

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: 30/01/2020

Pharmacy context

A community pharmacy, belonging to Lloyds pharmacy. It is attached to an out-of-town GP practice close to a residential area. As well as NHS Essential Services, the pharmacy provides Medicines Use Reviews (MURs), New Medicines Service (NMS), seasonal influenza vaccinations, emergency hormonal contraception (EHC) and drug misuse support services. The pharmacy also supplies medicines in multi-compartment compliance packs to people in the local community.

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	The pharmacy does not always have enough staff. And staff absences are not adequately compensated for. This means that the pharmacy is not always up-to-date with prescription dispensing and other tasks.
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 job roles. They listen to people's concerns and keep people's information safe. They discuss any mistakes they make and share information to help reduce the chance of making mistakes in future.

Inspector's evidence

Staff worked under the supervision of the responsible pharmacist (RP), whose sign was displayed for the public to see. Staff had standard operating procedures (SOPs) to follow. Team members had read those relevant to their roles. The pharmacy had a 'safer care' process for managing risks in the dispensing procedure, whereby all incidents, including near misses, were discussed at the time, and recorded. One of the dispensers then reviewed the records every month. This was done to identify trends and put follow up actions in place. With the support of the pharmacist, the dispenser discussed his findings with the team to help prevent the same mistakes being repeated. He then produced a safer care report. But at the time of the inspection the near miss log was not available to view. The dispenser had taken it home for the monthly review. However, he forwarded a photograph of the most recent entries along with the notes from the previous review.

Factors contributing to some mistakes had been due to different items having similar packaging or new packaging. And the reasons that some errors had occurred had been attributed to staff not reading the prescription properly. But not all records captured details of how the mistake might have been intercepted. Nor did they identify what the individual would do differently next time, in terms of the additional checks they might make while dispensing. And so, there was still scope for the team to use the near miss recording system to reflect on the robustness of their own dispensing procedures. But it was evident that previous mistakes had made staff aware of common risks. The most common mistake made in December had been due to mixed strengths of drug. And the frequency of this type of mistake had reduced the following month. They were also very aware of products with similar names such as lorazepam and loprazolam, amlodipine and amitriptyline. And they had pinned photographs of similarly packaged drugs and LASAs on the wall to act as a reminder.

The pharmacy team listened to customer feedback. A small number of respondents to the last customer survey indicated that they had not received any healthy living advice. Consequently, the healthy living champion had placed additional information to the Healthy Living Pharmacy (HLP) display. The display now contained advisory leaflets on alcohol intake, diet, health checks and smoking cessation. The display was regularly updated in line with local and national health awareness campaigns. When they could, staff tried to obtain the brands of medicines preferred by some patients. They did this to help patients comply with their prescription. Brands preferred by some patients included the Glenmark brand of lercanidipine 10mg. The packs were labelled with the patient's name and staff had placed a rubber band around the packs to make them easier to identify. The pharmacy had a documented complaints procedure. And a SOP for the full procedure was available for staff to refer to. Customer concerns were generally dealt with at the time and more formal complaints were recorded on the Lloyds on line reporting system. Details of the local NHS complaints advocacy service and PALs could be provided on request. These details were also available in a leaflet on display. The pharmacy had professional indemnity and public liability arrangements so, they could provide insurance protection for staff and customers. Insurance arrangements were in place until 30 June 2020 when they

would be renewed for the following year.

All the necessary records were kept and were generally in order including controlled drug (CD) registers. And records for private prescriptions, emergency supplies, the responsible pharmacist and unlicensed 'Specials'. The pharmacy had records for patient returned CDs. Records of returned CDs were kept for audit trail and to account for all the non-stock CDs which RPs had under their control. Staff understood the importance of safeguarding people's private information. They had received information governance training. Discarded labels and prescription tokens were discarded into a separate bin and collected for confidential disposal by a licensed waste contractor. And prescriptions were stored in a bay area in the dispensary where they could not be viewed by the public. The pharmacist and dispensers had completed level 2 CPPE safeguarding training. Staff had also completed dementia friends training. They had not had any concerns to report to social services but recalled reporting more than one concern to the local surgery.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy does not always have enough team members for its services. And it doesn't compensate adequately for staff absences. Team members 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

In general pharmacy services were delivered by the regular RP with the support of a full-time dispenser (manager), two part-time dispensers and four part time healthcare partners (HPs) working mainly as medicines counter assistants (MCAs). A healthcare partner is a job role within Lloyds for staff with both MCA and dispensing assistant training. On the day of the inspection the pharmacy was run by a locum, one of the part-time dispensers and a part-time HP working on the counter. Staff said they had fewer staff than normal. The pharmacy was quieter than usual. Customers were generally served promptly but queues built up from time to time. But the pharmacy was over two days behind with the prescription workload.

Staff were busy attending to their own tasks and assisting one another when required. The dispenser had been employed for almost two years but had not yet had a performance review. However, she described being able to raise concerns. And said she had regular informal discussions with the pharmacist, the manager and her other colleagues. She said she could make suggestions as to how things could be improved. Although she and her colleagues had raised concerns over staffing levels. Their concerns were partly influenced by current workload, new housing developments locally and the pending expansion of the surgery next door. Within the next few weeks the pharmacy was due to transfer a significant percentage of its dispensing to an off-site dispensing hub. Staff hoped this would alleviate some of the work load. Staff tried to keep their knowledge up to date through the Lloyds on-line training modules 'My-learn'. But often had to do their training at home. Recent topics included sepsis, safeguarding and risk management.

The locum pharmacist was not set targets for services such as MURs. She felt able to make decisions about when it was appropriate to offer a service whilst keeping the prescription service running efficiently. She said she would provide an MUR or an NMS consultation for people who would benefit from them. She had carried out two NMS consultations that morning.

Principle 3 - Premises ✓ Standards met

Summary findings

In general, the pharmacy's premises are adequately maintained and professional looking. They provide a safe, secure environment for people to receive healthcare services. But the pharmacy does not have enough storage. And so, some areas are not organised enough or clean and tidy enough.

Inspector's evidence

The pharmacy was in an out-of-town residential area. It was attached to the main surgery for the local area. It had a double front with full height windows and a glass door, all of which provided natural light. The shop floor was to the front with the dispensary behind. The pharmacy had a consultation room which the pharmacist used for private conversations and services such as MURs. The door to the room was on the shop floor to the side of the counter. The shop floor was clear of obstructions and wide enough for wheelchair users. There was a seating area for waiting customers. The pharmacy was bright and well ventilated with temperature control systems in place. Items stocked included a range of baby care, healthcare, beauty and personal care items.

The dispensary was relatively spacious. It had two separate areas for dispensing. The main dispensing area was to the front, with an open walk way between it and the counter. The main dispensary extended into the back shop where there was another dispensing area, an office area, a staffroom and a toilet. The main dispensary had an eight metre, U-shaped dispensing bench and a smaller one metre bench near the sink. The area of dispensing work surface nearest the counter was where staff dispensed and checked 'walk-in' prescriptions. In the back, the dispensary had a work surface of approximately four metres of L-shaped dispensing bench. And a further four metre run of dispensing bench where multi-compartment pack dispensing took place. Work surfaces were well used, with stacks of baskets containing prescriptions at various stages of the dispensing process. But the dispensary appeared slightly untidy due to lack of storage space. Bulky prescriptions were stored on the dispensary floor and bulky stock items, were stored on benches and on the floor in both the dispensary and behind the counter. The desk in the office area was piled with documents and paperwork. Floors in the back-shop area contained debris and dust and looked like they had not been cleaned for some time. But overall, the pharmacy was adequately organised and maintained. And there was a clear work flow.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides its services safely and effectively and makes them available to everyone. In general, the pharmacy manages its medicines safely and effectively. It checks to make sure that its medicines are fit for purpose. But it doesn't carry out all of its checks as thoroughly as it could. The pharmacy generally gives people the advice and support they need to help them use their medicines safely and properly.

Inspector's evidence

The pharmacy was clearly signposted. It had wide step-free access via a semi-automatic door, suitable for wheelchair access. The consultation room was also of a size suitable for wheelchair access. The pharmacy had a portable hearing loop and could provide large print labels if needed. Staff had a clear view of the pharmacy entrance from the medicines counter and dispensary. They could see people coming in and were able to offer assistance if required. The pharmacy had a healthy living pharmacy board. The board contained information and leaflets which supported both local and national health initiatives. A variety of patient information leaflets was also available in the consultation room.

In general services were delivered in accordance with SOPs. CDs were audited on a regular basis as per the SOP. The sample of CD stock checked was as stated in the register (Targinact 20/10). And dispensing labels were initialled by the person dispensing and the person checking, to provide a dispensing audit trail. This was as per the SOP. Multi-compartment compliance aids were provided for people who needed them. Patient information leaflets (PILs) were offered to patients with new medicines and regularly with repeat medicines. The medication in compliance aids was given a description, including colour and shape, to help people identify the medicines. The labelling directions on most compliance aids gave the required BNF advisory information to help people take their medicines properly but some trays did not contain this essential information. The print on compliance pack backing sheets was very faint. This could pose a difficulty for people with poorer sight.

The pharmacy had procedures for targeting and counselling all patients in the at-risk group, taking sodium valproate. The MHRA guidance pack was close at hand. And packs of sodium valproate in stock bore the updated warning label. The pharmacist had previously supplied valproate warning cards and booklets with relevant prescriptions. But the pharmacy did not currently have any patients in the at-risk group taking the medication. The flu vaccination service was delivered in accordance with up-to-date PGDs and service specifications for both the private and NHS vaccination services. People using the service had been asked to read and sign a consent form. Records were kept showing details of the consultation and the product administered.

Medicines and Medical equipment were obtained from established wholesalers; Alliance Healthcare and AAH. Unlicensed 'specials' were obtained from AAH. All suppliers held the appropriate licences and the majority of stock was stored in a tidy, organised fashion. Two CD cabinets and a fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read, recorded and monitored to ensure that the medication inside was kept within the correct temperature range. The pharmacy team were not yet scanning products with a unique barcode in accordance with the European Falsified Medicines Directive (FMD).

Stock was regularly date checked and records kept. Short-dated stock was identified and highlighted. General waste medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. A list of cytotoxic drugs (but not a full list of hazardous waste) had been placed on the wall above the waste medicines containers. This was to help staff dispose of waste medicines properly. The pharmacy also had a large amount of waste medicines awaiting collection. It had ten, full, waste medicines containers and another one part-filled. This took up a significant amount of space in the back-shop area. The pharmacy team generally responded promptly to drug recalls and safety alerts and kept records. They could recall responding to the recent recalls for ranitidine tablets and had not had any of the affected stock. But they were not aware of the more recent recall for Zapain tablets.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. In general, the pharmacy uses its facilities and equipment to keep people's private information safe.

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. Methadone measures were labelled with a red 'CD' sticker to identify them and prevent their use for other liquids. But one of the measures still had a watery residue of methadone in it. Amber dispensing bottles had been stored with their caps on to prevent contamination with dust and debris. The pharmacy had a separate triangle for cytotoxic tablets which was very clearly labelled, to reduce the chance of cross contamination with other tablets.

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, Patient.co.uk, and the NHS website. The pharmacy had three computers with a patient medication record (PMR) facility. And an additional computer for management tasks. Two of the PMR computers were in the dispensary and one in the consultation room. This appeared to be adequate for the workload. However, the pharmacy only had one working printer for all four computers which could, at times, be insufficient.

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. They were switched off when not in use. Computer screens could not be viewed by customers other than when being used for an individual patient during a consultation. Patient sensitive documentation was generally kept out of public view and confidential waste was discarded into a separate confidential waste bag and collected for confidential destruction by a licensed waste contractor. But staff were observed using the smart card belonging to a dispenser who was not present. The use of smart cards should ensure an accurate audit trail and ensure an appropriate level of access to patient records.

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.