General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 42 Elm Grove, HAYLING ISLAND, Hampshire, PO11 9EF

Pharmacy reference: 1031755

Type of pharmacy: Community

Date of inspection: 06/11/2019

Pharmacy context

This is a community pharmacy located along a parade of shops toward the north side of Hayling Island in Hampshire. The pharmacy dispenses NHS and private prescriptions. It offers a few services such as Medicines Use Reviews (MURs), the New Medicine Service (NMS), blood pressure testing and home deliveries. And, it supplies multi-compartment compliance aids to people if they find it difficult to manage their medicines.

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 not all met	1.1	Standard not met	The pharmacy is not identifying and managing some risks associated with its services as failed under the relevant standards and Principles. In addition, staff are not acting in a suitable manner to routinely protect people's private information. Private prescriptions are not stored securely, staff areas are unclean, there is no schedule to verify that medicines have been routinely checked for expiry and no records of calibration have been maintained for the blood glucose testing service
		1.2	Standard not met	There is not enough assurance that the pharmacy has a robust process in place to manage and learn from dispensing incidents. Staff are not routinely recording near misses, they are not completing their company's internal Safer Care processes and there is no evidence of remedial activity or learning occurring in response to mistakes
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 not all met	4.2	Standard not met	Pharmacy services are not managed or delivered safely and effectively. The pharmacy has not kept appropriate audit trails to verify processes for some of its services. This includes the delivery service and repeat prescription collection service. And, the pharmacy has no processes in place to ensure the safety of people prescribed higher-risk medicines
		4.3	Standard not met	The pharmacy cannot verify that it has been storing medicines that require refrigeration at the appropriate temperatures
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy doesn't always effectively manage the risks associated with the provision of its services. It has written instructions to help with this. But the team is not always following them. Members of the pharmacy team are not routinely monitoring the safety of their services. This mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. Team members don't always act in a suitable way to protect people's private information. But, they generally understand how to safeguard vulnerable people. And, the pharmacy keeps its records in accordance with the law.

Inspector's evidence

The pharmacy's workspaces were kept clear of clutter and the team generally managed the workload well. Prescriptions were processed and assembled on one side of the dispensary, there was a specific section to store and assemble multi-compartment compliance aids, the responsible pharmacist (RP) also worked as well as accuracy-checked prescriptions from a designated area. The company carried out audits to ensure its pharmacies were complying with the professional standards that they had set. Details about a previous audit were seen and some of the areas identified to improve the pharmacy's internal processes had been completed. When dispensing, staff were asked about how they ensured safety, they described using prescriptions to select medicines against, making relevant checks to ensure accuracy, double-checking that the correct details had been generated from repeat records and flagging details to the pharmacist if they saw issues with prescriptions such as duplicated medicines.

However, there were no systems or methods being used to identify or manage risks associated with the pharmacy's services. There was no evidence that near misses were being routinely identified and recorded as the details last seen recorded were from July 2019 and the pharmacy team was not complying with the company's 'Safer Care' processes. There was no designated lead member of staff for this process, workbooks had not been completed, one checklist from September and a few notes from August 2019 were only seen recorded in the last quarter and the noticeboard was not on display or up to date. Before then, recorded details were from 2018 and 2017. There was no evidence that staff had been actively learning from their mistakes.

Information about the pharmacy's complaints process was readily accessible and on display. The store manager explained that all members of staff could record details of incidents on the pharmacy's internal reporting system although she and the RP were usually the ones to handle incidents. This process was in line with the company's expectations and previous reports were seen. However, the team had not completed any root cause analyses or reflective statements. The last incident report only stated that when an out of date medicine had been supplied, this was rectified. Thus, apart from the situation being remedied at the time, there was no evidence that internal processes had been reviewed, reflected upon or anything implemented to assist the pharmacy team in preventing similar mistakes happening in future.

There was information on display to indicate that the pharmacy had completed the seven elements required for it to become dementia friendly in line with the South Wessex Local Professional Network framework. Team members were trained to safeguard vulnerable people, they referred to the RP or store manager in the first instance and described reading relevant information as part of their

training. The RP was trained to level two via the Centre for Pharmacy Postgraduate Education, this was described as having been completed the previous year but her certificate to verify was not seen. Contact details for the local safeguarding agencies were present. The company's chaperone policy was on display and a policy was available to provide guidance to the team. However, newer members of the team had not signed this and not all team members were aware of the existence of the contact details or where to locate this information. This could lead to a delay in the appropriate response being made.

Staff separated confidential waste before it was disposed of by the company. There was no confidential information left in the retail area, sensitive details on dispensed prescriptions could not be seen from the front counter and the pharmacy informed people about how it maintained their privacy. However, during the inspection, the store manager was observed handing a trainee member of staff generated dispensing labels with people's names and addresses, so that this could be used to collect prescriptions against from the nearby doctor's surgery. This member of staff then left the pharmacy, with the labels in her hand and later returned with the prescriptions (see Principle 4). The member of staff did not take anything with them to hold the prescriptions as they returned. This was not a secure way to collect prescriptions from the surgery and did not adequately safeguard people's confidential information. The company's information governance policy was present, but this had not been signed by members of the team and audits or checklists had also not been completed.

The pharmacy held a range of documented standard operating procedures (SOPs) to support its services. They were from 2017. The locum dispenser had worked for the company previously, he was familiar with the SOPs and described reading and signing them in another branch. There was evidence that some of the team had read and signed the SOPs, however this did not include two team members who had transferred from another branch. The store manager believed that they may have completed this in those pharmacies. The team's roles were defined within the SOPs, team members knew their responsibilities and the tasks that were permissible in the absence of the RP. The correct RP notice was on display and this provided details of the pharmacist in charge at the time.

The pharmacy was complying with its statutory record keeping obligations. The RP record, a sample of registers for controlled drugs (CDs), records of unlicensed medicines, emergency supplies and private prescriptions were all maintained in accordance with legal requirements. On randomly selecting CDs held in the cabinet, the quantities held matched balances within corresponding registers. Previous records of emergency supplies (from 2016) had been made with generated labels and the details had faded, this was not observed to be the team's practice going forward. However, the pharmacy had recently started using a new register for records of private prescriptions and the old register was full of private prescriptions whose details had been entered but were left tucked in between the pages. There was a risk that the prescriptions could become lost. Staff kept a complete record of CDs that had been returned by people and destroyed at the pharmacy. The pharmacy's professional indemnity insurance was in date, through the National Pharmacy Association and due for renewal after June 2020.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Members of the pharmacy team are suitably trained or undertaking appropriate training in line with their roles. They are working towards improving the pharmacy's standards. And, team members are provided with resources to help keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy was observed to have enough staff to manage its workload appropriately during the inspection. Staff present included a relief RP, the store manager who was a trained dispensing assistant and was also a cluster manager for the area, a pharmacy technician, two trained dispensing assistants, one of whom was a locum dispenser and a trainee medicines counter assistant (MCA). The locum dispenser was described as booked for holiday cover although according to the store manager, staff usually covered each other. The MCA and other dispenser had recently transferred from another branch. The pharmacy technician had worked at the pharmacy for the past two months and the store manager since May 2019. The pharmacy had previously been run on relief and locum pharmacists as there had not been a regular pharmacist for the past year. A new pharmacist had recently been employed and was described as due to start at the pharmacy soon.

Staff described the store manager instructing them every morning about their tasks for the day. Half the store manager's time in the week was spent on cluster manager duties which included being out of the pharmacy to visit other branches in the area. However, she explained that she always started her day at the pharmacy to help guide the team. There had been some previous staffing issues, but these had been resolved and since then, the team had been working to re-implement the pharmacy's procedures such as date-checking, clearing the dispensary, introducing organised sections for dispensed bags of medicines to be stored, using 'owing' labels and ensuring there were safe processes in place for dispensing the compliance aids.

Staff wore name badges, their certificates of qualifications obtained were not seen. The trainee MCA asked relevant questions before selling over-the-counter (OTC) medicines, she knew when to refer to the pharmacist and held a suitable level of knowledge to sell medicines safely. Course material was completed at work but only as and when it was possible. The trainee MCA stated that she was completing this in a timely manner. To assist with training needs, staff completed online modules every month through a company provided resource, some of this was described as mandatory training and took instructions from the store manager. Team members received formal appraisals every three to six months with ongoing feedback provided. The RP stated that she had not been set any targets to complete services at this pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises generally provide an appropriate environment for the delivery of healthcare services. The pharmacy is secure, and it can provide a suitable space for private conversations to take place.

Inspector's evidence

The pharmacy’s premises consisted of a relatively long and narrow retail space that led to a larger, rectangular shaped dispensary behind. Staff areas and a small stock room was at the very rear. The retail space was generally professional in its appearance although parts of the floor were marked and some of the fittings and fixtures (such as the drawers used to hold Pharmacy (P) medicines) were dated but still functional. Staff areas including the staff WC could have been cleaner. There were a few spiders in the WC and work surfaces in the kitchenette were dirty.

There was enough space for dispensing activity to take place. The dispensary floor was initially cluttered as staff were working on stock but were observed to clear this quickly and keep the dispensary clear of clutter. There were a few large totes on the floor to one side that contained bulky dispensed medicines awaiting collection. Staff had cleared a separate space to store them on the shelves and were working towards doing this. The lighting in the retail space appeared dimmer compared to the dispensary, but it was still enough to see clearly. The pharmacy was appropriately ventilated. P medicines were stored inside unlocked Perspex units that lined up against one wall by the front counter. They were marked to ask staff for assistance. A signposted consultation room was available for services or private conversations. This was of an adequate size for this purpose. The room and cabinets in here were kept unlocked. There was no confidential information present or accessible.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy doesn't always provide its services or can show that all of its medicines are stored in a safe and effective way. Some of the pharmacy's records about its services are unsatisfactory or missing altogether. The pharmacy cannot show that it has safely delivered medicines to people, that it routinely deals with safety alerts appropriately or when it has obtained repeat prescriptions for people. It also cannot show that temperature sensitive medicines are stored appropriately. And, the team does not do enough to be able to demonstrate that they are checking the expiry dates of their medicines. But the pharmacy team is helpful. The pharmacy obtains its medicines from reputable suppliers. And, its team looks for appropriate ways to help reduce medicines wastage.

Inspector's evidence

Access into the pharmacy was by a ramp from the street. There was clear, open space inside the premises which enabled people using wheelchairs to easily access the pharmacy's services. Counter staff explained that they physically assisted people who were visually impaired, they read instructions to them and explained details. People who were partially deaf were offered the use of the consultation room so that background noise from the pharmacy could be reduced. There were five seats available for people waiting for prescriptions. The pharmacy's opening hours and services provided were on display. However, some of the services listed were not being provided by this pharmacy.

The store manager stated that she was the only member of staff to provide blood pressure or blood glucose tests. She had been trained through the company's knowledge checks and from watching someone else. Once the measurements were taken, every result was brought to the attention of the pharmacist before providing the person with the details. There had been no referrals required to the person's GP. As the blood glucose monitor was broken, this service was not currently being provided (see Principle 5 regarding record keeping).

A few interventions had been undertaken and some details were seen documented. However, there was only one record out of the records completed for this year that had the full details recorded. Every other record had details missing about the summary of the advice given or the reason for the referral and this limited the ability of the pharmacy to fully show that it had been making the relevant safety checks for people. The completed intervention record was about a prescription seen for verapamil 120mg with a dose to be given once daily. As this should have been in divided doses, this was checked with the persons representative who confirmed that upon discharge from the hospital, the person was prescribed a modified release formulation. The pharmacy then liaised with the GP surgery to rectify this situation.

The store manager explained that when she first started working at the pharmacy there was a high level of unwanted medicines being returned to the pharmacy and increasingly large amounts of paracetamol and Ventolins being prescribed. According to her, this may have been because people were automatically asking for everything on their repeat slips to be re-ordered. To help reduce wastage therefore, the manager had attended a meeting at the surgery last month and arranged for them to start removing details of medicines that were on a 'when required' basis from people's repeat requests.

The pharmacy operated a repeat prescription ordering system where the team ordered prescriptions for people on their behalf. When people came in to collect their medicines, they were asked which medicines were required for the following month, details were ticked on their repeat requests, the date of collection was provided, and the repeat requests were stored at the pharmacy before they were processed. Upon handing out the next supply of medicines, staff also re-checked with people that all the medicines were required. However, when the trainee member of staff arrived back with the repeat prescriptions from the surgery, they were handed to staff to start dispensing. There were no audit trails being used to verify whose prescriptions had been collected, when they had been ordered and no processes used to verify if there were any changes or missing items.

Staff were aware of the risks associated with valproates, this medicine was stored inside separate drawers with caution stickers placed in front to help alert staff to the risks. There was plenty of educational material available to provide to people at risk if this medicine was prescribed and dispensed at the pharmacy. There was no audit seen to be completed that could have helped the pharmacy to identify if any females at risk had been supplied this medicine. Staff stated that they had not seen any prescriptions that required intervention. People prescribed higher-risk medicines were not being routinely identified, counselled or relevant parameters checked. This included people receiving compliance aids. Although warfarin was provided separately for people with compliance aids, there were no checks made about the International Normalised Ratio (INR) level.

Compliance aids were set up for people after the person's GP initiated them. The pharmacy technician and store manager were responsible for managing this section. This process was described as work in progress, the team had completed compiling individual records for people and had re-implemented a schedule to keep track of when prescriptions were received, processed and who dispensed and checked them. Once the pharmacy had ordered prescriptions on behalf of people, the details were then cross-referenced against the individual records. This helped them to identify any changes or missing items and records were maintained to verify this. All medicines were de-blistered into the compliance aids with none supplied within their outer packaging. The compliance aids were not left unsealed overnight when assembled. Descriptions of medicines were provided and patient information leaflets (PILs) were routinely supplied. The process for mid-cycle changes was described as dependent on the pharmacist, the team sometimes retrieved, amended, re-checked and re-supplied them or they obtained new prescriptions.

The pharmacy provided a delivery service. The driver used a hand-held device to obtain people's signatures once they were in receipt of their medicines. Failed deliveries were brought back to the pharmacy, notes were used to inform people of the attempt made to deliver which also asked them to attend the pharmacy to collect them. However, other than for CDs, the team was not maintaining an audit trail or records at the pharmacy that could verify when, where and to whom prescription-only medicines had been supplied. This was not in keeping with the GPhC's guidance for registered pharmacies providing pharmacy services at a distance, including on the internet.

During the dispensing process, the team used baskets to hold prescriptions and medicines and this helped to prevent the inadvertent transfer of items. Baskets were colour co-ordinated to highlight priority and a dispensing audit trail was used to identify the staff involved. This was through a facility on generated labels. Dispensed prescriptions awaiting collection were stored within an alphabetical retrieval system. The team identified fridge items and CDs (Schedules 2 to 4). Clear bags were used to hold assembled fridge items and CDs. This assisted in identifying the contents when they were handed out to people.

The pharmacy used licensed wholesalers such as Alliance Healthcare and AAH to obtain medicines and

medical devices. Unlicensed medicines were obtained from AAH. Staff were knowledgeable about the European Falsified Medicines Directive (FMD) and relevant equipment was present. However, this was not functioning at the point of inspection, team members described it as working intermittently and the pharmacy was not yet complying with the decommissioning process.

Medicines were stored in an organised manner, short-dated medicines were identified and there were no date-expired medicines or mixed batches seen. Staff described date-checking medicines for expiry every month. However, there was no schedule seen or located that could verify when this process had been carried out. Liquid medicines were marked with the date upon which they were opened, and medicines were stored evenly in the fridge. CDs were stored under safe custody and keys to the cabinet were maintained in a manner that prevented unauthorised access during the day as well as overnight. A CD key log was also kept helping verify this. The pharmacy team was storing unwanted medicines inside appropriate designated containers. There was a list available for staff to identify hazardous or cytotoxic medicines. People returning sharps for disposal were referred to the local council. Returned CDs were brought to the attention of the RP, details were taken down, the CDs were segregated and stored in the CD cabinet prior to destruction.

There were issues with the ability of the pharmacy to verify that medicines had been appropriately stored in the two medical fridges. The fridges were packed with stock. The team had only kept full records for the past month (October 2019). Before that, there were several and sustained gaps in the records in the previous two months and either no records kept for the intervening months since 2018 or only the odd few. In addition, when temperature fluctuations were seen above the required range of two to eight degrees Celsius, there had been no details recorded about the action taken in response. Drug alerts and product recalls were received through the company, staff described checking stock and acting as necessary. However, the pharmacy had only kept a very limited audit trail to verify this. This included a few safety alerts from October 2019 and before that they were from June 2019. There were therefore several safety alerts missing, and this limited the ability of the pharmacy to demonstrate that it had taken the appropriate action in response to affected batches of medicines.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the necessary equipment and facilities it needs to provide its services safely. It uses its facilities appropriately to protect people's privacy.

Inspector's evidence

The pharmacy held an appropriate range of equipment for its services. This included current reference sources and standardised conical measures for liquid medicines. The CD cabinets were secured in line with statutory requirements. The dispensary sink used to reconstitute medicines was relatively clean. There was hand wash and hot as well as cold running water available. The blood pressure machine was marked as replaced in 2018. The blood glucose monitor was not currently functioning, and a request had been made for a replacement. However, there had been no records of calibration kept for this device, open packs of test strips were present, one pack had very recently expired (October 2019) but had not been disposed of. Staff could use lockers to store their personal belongings. Computer terminals were password protected and positioned in a manner that prevented unauthorised access. There were cordless phones present to provide conversations in private if needed and the team held their own NHS smart cards to access electronic prescriptions. They were stored securely overnight.

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.