General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 22 Manchester Road, Woolston, WARRINGTON, Cheshire, WA1 3PP

Pharmacy reference: 1029844

Type of pharmacy: Community

Date of inspection: 19/06/2019

Pharmacy context

This is a community pharmacy in the village of Woolston in Warrington, Cheshire. The pharmacy mainly sells over-the-counter medicines and dispenses NHS and private prescriptions. It also provides a range of services such as blood pressure monitoring and diabetes testing, medicine use reviews (MURs) and the NHS new medicines service. And it supplies medicines in multi-compartmental compliance packs to people living in their own homes.

Overall inspection outcome

✔ **Standards met**

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has processes and up-to-date procedures to help the team manage the risks to services. And it keeps the records it must by law. It advertises how people can provide feedback and raise concerns and listens to their feedback to make improvements for people accessing the pharmacy. The pharmacy keeps people's private information safe. It has processes available to its team members, to help them protect the welfare of vulnerable people. The team does not always record details of the errors that happen with dispensing. And so, the team members may miss the opportunity to learn from mistakes and improve services.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. They were stored in a folder with an index at the front. Which made it easy to find a specific SOP. The SOPs were due for their next review in August 2019. All the team members had read the SOPs that were relevant to their role. Each team member had a list of the SOPs which were relevant to their job. The team members said they would ask the pharmacist if there was a task they were unsure about or felt unable to deal with.

The pharmacy had implemented the company's Safer Care requirements to help improve patient safety. This involved the team completing rotating weekly checks over three weeks and it included checks on the pharmacy environment and staffing. A Safer Care briefing was completed on the 4th week. The briefing focused on any issues found. The Safer Care checks were seen to be completed weekly.

A process was in place to report and record near miss errors that were made while dispensing. The pharmacist typically spotted the error and then made the team member aware of it. And then asked them to rectify it. The team member who made the error then recorded the details of the error on a log. The details recorded included the time, date and cause of the error. The regular pharmacist analysed the near misses each month. And the findings were documented and discussed with the team during a monthly team meeting. The team had recently separated olanzapine and oxazepam, and propranolol 10mg and 40mg after a series of picking errors. A dispenser said that this had stopped these medicines getting mixed up. The team did not always record every error that was spotted. This was due them often being too busy to do so. The dispenser on duty said that on average the pharmacist picked up on at least one error a day. But only five errors had been recorded in June 2019. The pharmacy had a process in place to record, report and analyse dispensing errors that had been given out to people. It recorded the details of the errors on to an electronic reporting form called PIMS and the form was sent to the superintendent pharmacist’s team to be analysed. The form was printed and filed for future reference. The details recorded included the reason why the error had happened and what the team had done to prevent similar errors happening in the future. Five dispensing errors had been recorded in the last 12 months. The most recent error involved the pharmacy supplying the person with the incorrect strength of gabapentin. The review of incident recorded that a review of the dispensary shelves was completed to prevent the error happening again. But it was unclear from looking at the dispensary shelves what had been done.

The pharmacy had a leaflet of how people who used the pharmacy could make a complaint. But the leaflet was stored in the consultation room. And so, was not easily accessible for people to self-select.

The pharmacy obtained feedback from people who used the pharmacy, through a community pharmacy questionnaire. The team members said the feedback they received was generally positive. The pharmacy displayed the results of the latest survey on a wall in the retail area. So, they were easy for people to see. The waiting area was identified requiring improvement. The team had installed an additional chair as a result.

The pharmacy had up to date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. For the sample checked, the responsible pharmacist register was correctly completed each day. A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries made in chronological order. Running balances were maintained and audited every month. A random CD item was balance checked and verified with the running balance in the register (Oxynorm Solution X 400ml). The pharmacy recorded the destruction of patient returned CDs. The pharmacy kept complete records of private prescription supplies and supplies of unlicensed medicines. The pharmacy kept complete records of medicines that were supplied to people in an emergency.

A privacy policy was on display in the retail area. It outlined how the pharmacy protected their private information. The pharmacy had an information governance (IG) policy in place. It contained information on how the team should protect people's information and data. The team were clear of the importance of protecting the confidentiality of the people they provided services to. The pharmacy stored confidential waste in separate containers. The waste was collected by a third-party contractor who arranged its destruction.

The pharmacist on duty had completed training on safeguarding the welfare of vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). Other team members had completed a company training course. The team members gave several examples of symptoms that would raise their concerns. A safeguarding incident handling and reporting policy was available to the team. And all the team members had signed it. The team explained that they would always bring any potential concerns to the attention of the on-duty pharmacist. The team said that they had not had any concerns to deal with to date.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the right skills and qualifications to undertake the tasks within their roles. The team members receive regular performance appraisals. During which they can discuss their development and set personal goals. Many of the pharmacy team members are new to their roles and in-training. This puts pressure on the team at times to manage the dispensing workload. There is a risk if the team members don't get the necessary support and also time for training this will impact on the team and people using pharmacy services.

Inspector's evidence

At the time of the inspection, the team members present were a locum pharmacist, one NVQ2 qualified pharmacy assistant, a trainee pharmacy assistant, and a counter assistant. Other team members who were not present included the resident pharmacist, who was also the pharmacy manager, a trainee pharmacy assistant, a pharmacy assistant and a counter assistant. The team members often worked overtime to cover both planned and unplanned absences. They were not permitted to take time off in December, as this was the pharmacy's busiest period.

The pharmacist supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team was aware of what could and could not happen in the pharmacists' absence.

The pharmacy was experiencing difficulties maintaining the correct level and skill mix of team members. The difficulties had been happening for almost 12 months. This was because two long-term and experienced team members had left the business. These team members had been replaced with others, but they were enrolled on training courses and were not currently involved in the dispensing process. The pharmacy was aiming for these team members to start dispensing within the next three to six months. Every Monday and Wednesday the on-duty pharmacist was supported by only one dispenser. And the pharmacist worked with only one counter assistant after 5.15pm on Mondays. This was a quieter period, and so the pharmacist did not have to self-check many prescriptions.

On the day of the inspection the dispenser was seen to be working through an heavy workload that was becoming increasingly difficult to manage. But the assistant had coped well with the situation. Three phone calls from people went unanswered when the pharmacy assistant took her lunch break.

The pharmacy did not have structured process to help its team members to engage in ongoing learning. The team had access to an online learning programme. The programme consisted of several modules that the team worked through. The modules were often mandatory and were based on various topics or new SOPs. Other modules could be completed voluntarily and were could be done when team members wanted to learn about a certain healthcare topic. But the team did not have the opportunity to regularly train at the moment due to the pressures of the dispensing workload.

The team members were scheduled to have a team meeting every month. The meetings were for the team to discuss, errors, company news, concerns and to give feedback on how they can improve the services. But the meetings had not formally taken place since the beginning of the year.

The pharmacy had a structured performance appraisal process in place. The appraisals were a one-to-one conversation between a team member and the pharmacist. The appraisals were an opportunity for the team member to discuss what they enjoyed about their job and what they wanted to achieve in the future. They were set goals to achieve by the time the next appraisal took place.

The team members confirmed that they were able to discuss any professional concerns with the pharmacist. And they were aware of how they could raise concerns externally if they required. A whistleblowing policy was in place. So, team members could raise a concern anonymously.

The pharmacy set the team some targets to achieve. These included NHS prescription items and MUR consultations. The team said they strived to achieve the targets, but they often didn't due to the dispensing workload. The team members said that the company was understanding of this.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy dispensary and retail area appeared clean, hygienic and well maintained. The floor spaces were clear and there were no obvious trip hazards. There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a WC and a sink on the first floor with hot and cold running water and other facilities for hand washing. The area was free of clutter. The pharmacy had a sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. The lighting was bright, and the temperature was comfortable throughout inspection. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people and it provides services to support people's health needs. The pharmacy sources its medicines from licenced suppliers. And it generally stores and manages it medicines appropriately. It completes date checks of its medicines regularly, so it can make assurances its medicines are fit for purpose.The pharmacy has robust procedures that the team members follow when they dispense medicines into multi-compartmental compliance packs. They provide some information with these packs to help people know when to take their medicines and to identify what they look like. But sometimes this information isn't specific enough to allow people to identify their medicines.

Inspector's evidence

The pharmacy had level access from the street. The pharmacy advertised the services it offered via displays in the main window. It provided seating for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer.

The team members attached stickers to the prescriptions during the dispensing process to alert the pharmacist during checking of any issues, interactions or new medicines. And this also alerted team members during the hand out process, for example to the presence of a controlled drug or fridge line. The pharmacy had an audit trail for dispensed medication. The team achieved this by using dispensed by and checked by signatures on dispensing labels. The team members used separate areas to undertake the dispensing and checking parts of the dispensing process. They used baskets to keep prescriptions and medicines together. This helped prevent people’s prescriptions from getting mixed up. The team piled several baskets containing prescriptions to be dispensed, on top of each other. The pile gradually increased during the inspection.

The team members identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling if the pharmacist felt there was a need to do so. But details of these conversations were not recorded on people’s electronic medication records. So, the pharmacy could not demonstrate how often these checks took place. The pharmacy did not always assess the INR level. The pharmacist said that he had given counselling to a person who was taking methotrexate on the day of the inspection. The team knew about the pregnancy prevention programme for people who were prescribed valproate. The team said that they knew about the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had completed an audit to identify people they regularly supplied valproate to. But the team did not have access to information cards about the programme that they could provide to people. This is not in line with the requirements of the programme.

People could request for their medicines to be dispensed in multi-compartmental compliance packs. The team members dispensed the packs in a separate area at the back of the dispensary. They said that this was to prevent them from having to break off from dispensing to serve people who were waiting in the retail area. The team were responsible for ordering the person’s prescription. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team queried any discrepancies with the person’s prescriber. The team recorded details of any changes, such as dosage

increases and decreases. The team supplied the packs with backing sheets which contained dispensing labels and information which would help people visually identify the medicines. But they were not always clear. For example, a backing sheet was seen that described three separate medicines as 'white square tablet'. And so, people would struggle to differentiate between them. The team supplied patient information leaflets to people each month as required by law.

The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. The pharmacy supplied people with a note when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy gave people owing slips when it could not supply the full quantity prescribed. One slip was given to the person and one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day.

The team checked the expiry dates of stock every three months and the team kept a record of the activity. The records were complete. No out of date medicine were found following a random check. The team used alert stickers to highlight any stock that was expiring in the next 6 months. The date of opening was recorded on liquid medication that had a short-shelf life once opened. The team were not currently scanning products as required under the Falsified Medicines Directive (FMD). The pharmacy did not have any software installed to assist the team to comply with the directive. The team members had received any training on how to follow the directive. Pharmacy only medicines were stored behind the pharmacy counter and in two glass cabinets at the side of the counter. The glass cabinets at the side of the counter were unlocked and could be opened by people without any help. The cabinets had a note on the front reminding people to ask for assistance if they wanted to choose any of the medicines inside. The team used digital thermometers to record fridge temperatures each day. A sample of the records evidenced temperatures were within the correct range.

The pharmacy obtained medicines from several reputable sources. It received drug alerts via email and the team actioned them. The pharmacy kept records of the action taken after the alert. But the records were not available for inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The equipment and facilities the pharmacy uses in the delivery of services are clean, safe and mostly protect people’s confidentiality.

Inspector's evidence

The pharmacy had several reference sources available. And the team had access to the internet as an additional resource. The resources included a hard copy of the British National Formulary (BNF). The pharmacy used a range of CE quality marked measuring cylinders. And ones that were only used for dispensing methadone. The medical fridges were of an appropriate size. The medicines inside were well organised. The computers were password protected and access to people's records were restricted by the NHS smart card system. And computer screens were adequately positioned to ensure confidential information wasn’t on view to the public. The computers were password protected.

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.