to give to people about pregnancy prevention when supplying valproate medicines. There was a specific SOP for supplying these medicines. The pharmacy had completed an audit of its patients. And it had the relevant educational literature available to give to people.

The pharmacy manager had completed the necessary training for the services offered under patient group directions (PGDs) including the flu vaccination service. The pharmacy kept copies of the PGD documents so these could be referred to when providing the services. Due to manufacturing issues with adrenaline auto-injectors, the pharmacy had adrenaline vials available as an alternative to treat possible anaphylactic reactions following a flu vaccination. The pharmacy kept syringes and needles with the vials, so they were readily accessible.

A dispenser explained their involvement in blood pressure checks. They had been trained to provide the service and knew how to make the appropriate records. They also understood the need to involve the pharmacist, especially if the person's readings were outside the usual range. An example was given about a person whose blood pressure was very high when tested. The person was also displaying other signs linked to high blood pressure. The pharmacy had referred the person to their GP, and they were now taking medicines to reduce their blood pressure.

Medicines were obtained from licensed wholesalers and specials were obtained from specials manufacturers. No extemporaneous dispensing was carried out. The storage space in the dispensary was limited which meant there was very little space between different items. Pharmacy-only medicines were stored out of reach of the public. The medicines fridge was equipped with a maximum and minimum thermometer. Temperatures were checked daily and recorded and the recorded temperatures were within the appropriate range. The pharmacy had the equipment needed to authenticate medicines, in line with the Falsified Medicines Directive but the team was not yet using it. Some training about this had been done.

Date checking was said to be carried out regularly though records about this were not always kept up to date. The company process was to date check stock every three months, but the records had not been updated for some sections since July and August 2019. Stickers were usually applied to short-dated medicines so they could be readily identified when dispensing and date checking. One date-expired medicine was found amongst dispensing stock when a sample of items were checked at random; this had not been highlighted. Out-of-date medicines and patient-returned medicines were transferred to designated bins and stored separately from dispensing stock. Most medicines were kept in appropriately labelled containers though one container was found to hold mixed batches and the pack had not been marked to show this. This could make it harder to locate recalled medicines. It was removed from the shelf when this was pointed out. Appropriate arrangements were in place for storing CDs securely.

The pharmacy could show that recent drug recalls and safety alerts had been received and appropriate action had been taken to protect people's health and wellbeing. There was an audit trail to evidence that the pharmacy had received recent recalls involving ranitidine products and had removed affected stock from sale.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the equipment and facilities it needs to provide its services safely. It makes regular checks to make sure its equipment is working properly.

Inspector's evidence

Measuring equipment of a suitable standard was available; some glass measures were marked for specific use to prevent cross-contamination. A counting triangle was reserved for methotrexate only. There was a range of up-to-date reference sources available to assist with clinical checks and other services. All portable electrical equipment was safety tested each year. The pharmacy had a blood pressure meter; this device was changed every two years. The blood glucose meter was checked regularly using control solutions to make sure it was giving reliable results.

Patient medication records were stored electronically. And there was access to these records in the consultation room. Screens for the pharmacy computers were not visible to the public. The pharmacy had cordless phones and team members could make phone calls out of earshot of waiting customers if needed.

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.