General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Stokewood Medical Centre, Fairoak Road, Fairoak, EASTLEIGH, Hampshire, SO50 8AU

Pharmacy reference: 1031684

Type of pharmacy: Community

Date of inspection: 22/05/2019

Pharmacy context

A community pharmacy, belonging to the Lloyds multiple pharmacy chain. As well as the NHS Essential Services, the pharmacy provides Medicines Use Reviews (MURs), New Medicines Service (NMS), Multicompartment compliance aids (MDS trays), seasonal influenza vaccinations, Emergency Hormonal Contraception (EHC) and drug misuse support services including the supervised consumption of Methadone. The pharmacy also has a prescription delivery service for the elderly and housebound.

Overall inspection outcome

Standards not all 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 not all met	2.1	Standard not met	There are not enough staff to prepare prescriptions in a timely manner and to keep up-to-date with other tasks such as stock management and staff training.
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's working practices are safe and effective. Its team members understand their roles and responsibilities and keep people's information safe. The pharmacy's team members generally log, review and learn from the mistakes they make, but could do more to reflect on how they could improve their own procedures. The pharmacy responds well to people's feedback by making changes to improve the quality of its services.

Inspector's evidence

The pharmacy was managed by the regular full-time pharmacist with support staff in the dispensary and on the counter. The pharmacist's days off were covered by Lloyds' relief pharmacists and locums. Staff operated services in line with an up to date set of standard Operating procedures (SOPs).

The pharmacy team recorded its near misses and errors. They did this to identify and monitor risks to the safety of their dispensing. Each mistake was discussed with the team member concerned to give them an opportunity to reflect on what had gone wrong. Records were reviewed and discussed during regular meetings. This was done to give the team an opportunity, to identify trends, monitor improvement and put follow up actions in place. Follow up actions for dispensing near misses however did not include a requirement for individuals to reflect on their own dispensing technique and identify any steps which could have prevented the error.

When similarly-packaged products were received in the medicines' delivery, the team would alert one another. They had done this for the Crescent brand of furosemide 40mg tablets and citalopram 20mg both of which had very similar packaging and livery. Various Tillomed and Actavis products had been separated due to branding similarities.

Staff understood their roles and responsibilities and were working in accordance with current Standard Operating Procedures (SOPs). There was a task and role matrix in place which gave a clear indication of who could carry out which tasks.

Customer feedback was sought through customer feedback surveys. Following a recent survey, the pharmacy had improved its provision of healthy living information. Additional information on diet, exercise, dementia and smoking cessation had been added to the Healthy Living Pharmacy (HLP) display. The display was regularly updated in line with local and national health awareness campaigns.

The pharmacy had a complaints' handling procedure. Complaints and dispensing incidents were recorded on the company's on-line reporting system. Customers were encouraged to raise concerns with pharmacy staff at the outset. Details were available for those who wished to raise their complaint with head office and details for the NHS Local area team were also available on request.

The team described how they ordered the same brands of medicines for certain people to help with compliance. Customer preferences included the Glenmark brand of pramipexole 0.18mg and the MSD

brand of ezetimibe 10mg (Ezetrol). Notes had been added to the relevant patient medication records (PMRs) as a reminder for staff when dispensing and checking. A reminder was also printed on the labels. These preferred brands were kept separate from normal stock.

Professional indemnity and public liability arrangements were in place until 30th June 2019. When insurance arrangements would be renewed for the following year. This was to provide insurance protection for staff and customers.

All the necessary records were kept and were in order including those for Controlled Drugs (CDs), Unlicensed 'Specials,' Private Prescriptions and the Responsible Pharmacist. Records were kept for Patient returned and destroyed CDs. Records for Emergency Supplies did not all show the date of the supply, a detail required in legislation.

Staff were aware of the need to protect patient confidentiality. Staff had read information governance guidance and signed confidentiality agreements. Confidential waste had separate disposal arrangements to non-confidential waste.

The pharmacist was aware of the importance of safeguarding and had completed CPPE level 2 training. He would check the internet for details of the local safeguarding officers at the local council if he needed them. Dispensing staff had completed a safeguarding training module on the company's online training programme. A safeguarding policy and procedures guide were available for reference. It contained details of the local safeguarding authorities. Staff had not had any concerns to report.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not have enough team members for its services. Team members are not up-to-date with dispensing and other important tasks. They undertake ongoing training but are not always able to do it at work. This may limit the opportunities they have to keep their knowledge and skills up to date.

Inspector's evidence

On the day of the inspection services were managed by a locum, a dispenser, a trainee dispenser working in the dispensary and a medicines counter assistant (MCA) working on the counter. The pharmacy was short staffed in the run up to a bank holiday weekend. The manager who was also a full-time dispenser was absent for the week and another part time dispenser had been absent for a month. Another dispenser had left recently. The shortage had been compensated in part by a part time trainee dispenser who worked two full days per week for two weeks. But although the pharmacy was one day behind with its dispensing workload, staff felt confident that they would catch up with the backlog after the bank holiday.

Staff were busy. They were observed to work well together, each attending to their own tasks and assisting one another when required. They assisted each other on the counter when queues built up from time to time. The trainee dispenser could not find time during working hours to do her training modules, but instead did them at home. Regular staff said it was difficult to find time to coach new and less experienced staff and said they had not had regular team meetings for a few months.

The MCA described being able to raise concerns. She described having regular informal discussions with the pharmacist, the area manager and her other colleagues. She said she could make suggestions as to how things could be improved. She was also a healthy living champion. She had put together a display promoting healthy living tips, stop smoking advice, healthy eating and a high fibre diet.

The pharmacist was set targets for services such as MURs. But said these did not compromise patient care. He had to prioritise the prescription workload currently due to the backlog and staff shortages.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare. But, its team members could do more to ensure that people's private information is protected at all times.

Inspector's evidence

The pharmacy was in a residential community out of town. It was attached to the medical centre next door. It had a spacious shop floor and dispensary and a consultation room for private consultations such as flu vaccinations and MURs. Customer areas were generally clean and tidy although there was some clutter with stock on the floor behind the counter.

Pharmacy only medicines were kept behind the counter. The pharmacist had a clear view of the medicines counter from the dispensary. He could listen to conversations at the counter and intervene where needed. However, the MCA was observed leaving a small number of prescriptions unattended on the medicines counter when a customer was waiting while she served another customer.

The dispensary was situated behind the counter and staff could access it easily from the counter. Prescriptions were stored in a bay area in the dispensary and could not be viewed by the public. The dispensary had clearly defined areas for dispensing and accuracy checking and for making up MDS trays. The front of the dispensary was where the majority of dispensing and checking took place. There were additional dispensing surfaces in the back- shop area as well as storage facilities, a staffroom and toilet. Staff toilet facilities were clean with hand washing facilities.

The main dispensary had approximately eight metres of U -shaped, dispensing bench and a smaller one metre length of dispensing bench next to a sink. In the back shop there was a further four metres of L-shaped work surface and another dispensing bench approximately four metres in length. This area was used for dispensing and storing MDS trays.

The dispensary was generally clean, tidy and maintained. But there was a lack of storage facilities and bulky bags of prescriptions were stored on the floor. Excess stock was stored on the MDS bench and on the floor beside the sink. A bag of confidential waste was stored in the staff toilet.

The pharmacy had a heavy steel door to the rear. At the time of the inspection, the weather was warm, and the door had been left open. There was a mesh grille which was there to prevent unauthorised access when the door was open, but it hadn't been pulled across. Staff from the surgery were observed to come into the dispensary via the back door to talk to staff. Staff said that they had given surgery staff authority to come into the dispensary that way. They felt that the risk to patient confidential information was low as the majority of their prescriptions came from the same surgery. However, there were also a small number of prescriptions from other surgeries and private prescriptions from elsewhere.

The pharmacy was bright and well ventilated with temperature control systems in place. It had a professional appearance and stocked a range of items for health and personal care.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and effectively and makes them available to everyone. In general members of the pharmacy team give people the advice and support they need to help them use their medicines safely and properly. The pharmacy gets its medicines from reputable sources and stores them appropriately. But the pharmacy's team members could do more to make sure that medicines with a short shelf life left are removed from stock promptly. In general, the pharmacy manages its medicines safely and effectively. But, it is not yet scanning products with a unique barcode, as required in law.

Inspector's evidence

The pharmacy had signage outside to let people know it was there. It had wide step free access and a semi-automatic door. Staff had a clear view of the entrance from the medicines counter and dispensary, so they could assist people trying to enter the pharmacy if needed. The pharmacy had a portable hearing loop and its team could provide large print labels on its medicines if required. And it offered a prescription delivery service for those who needed it. It had a range of patient information leaflets in the consultation room and on the healthy living pharmacy (HLP) board. But, the HLP board was in a corner next to a make-up display and wasn't prominently displayed.

SOPs had been read and understood by staff. A sample of SOPs was checked with regard to the management of CDs and the assembly labelling and accuracy checking process. Observation of staff performing these activities indicated that procedures were being followed. There was a clear audit trail of the dispensing process in place and CD records were maintained with weekly stock counts. When checked, the running balance of a randomly selected drug (Oxycontin 20mg tablets) was correct.

The pharmacist gave additional counselling to people on high risk medicines. Staff were aware of recent safety alerts for Sodium Valproate use in women and girls in the at-risk group and could locate the warning leaflets and cards. Packs of sodium valproate in stock had up to date warning labelling. Pharmacy labels also had an additional warning. The pharmacist said that he would provide warning cards with each prescription and additional counselling with each supply to women and girls to ensure that they were on a pregnancy protection programme, where appropriate. MDS trays had descriptions of the medication they contained, and product information leaflets (PILs) were supplied with them on a regular basis. However labelling information was very faint and difficult to read.

Medicines and Medical equipment were obtained from established wholesalers; Alliance Healthcare, AAH, and Sigma. Unlicensed 'specials' were obtained from AAH. All suppliers held the appropriate licences.

Stock was stored in a tidy, organised fashion. But expiry date checks had fallen behind in recent weeks. Various mixed batches and expired items were found with dispensing stock. The pharmacist said that expiry dates were checked when dispensing and checking. The pharmacy team were aware of the European Falsified Medicines Directive (FMD). They had the appropriate hardware and reported that the software was currently undergoing updates from their head office.

Items requiring refrigeration were stored in a fridge for which temperatures were recorded and

monitored. Blue ‘Fridge’ stickers were used to remind staff when a patient’s medication included an item stored in the fridge so that it wasn’t forgotten.

Drug safety alerts and medicines recalls were received by email from the MHRA and head office. Staff could recall checking the recent recall for Irbesartan and Losartan. None of the affected stock was found. Waste medicines were disposed of in the appropriate containers and collected on a periodic basis for safe disposal by a licensed waste contractor.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities for the services it provides. In general, the pharmacy uses its facilities and equipment to keep people's information safe. But, could do more to ensure that staff have the appropriate level of access to patient records.

Inspector's evidence

The pharmacy had all the necessary facilities and equipment for the services offered. Equipment was generally clean and in good order. There was a range of crown stamped measuring cylinders and tablet and capsule counting equipment. But one of the measures was sticky on the outside and the Methadone measure contained a watery residue of Methadone liquid. Methadone measures had a red CD sticker placed at the bottom to identify them and prevent their use for measuring other liquids. Amber dispensing bottles had been stored with their caps on to prevent contamination with dust and debris.

There were three computers with a patient medication record (PMR) facility. Two in the dispensary and one in the consultation room. There was an additional computer for general management activity. This appeared to be adequate for the workload.

There were up to date information resources available in the form of a BNF, a BNF for children and the drug tariff. Pharmacists also had access to a range of reputable online information sources such as EMC, Stockley, and the NHS website.

Confidentiality was maintained through the appropriate use of equipment and facilities. Computer terminals were password protected and were out of view of patients and the public. Computer screens could not be viewed by customers and were switched off when not in use. Patient sensitive documentation was generally kept out of public view and confidential waste was set aside in a basket and shredded daily. But, staff were observed using the pharmacist's smart card rather than their own

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.