General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 11 The Parade, Wharf Road, Ash Vale, ALDERSHOT, Hampshire, GU12 5AZ

Pharmacy reference: 1031626

Type of pharmacy: Community

Date of inspection: 05/07/2022

Pharmacy context

This is a busy NHS community pharmacy set on a parade of shops in Ash Vale. The pharmacy is part of a large chain of pharmacies. It opens six days a week. It sells a range of health and beauty products, including some over-the-counter medicines. It dispenses people's prescriptions. It delivers medicines to people who can't attend its premises in person. And it supplies substance misuse treatments. The pharmacy dispenses medicines to people who live in a care home. It provides multi-compartment compliance packs (compliance packs) to help people take their medicines. And people can get a flu jab (vaccination) from the pharmacy.

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 generally manages its risks appropriately. It has written instructions to help its team works safely. It mostly keeps the records it needs to by law. And it has appropriate insurance to protect people if things do go wrong. People who work in the pharmacy can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. They understand their role in protecting vulnerable people. And they review the mistakes they make. So, they can learn from them to try and stop them happening again.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. And a team at its head office regularly reviewed these. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. They stopped providing fit-to-fly tests and other diagnostic tests, such as checking a person's blood pressure, due to a high turnover of staff and the pharmacy's large dispensing workload. The pharmacy had considered the risks of coronavirus (COVID-19). And, as a result, it completed an occupational risk assessment for its team members and put some plastic screens on its counter to try and stop the spread of the virus. Members of the pharmacy team were encouraged to self-test for COVID-19. They knew that any work-related infections needed to be reported to the appropriate authority. They had the personal protective equipment they needed. And hand sanitising gel was freely available.

The team members responsible for making up people's prescriptions kept the dispensing workstations tidy. They kept an audit trail for each stage of the dispensing process from clinical screening by a pharmacist through to the final accuracy checking of the assembled prescription. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by an appropriately trained checker who also initialled the dispensing label.

The pharmacy had processes to review the dispensing mistakes that were found before reaching a person (near misses) and dispensing mistakes where they had reached the person (dispensing errors). Members of the pharmacy team discussed and documented the mistakes they made to learn from them and reduce the chances of them happening again. And they had recently reintroduced a system to review these regularly to help them spot patterns or trends with the mistakes they made. The pharmacy team generally highlighted and separated medicines involved in dispensing mistakes or were similar in some way, such as medicines that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being picked.

The pharmacy displayed a notice that told people who the responsible pharmacist (RP) was. Members of the pharmacy team were required to wear name badges which identified their roles within the pharmacy. They knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were also described within the SOPs. A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints procedure. And in-

store leaflets asked people to share their views and suggestions about how the pharmacy could do things better. The pharmacy tried to keep a person's preferred make of a prescription medicine in stock when its team was asked to do so. The pharmacy recently received online feedback from people mostly about their experiences of long queues and waiting times for prescriptions. And the company that owned the pharmacy could do more to make sure the pharmacy had enough of the right people working at the right time to improve people's access to the pharmacy's services.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and when. The pharmacy kept a controlled drug (CD) register. But some headings and the details of where a CD came from weren't always completed in full. The pharmacy team checked the stock levels recorded in the CD register regularly. The pharmacy generally kept appropriate records for the supplies of the unlicensed medicinal products it made. But its team occasionally forgot to record when it had received an unlicensed medicinal product. The pharmacy used a private prescription register to record the emergency supplies it made and the private prescriptions it supplied. And the entries seen in the private prescription register were in order.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy displayed an in-store notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. It had arrangements to make sure confidential information was stored and disposed of securely. And it had policies on information governance and safeguarding. Members of the pharmacy team were required to complete safeguarding training relevant to their roles and training on information governance. And a team member demonstrated that they had finished training on the NHS Data Security and Protection toolkit for this year. The pharmacy had the contacts it needed if a member of the team needed to raise a safeguarding concern. And its team members knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has just enough people in its team to deliver safe and effective care. But sometimes team members are so busy they struggle to do all the things they are expected to do. Members of the pharmacy team do the right training for their roles. They work well together and make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy and its services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacy manager, a full-time accuracy checking pharmacy technician (ACPT), a full-time healthcare partner and a part-time trainee healthcare partner. The pharmacy manager was a pharmacy technician. A company-employed relief pharmacist (the RP) worked at the pharmacy one day a week. And locum pharmacists mainly covered the remainder of the week as the pharmacy didn't have a regular company-employed pharmacist. A few team members had recently resigned and left the pharmacy. And some experienced team members were due to leave over the coming weeks. The pharmacy had recruited two trainee healthcare partners who were due to start this month. And it was trying to fill the remaining vacancies and had advertised these jobs online. The RP, the pharmacy manager, the ACPT and the trainee healthcare partner were working at the time of the inspection. And they were supported by a regional colleague and a locum dispenser. The pharmacy relied upon colleagues from other branches, relief team members or locum pharmacists to cover absences or help when the pharmacy was busy. The pharmacy had occasionally been unable to open on time or for parts of the day as it didn't have a pharmacist. And the pharmacy closed between 1pm and 2pm each day so the pharmacy team could take a break. The pharmacy dispensed a large volume of prescriptions. Members of the pharmacy team were adequately managing the pharmacy's workload. They supported each other so prescriptions were processed safely. And no queues were seen outside the pharmacy during the inspection. People entering the pharmacy were generally acknowledged and served readily without them having to wait too long for their prescriptions. And team members served people at the pharmacy counter as soon as they could.

Members of the pharmacy team needed to complete mandatory training during their employment. They were required to undertake accredited training relevant to their roles too. They discussed their performance and development needs with their line manager when they could. They encouraged each other to ask questions and share learning from the mistakes they made. And they were also asked to complete online training when the pharmacy wasn't busy to make sure their knowledge was up to date. The pharmacy team sometimes struggled to do all the things it was expected to do. And the pharmacy could do more to make sure it had enough of the right people working at the right time so it could continue to deliver its services safely and people were served promptly.

But members of the pharmacy team didn't feel these things or the targets they were set stopped them from making decisions that kept people safe. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And their feedback led them to review their process for dealing with people at the counter so when a person's prescription couldn't be easily found another team member was tasked with finding it.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare in. And its premises are bright and tidy. The pharmacy has a room where people can have private conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy was air-conditioned, bright, secure, tidy and professionally presented. It was modern and spacious. And it had markings on its floor to encourage people to socially distance from one another and move round it in one direction. The pharmacy had the workbench and storage space it needed for its current workload. And it had a consulting room for the services it offered and if people needed to speak to a team member in private. People's conversations in the consulting room couldn't be overheard outside of it. The consulting room couldn't be locked when not in use. But members of the pharmacy team made sure its contents were appropriately secure when it wasn't being used. The pharmacy had several sinks. And it had a supply of hot and cold water. The pharmacy team was responsible for keeping the premises clean. And a record of when the pharmacy was last cleaned was kept.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access. Its working practices are generally safe and effective. And its team is helpful. Members of the pharmacy team dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources. And it stores them appropriately and securely.

Inspector's evidence

The pharmacy had an automated door. Its entrance was level with the outside pavement. And it had wide aisles. These things made access to the pharmacy, and its services, easier for people who used wheelchairs or mobility scooters. The pharmacy had some notices that told people about its products and the services it delivered. And it had a few seats for people to use if they wanted to wait in its premises. Members of the pharmacy team were helpful and knowledgeable. And they knew where to signpost people to if a service wasn't provided.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. It used a third-party company to make its deliveries. And it kept an audit trail for each delivery to show that the right medicine was delivered to the right person. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And its team checked whether a medicine was suitable to be re-packaged. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. It provided a brief description of each medicine contained within the compliance packs. But an identical description, namely 'white round tablets, was used to describe many tablets contained within the same compliance packs. And patient information leaflets weren't always supplied. So, sometimes people didn't have all the information they needed to make sure they took their medicines safely. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. Prescriptions were highlighted to alert the team member when these items needed to be added or if extra counselling, such as with antibiotics or medicines used to thin people's blood, was needed. But some assembled CD prescriptions awaiting collection had expired. So, these were removed during the inspection to make sure no unlawful supplies were made. Team members knew that women or girls able to have children mustn't take valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed valproate needed to be counselled on its contraindications. And they had access to the valproate educational materials they needed.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines and medical devices in an organised fashion within their original manufacturer's packaging. Team members marked containers of liquid medicines with the date they were opened. They were required to check the expiry dates of medicines regularly or before they dispensed them. And they marked products which were soon to expire. These steps helped reduce the chances of them giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, appropriately between two and eight degrees Celsius. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy team recorded the destruction of the CDs that

people returned to it. And out-of-date CDs were kept separate from in-date stock. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in an appropriate pharmaceutical waste bin. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And one of its team members described the actions they took and demonstrated what records they made when they received a drug alert. But there were several outstanding alerts that had been actioned by the team which needed to be signed off electronically by a pharmacist.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the superintendent pharmacist's office to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the refrigerators' maximum and minimum temperatures. The pharmacy team replaced the blood pressure monitor and checked that the pharmacy's diagnostic equipment was working properly during the inspection. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were stored securely when they weren't working.

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.