General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 2 Tadworth Parade, Elm Park, HORNCHURCH, Essex, RM12 5AS

Pharmacy reference: 1031222

Type of pharmacy: Community

Date of inspection: 21/05/2019

Pharmacy context

This is a pharmacy situated in a shopping parade. It dispenses NHS prescriptions and offers an anticoagulation monitoring and supply service. It supplies medicines in multi-compartment compliance aids to a number of people to help them take their medicines safely. And it also supplies medicines as part of an online doctor's 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	1.2	Good practice	The pharmacy proactively reviews dispensing incidents and continuously learns from them.
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 generally identifies and manages the risks associated with its services. It largely keeps all the records it needs by law. The pharmacy's team members understand their role in protecting vulnerable people. They undertake regular training to keep people's information safe. They are good at recording and learning from any mistakes. This helps them make the pharmacy's services safer.

Inspector's evidence

Up-to-date standard operating procedures were available which had been read by all team members. Team members had individual records of competence. Team roles were defined within the SOPs. The locum pharmacist said she had been asked to read the SOPs when she had initially started working with Lloyds. She said that now all locum bookings were made via the 'venlock' system which the company used to communicate any changes, updated SOPs and requested training to be completed. The pharmacist said that this system had been used to highlight changes in dispensing sodium valproate. Pharmacists were not able to book shifts until the required action had been taken.

Near misses were brought to the attention of the person who had made the mistake, rectified and recorded on the near miss log. Entries were made on the log by the person who had made the error. These were then reviewed at the end of each month as part of the 'Safer Care' audit.

As part of Safer Care, different audits were completed each week looking at different aspects ranging from environmental factors to training completed by the team. A briefing was completed in the third week where the Safer Care Champion held a huddle in the morning when most of the team members were working. The week prior to the inspection the team had discussed a near miss in which two medicines (amlodipine and anastrozole) had been mixed. The team had identified these as look alike sound alike medicines and brought it to the attention of all team members and a note was left for Saturday staff. As a result of previous briefings different strengths of amitriptyline tablets had been separated. The dispenser said that when something was mis-picked the team usually separated the two items by placing something else in between. Drawers used to store medicines had also been labelled with warning stickers asking the team to take care when picking certain medicines. The briefing document was signed by all team members. The dispenser said that they had been asked by the regular pharmacist to let her know if they were finding anything difficult.

Dispensing incidents were reported on an internal system. Team members involved were required to complete a reflective account. And a root cause analysis was also completed which was sent to the superintendent's office, with a copy filed in the dispensary. As a result of an incident where the incorrect quantity of tramadol had been dispensed due to the similarity in pack size, both had been moved to separate drawers. The team said that for this incident the GP had also been informed and as a controlled drug (CD) was involved a separate CD incident report was completed and the Accountable Officer was also informed. If a locum was involved in a dispensing incident they were notified by the superintendent's office.

The pharmacy had started sending some prescriptions to be dispensed at the Lloyds 'hub', which was a central dispensing facility. Before a team member was authorised to enter data to be transmitted to the hub, they were required to dispense 200 items without making any errors. After this they were signed off by the area manager. The pharmacy had started sending prescriptions to the hub approximately a

month before the inspection. The team said that they had not seen a massive difference in terms of workload as it was still relatively new and there was a very small number of prescriptions which were eligible to be sent.

The correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. Professional Indemnity insurance was in place.

The pharmacy had a complaints procedure and also completed an annual patient satisfaction survey. The pharmacist said that they would try and resolve complaints in store where possible. Complaints were reported on an internal system. The pharmacist could not think of any changes that had been made as a result of feedback. As most feedback had been in relation to stock availability, which was outside of the pharmacy's control.

Records for private prescriptions, emergency supply, unlicensed specials, RP records and controlled drug (CD) registers were well maintained. CD balance checks were carried out weekly. A random check of a CD medicine complied with the balance recorded in the register. CD patient returns were recorded in a register as they were received.

Assembled prescriptions were stored away from the view of people who used the pharmacy. The dispensary team had individual Smart cards. The RP had access to Summary Care Records and consent to access these was gained verbally. The pharmacy had an information governance policy in place and all team members were required to read the confidentiality agreement. The team had also completed a 'MyLearn' (the pharmacy's online training system) module on the General Data Protection Regulation (GDPR). The RP said that the team had looked through the information governance action pack.

A safeguarding folder was kept in the dispensary and details of local contacts were displayed in the dispensary. The pharmacists and technicians had completed level 2 safeguarding training and team members had completed training on the MyLearn.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services provided, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively. And they refer to the pharmacist if they are unsure.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the RP (a locum pharmacist), two trained medicines counter assistants (MCAs), an accuracy checking technician (ACT) and the pre-registration trainee (pre-reg). The store-based pharmacist had been doing home visits as part of the INR monitoring service and came partway through the inspection. Team members said that it was usually busier in the morning, so they had two dispensers. They also had two pharmacists on Friday when it was busy.

The pharmacist said that there were enough staff in the dispensary but since an MCA had left, dispensary staff had to support by covering the counter if any counter staff called in sick. The pharmacy was in the process of recruiting new counter staff.

The MCA described the questions she asked before recommending over the counter medication. She would refer to the pharmacist when faced with a request for multiple sales. She described handing out prescriptions in line with SOPs and said that she would show the pharmacist a prescription for pregabalin before handing it out.

Team members had annual appraisals; as part of these targets were set in line with the company's key performance indicators (KPIs). A discussion was held as to how the team member could support the pharmacist to deliver the branch's KPIs. And the RP would also look at training needs and check if the team member needed any support.

To keep up to date team members completed e-Learning on My Learn; this had new modules to complete each month. Team members were given half an hour training time each week. In the past, training completed had covered the new Clarinase spray, and Syndol as it had come back in stock after some time.

Team members undergoing formal training courses had training time and also had time where they could sit down with the pharmacist. The pharmacist said that trainees usually worked through their books. And made notes on areas that they were uncertain about and then asked the pharmacist or spoke to their colleagues. The pre-reg attended monthly training sessions and had allocated study time in store. He said that he was well supported by the tutor.

The team received information from head office via emails and received a 'daily dose' (a daily email with updates), as well as a summary of the week on Friday. These contained information of changes and incidents which may have occurred. Safer Care case studies were also received which were discussed by the team as part of the huddle. The pharmacist said that as team members worked different shifts, things were discussed as they came up and other team members would be briefed when they started their shifts.

Team members said that they were able to provide feedback. The locum pharmacist felt able to give

feedback if she was not happy. The RP said that locum pharmacists were not set any numerical targets for services provided by the pharmacy. The pharmacy had targets set, and she would help to support the team to meet them. The store-based pharmacist said targets were in place for the services offered and an email was usually sent at the beginning of the week. She said that pressure to meet the targets had eased off. The pharmacist would not let the targets affect her professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure, and maintained to a level of hygiene appropriate for the pharmacy's services.

Inspector's evidence

The premises were clean and the pharmacy was bright and airy. The dispensary was clean and organised and had ample workbench space which was allocated for certain tasks. Cleaning was done by the team members who used a rota. A separate area was dedicated to preparing multi-compartment compliance aids at the back. A sink was available. Medicines were held in drawers in a tidy and organised manner. Pharmacy only medicines were stored on the shop floor in perspex boxes.

The consultation room had a wide door suitable for wheelchair users and was clean and tidy. It was accessed from the side of the medicines counter. The door was closed when the room was not in use. On the day of the inspection the regular pharmacist had been running the INR clinics and there was a basket with warfarin in the room. These were brought into the dispensary during the course of the visit.

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of healthcare. Air conditioning was available to regulate the temperature.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally delivers its services in a safe and effective manner. It obtains its medicines from reputable sources. And it generally manages them appropriately so that they are safe for people to use. The pharmacy's team members are helpful and give advice to people about where they can get support. They also make sure people have all the information they need so that they can use their medication safely.

Inspector's evidence

Access to the pharmacy was via large automatic doors at street level; there was also ample room in between aisles to manoeuvre wheelchairs or prams. The counter had a hearing aid loop installed. There was a wide range of leaflets and posters advertising services provided. The team were aware of the need to signpost people to other providers if a service was not available at the pharmacy. Team members were multilingual and spoke a range of languages.

The pre-reg and dispenser said that the Medicines Use Review service had an impact as they felt it helped to reduce the wastage of medicines. The pharmacist said that when the smoking cessation service was offered it had a big impact on the local population. The pharmacy had offered the flu vaccination service for the first time and had provided approximately 70 vaccines.

The pharmacy had previously run INR monitoring clinics twice a week. However, many people locally were being switched from warfarin to other medicines. As a result of this the clinic was now only run once a week. The pharmacy was due to launch a hearing aid service. This would possibly be offered once a month and people would be booked in advance.

Most prescriptions were received by the pharmacy electronically and a number of people were part of the repeat prescription service. There was an established workflow in place and prescriptions were dispensed by the dispensers or technician and checked by the RP. Usually there were enough dispensers, so the RP did not need to self-check. Repeat prescriptions were labelled by someone in the morning and then dispensed. An electronic system was used to manage repeat prescriptions, and audit when these were received and sent off. The repeat request system tracked prescriptions which had been received and those which had not been received were chased. The pharmacy was trying to get all new recruits enrolled on the joint medicines counter and dispenser course so that all team members could help when needed.

Dispensed and checked by boxes were initialled to help maintain an audit trail. The pharmacy team also used colour-coded baskets to ensure that people's prescriptions were separated and reduce the risk of errors as well as to help manage the workflow. CD stickers were used on bags which contained CDs, including schedule 3 and 4. The prescription's expiry date was annotated on these.

The pharmacy had to gain consent from people before their prescriptions could be sent to the hub for dispensing. Currently prescriptions were only sent to the hub for people on the express service. The pharmacy sent prescriptions for about three to four people per week.

Both the locum pharmacist and pre-reg were aware of the change in guidance for dispensing sodium valproate and were able to describe what they would do. The pharmacy had completed an audit for

sodium valproate. Only one regular person had been identified but they did not fall in the at-risk group. Most people who used the pharmacy were older.

For high-risk medicines the team would check that the person was having regular monitoring and for methotrexate ensure that the dosage was taken weekly. The team described an occasion where a prescription had been corrected as methotrexate had been prescribed for daily use.

For people who had their medicines supplied in multi-compartment compliance aids the pharmacy had allocated them by weeks, and records were set out in folders arranged depending on days that they were due. Repeat prescriptions were ordered a week or two in advance of the compliance aid being due and these were prepared a week in advance. Individual records were in place for each person. Patient record sheets were amended and the electronic system flagged up any changes or omissions. Team members would then call the GP to confirm changes or if the person was present they would check their summary care records. One of the dispensers and one of the trainees were being trained to dispense the compliance aids so that the ACT would be able to check them. Compliance aids were sealed as soon as they were prepared and then checked by the pharmacist. If there were a number of items in the compliance aids these were brought to be checked before they were sealed.

The pharmacy received a yearly batch of prescriptions for care homes. Care homes had been asked to send a note if anything had changed.

Medication administration record (MAR) charts were supplied to both care homes and were prepared by the dispenser and then checked by the pharmacist. Care homes had to send in any acute prescriptions by 3pm for same day delivery. A MAR chart and copy of the prescription was also sent.

Assembled packs observed were labelled with product descriptions and mandatory warnings. Patient information leaflets (PILs) were handed out monthly and there was an audit trail in place to show who had prepared and checked the packs.

The pharmacy had a designated driver employed by AAH. Signatures were obtained for medicines delivered by asking the recipient to sign an electronic device. In the event that a person was not in, medicines were returned to the pharmacy. The driver had worked at the branch for years, and so was familiar with the people they delivered to.

INR clinics were run through the Clinical Commissioning Group. The INR was monitored and supplies were made under Patient Specific Directions (PSD). In cases where the doctor had not signed the PSD the person's GP would issue a prescription after the monitoring was done. At the moment there were 148 patients enrolled on the service and the pharmacist carried out approximately 11 to 12 home visits per week. People were referred to the service from secondary care and their conditions were mainly stable. The service was provided on an appointment basis. There was another trained pharmacist at another branch who would cover if the regular pharmacist was not there.

Prescriptions were also dispensed as part of the online doctor service. The pharmacy was sent an email to notify them that a prescription was waiting. The service emailed the patient asking them to check stock availability with the pharmacy before going. The portal could be accessed by dispensers. The team were required to carry out biometric tests before being able to dispense prescriptions for the contraceptive pill. A prescription was not generated if the levels did not fall within the required range. All prescriptions were physically collected from the pharmacy; with patients bringing in ID. The team were able to contact the prescriber if needed. The pharmacist said she had contacted the prescriber in the past and the process had been easy.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines

requiring special consideration such as controlled drugs (CDs) and those requiring cold storage. Fridge temperatures were monitored daily and were within the required range for the storage of medicines. CDs were kept in securely.

The pharmacy was set up with all the equipment required for the Falsified Medicines Directive (FMD) and all members of the team were aware of what they had to do. However, the system had not gone live.

A date-checking schedule was displayed on the dispensary wall which had not been updated; date checking was carried out by dispensary staff on Saturday. Short-dated stock observed was labelled with stickers and recorded in a book. There was no date expired medication observed on the drawers and shelves sampled.

Out-of-date and other waste medicines were disposed of in the appropriate containers which were segregated at the back from stock and then collected quarterly by a licensed waste carrier.

Drug recalls were received via email from head office. Emails could be accessed by all members of the team. The last actioned alert had been for prednisolone tablets. The pharmacist had also seen the recall for co-amoxiclav suspension on another website but this had not been sent through the Lloyds system.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment and facilities it needs to provide its services.

Inspector's evidence

A range of calibrated glass measures were available. Tablet counting triangles were also available including one segregated for use with cytotoxic medicines. This helped avoid cross-contamination.

An electronic tablet counter was also available; this required cleaning. The tablet counter was usually calibrated by an external company; there was no evidence this had been done recently. The pre-reg said that this would be cleaned following the inspection.

A range of up to date reference sources was available. A blood pressure machine was in use; the date obtained was recorded on the machine. This was replaced every two years. The blood glucose monitor was replaced every two years, with control checks done every 13 weeks.

The Coagucheck machine was checked each time a new pack of strips was opened using control solutions; it was also checked each quarter using a sample sent by an external company (NEQAS UK) and results were fed back to the pharmacy.

The pharmacy had two fridges of adequate size. One was used to store stock and the other to store dispensed medicines. Dispensed fridge medicines were stored in clear bags. Confidential waste was collected in confidential waste bags; these were collected by head office for destruction. Computers were password protected and all team members had their own log in detail. Computer screens were not visible to people using the pharmacy.

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.