General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, South Grange Medical Centre, Trunk Road, Eston, MIDDLESBROUGH, Cleveland, TS6 9QH

Pharmacy reference: 1029965

Type of pharmacy: Community

Date of inspection: 08/10/2019

Pharmacy context

The pharmacy is on a busy road in Eston, Middlesbrough. It is attached to a busy health centre. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy offers a prescription collection service from local GP surgeries. And it delivers medicines to people's homes. And it provides NHS services such as flu vaccinations and a substance misuse service.

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	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. The pharmacy's team members record and report any errors made when dispensing. 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.

Inspector's evidence

The pharmacy had a small sized retail area. And the dispensary was small. Pharmacy team members made the best use of the space available. The pharmacy had a set of up-to-date standard operating procedures for the team to follow (SOPs). And these included SOPs for dispensing controlled drugs (CDs), responsible pharmacist (RP) and services provided from the pharmacy. There was a record of competence for each member of staff. And these were signed to indicate that team members had read and understood SOPs. The Superintendent (SI) had authorised the SOPs. Pharmacy team members had only signed the SOPs relevant to their level of expertise. Pharmacy team members demonstrated understanding of the contents of SOPs. A process was in place to report and record near miss errors that were made while dispensing. The checker spotted the error and then made an entry of the date of the error. And the team member who made the error recorded details such as what happened, the contributory factors and the lessons learned. The records showed that some of these sections were blank and the rest had generic comments such as “don’t rush” and “double check”. The responsible pharmacist said that she was aware that the pharmacy team members were not always recording enough detail, and this made making a meaningful review and effective change more difficult. She said that this was something the team were working on. The safer care champion analysed the near misses each month. And the findings were discussed with the team during a monthly team meeting. The pharmacy team members made some changes to try to reduce the risk of a similar error occurring. For example, some of the look-alike sound alike drugs has been marked with a warning sign. And some were separated into red baskets with a warning. This was seen on the quinine and quetiapine. The RP said that she had noticed that some members of the pharmacy team were selecting the wrong insulin preparations. So, when the pharmacy was quieter she showed the team the different preparations such as insulin cartridges, pens and vials. She also discussed the different types of insulin and the strengths. She thought that the number of wrong selections of insulin had reduced.

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. The file was tidy and ordered. There had been an error when in August when a patient had been supplied with a sodium valproate and it was labelled as 12 millilitres to be taken twice a day. However, 11 millilitres were required. The dispensing assistant had made an error when converting the requested milligrams on the prescription to millilitres. A root cause analysis and a reflective statement had been completed. And these were in the file. To help to prevent this happening again a second check of the calculation was

now required before the prescription was presented to the pharmacist for checking. The pharmacy had a leaflet of how people who used the pharmacy could make a complaint. 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 results of the questionnaire were displayed in the pharmacy and showed that 97% of people thought that the overall service they received was either excellent or good. Some people had expressed dissatisfaction about waiting times. As a result of this red baskets were consistently used to indicate that a person was waiting in the shop for their prescription and these were dealt with in order. This was seen to be the case during the inspection.

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 week. 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. Unlicensed special records were retained in order in a marked file. Certificates of conformity, invoices and patient details were retained together.

Pharmacy staff had completed information governance training. A statement that the pharmacy complied with the Data Protection Act and the NHS Code of Confidentiality was found in the pharmacy's practice leaflet. Confidential waste was segregated. The team said that the waste was collected and destroyed off site. A team member demonstrated their understanding of data protection and the ways in which people's confidential information was protected. The pharmacy's team members had completed training about safeguarding vulnerable adults and children. The contact details for local safeguarding organisations were displayed on the wall. And there was a flow chart for dealing with a safeguarding concern. The team explained that they would always bring any potential concerns to the attention of the 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 team are knowledgeable and skilled. The pharmacy team members keep their skills up to date through regular training. And they work well together in an open and honest environment. The pharmacy provides regular feedback to team members about their performance and helps to identify any training needs.

Inspector's evidence

The pharmacy team, on the day consisted of the RP who was a company employed and worked two days in the pharmacy along with another regular pharmacist who worked three days a week. There were also three dispensing assistants and a medicines counter assistant. The pharmacy team members thought that they usually managed with the current staffing levels. Holiday cover was not usually provided. But the pharmacy team members thought they managed. The pharmacy was busy and there was a constant stream of people bringing prescriptions from the attached surgery. The pharmacy team coped well taking in prescriptions and prioritising those whose were waiting for their prescriptions. And keeping the people updated about wait times. And reminding the pharmacist when call back people had returned.

Training was provided through the My Learn system. Members of the pharmacy team said that they were up to date with their mandatory training. The pharmacy team had recently completed emergency hormonal contraception (EHC) training. The manager monitored compliance. The pharmacy was a healthy living pharmacy and three members of the team had completed this so that they could offer and advice and support to people about healthy living and lifestyle choices. The pharmacy teams' performance was reviewed, and each member had received a performance review. Personal development was discussed. A team member said that they had My pad review in April.

The pharmacy team offered evidence during the inspection and spoke in a confident open manner. The pharmacy team thought that the manager was approachable and reported that they worked together as a team. They felt able to make suggestions. Dispensing incidents were discussed as they occurred, and the safer care champion did monthly safer care update. The RP said that targets were set for services such as MURs and these were done when time allowed. And for the benefit of people accessing the service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and adequately maintained. It has a sound-proof room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The retail area and the dispensary were small. The pharmacy was professional in its appearance. And was generally clean, hygienic and adequately maintained. Although the carpet and hard flooring would benefit from cleaning. Floor spaces were clear with no trip hazards evident. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. The working benches area were free of clutter. The pharmacy was well lit, and the temperature was comfortable during the inspection. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities, a desk, chairs and a computer. The room was professional in appearance. The door did not lock. But there was no confidential information on display.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. The services are generally well managed. It generally stores, sources and manages its medicines safely. And it identifies and manages most risks adequately. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. And it makes sure that its medicines and devices are safe to use. The pharmacy may not always give advice to people who get higher-risk medicines. And when they do they don't always record it. So, it may not be able to refer to this information in the future if it needs to.

Inspector's evidence

There was direct access from the street into the pharmacy. The pharmacy advertised its services and opening hours in the window. Seating was provided for people waiting for prescriptions. A range of healthcare related leaflets were available for people to select and take away. An audit trail was in place for dispensed medication using dispensed by and checked by signatures on labels. The dispensary was small. But the pharmacy team members made the best use of the space. And they had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. Coloured baskets were available to hold prescriptions and medicines. This helped the team to stop people's prescriptions from getting mixed up. The team sometimes identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling by the pharmacist if there was time. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place.

The team were aware of the pregnancy prevention programme for people who were prescribed valproate. And a had completed two audits to identify people who may be eligible. There were patient information leaflets and advise cards positioned near the labeller on the checking bench. So that they could be supplied to people receiving a valproate prescription. People could request multi-compartmental compliance packs. And these were supplied to people to help them take their medicines at the right time. These were prepared at a nearby branch and returned to the pharmacy checked and sealed for handout. There was a protocol in place for this. The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included an electronic signature of receipt. A separate delivery sheet was used for controlled drugs. Owing slips were usually given to people on occasions when the pharmacy could not supply the full quantity prescribed. But they had run out and were on order. In the meantime, the pharmacy team members were sticking the owing label on paper and giving one to the customer and keeping the other with the prescription.

Stock was arranged on shelving. The shelves were overcrowded in some places. The team checked the expiry dates of the stock every three months. And the team kept records of the activity. The team used stickers to highlight medicines that were expiring in the next six months. For example, Carbogen was marked as due out of date in November 2019. The team recorded the date the pack was opened on liquid medicines. And this was noted on the oramorph liquid which was marked as opened on 4 October 2019. This allowed them to identify medicines that had a short-shelf life once they had been opened. And check that they were fit for purpose and safe to supply to people.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). Scanners were in place. The team members had not received training yet, And the pharmacy team were unsure if there were SOPs in place for this. Fridge temperatures were recorded daily, for both fridges, using a digital thermometer. A sample of the records were looked at found that they were within the accepted range. The pharmacy obtained medicines from several reputable sources. Drug alerts were received electronically. The pharmacy kept a record of the action the team had taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe, and the pharmacy uses it appropriately to protect people's confidentiality.

Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. There were four marked measures for measuring methadone. Tweezers and gloves were available to assist in the dispensing process. The fridges used to store medicines was of an appropriate size. Prescription medication waiting to be collected were stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't on view to the public. The computers were password protected. Cordless phones assisted in undertaking confidential conversations. Members of the pharmacy team had their own NHS smart cards. And were using these appropriately.

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.