General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 13 Forbes Road, BOSTON, Lincolnshire, PE21 0PD

Pharmacy reference: 1034237

Type of pharmacy: Community

Date of inspection: 06/04/2022

Pharmacy context

The pharmacy is on a residential estate in the market town of Boston, Lincolnshire. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. It also supplies medicines to people living in a local care home. And it offers a medicine delivery service. The pharmacy offers some private health services including blood pressure testing and weight management. The inspection took place during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 identifies and manages the risks associated with its services appropriately. It keeps people's private information secure and it keeps the records it must by law. The pharmacy has adequate processes in place to manage feedback about its services. It protects people's private information. And its team members understand how to help safeguard potentially vulnerable people. Pharmacy team members engage in regular discussions about patient safety. And they act with care to reduce the risk of making similar mistakes again.

Inspector's evidence

The pharmacy had some continued processes in place to support its team members in reducing the risks associated with managing pharmacy services during the COVID-19 pandemic. These included using markers on the floor to support people with social distancing within a healthcare environment. The pharmacy had one solid plastic screen which covered part of its medicine counter and it used plastic sheeting to shield the remaining counter area. Team members had access to personal protective equipment (PPE) and most wore face coverings whilst working. The pharmacy had experienced a number of acute closures during the pandemic due to no pharmacist cover. The last closure was several weeks prior to the day of inspection. The pharmacy team was still catching up with work following the two day closure. Work benches were lined with baskets of medicines waiting to be checked. Team members were observed making appropriate checks with people visiting the pharmacy to establish if medicines were needed urgently.

The pharmacy had standard operating procedures (SOPs) to support the safe running of the pharmacy. These covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. A new set of electronic SOPs was in the process of being introduced. A team member demonstrated how e-learning modules tested their understanding of the SOPs. And all team members were observed working in accordance with SOPs during the inspection. For example, applying their signature to medicine labels after checking their own work to confirm they had assembled a medicine. The pharmacy team engaged in regular audits through the company's 'Safer Care' programme. These audits ranged from weekly checklists designed to support a safe and effective working environment, to quarterly audits designed to maintain professional standards. The pharmacy maintained Safer Care records. And these included recent data accuracy input competency checks completed by team members. These checks supported the pharmacy preparing to move some workload to the company's offsite dispensing hub.

The pharmacy had clear processes for recording mistakes made during the dispensing process. This included the completion of dispensing incident reports submitted to the SI's office. And the routine completion of near miss records. Team members corrected and recorded their own near misses as part of the learning process. The regular pharmacist supported a monthly near miss review. This was used to identify patterns in near misses and to apply learning to reduce the risk of similar mistakes occurring. Team members demonstrated the actions they took to reduce risk following these reviews. For example, the team separated and highlighted 'look-alike' and 'sound-alike' (LASA) medicines on the dispensary shelves to prompt additional checks during the dispensing process.

The pharmacy had a complaints procedure and this was advertised in its practice leaflet. Team members reported that most concerns related to unexpected closures. And a team member shared details of how they had managed a recent concern. This included providing the details of the pharmacy's head office when a person wanted to escalate their concern. Pharmacy team members demonstrated a clear understanding of how to recognise and report a concern about a vulnerable adult or child. And the pharmacy had procedures in place to support its team members in raising safeguarding concerns.

The pharmacy had up-to-date indemnity insurance arrangements in place. A sample of pharmacy records examined confirmed the pharmacy kept the records required by law in good order. For example, the pharmacy maintained running balances in the CD register. And completed weekly full balance checks of CD stock against the register, in accordance with SOPs. A random physical balance check of a CD conducted during the inspection complied with the running balance in the register. The pharmacy stored personal identifiable information in staff-only areas of the premises. It held confidential waste in designated bags. And the team sealed these bags and held them securely prior to them being collected for safe disposal.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy services are provided by a highly dedicated team of people who work together well. The pharmacy provides its team members with support to complete ongoing learning associated with their roles. Pharmacy team members actively engage in continual learning opportunities designed to improve patient safety. They take opportunities to provide feedback. And they are aware of how to raise professional concerns. But the pharmacy team is under some ongoing pressure due to the impact of frequent acute closures. And this increases the risk of an adverse event occurring.

Inspector's evidence

On duty during the inspection was the RP, who was the regular pharmacist providing three days cover each week, three dispensers and a pre-registration pharmacy technician. The pharmacy also employed two additional dispensers, one of which was the pharmacy manager. And a regular delivery driver provided the medicine delivery service. On the day of inspection one team member was working additional hours to cover for annual leave. But the impact of the frequent closures on workload was evident. On the day of inspection workload was three-four days behind schedule. The team was observed managing the backlog well by prioritising higher risk and urgent activities. Some team members had recently worked into the evening to support the pharmacy in catching up with dispensing tasks. The pharmacy also received some support from an accuracy checking technician, from another local pharmacy.

There was some focus on the achievement of targets related to pharmacy services. These targets included New Medicines Service (NMS) completions and flu vaccinations. The team reported that during the busy flu vaccination season it had been required to book appointments despite no pharmacist being booked on the rota to cover a shift. In some circumstances this had increased pressure on the team managing an acute closure as people needed to be contacted to re-book appointments. And it had led to clinics being busier on the regular pharmacist's days at work. A discussion with the pharmacy's regional manager following the inspection provided assurances of learning from this situation to avoid a similar event occurring in the future. And a discussion with the RP during the inspection confirmed that they were able to exercise their professional judgement when making the decision to provide a service. And this judgement included an assessment of risk factors such as the backlog of work in the dispensary.

Pharmacy team members engaged in a structured appraisal process. The pre-registration pharmacy technician received regular one-to-one support from the regular pharmacist. And all team members completed regular training associated with their roles. A team member demonstrated their 'My Learn' training record, this included recent learning associated with SOPs. Pharmacy team members engaged in regular conversations about workload management and patient safety. These conversations included informal discussions throughout the working day as well as structured Safer Care briefings. And it was clear that team members worked well together to achieve common goals designed to reduce risk. For example, by identifying personal near miss patterns, and supporting each other by completing additional checks of medicines commonly involved in near misses prior to the accuracy check. The pharmacy had a whistle blowing policy to support team members in raising and escalating concerns at work. And its team members knew how to raise a concern and put forward ideas for improvement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitably maintained. They provide an adequate space for the delivery of healthcare services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy premises were secure and appropriately maintained. The pharmacy was generally clean but some areas did distract from the overall professional appearance. For example, the floor in the public area had not benefitted from a professional clean for some time and limescale build-up was evident around the dispensary sink. Lighting was bright and ventilation was appropriate with air conditioning used to maintain an ambient temperature. Pharmacy team members had access to hand washing facilities, including antibacterial hand wash and hand sanitiser. The dispensary sink was primarily used for the reconstitution of liquid medicines.

The premises consisted of a small public area, a consultation room, dispensary, storeroom and staff facilities. The dispensary was small for the work activity taking place and it had limited storage space. The size and layout of the room meant that the team held some medicines in tubs down the side of the dispensary. Although this arrangement was not ideal, the team acted with care to ensure the tubs did not present a trip hazard. A small work area at the back of the dispensary was reserved for higher risk tasks such as assembling multi-compartment compliance packs. A small storeroom to the side of the premises led to a fire exit. The fire exit was kept clear of obstruction. The pharmacy's consultation room was small. But it provided a suitably protected space to people accessing private consultation services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally accessible to people. On occasions when it is unable to provide a service or supply a medicine the team appropriately signposts people to other healthcare providers. The pharmacy obtains its medicines from reputable sources. And it stores them safely and securely. Pharmacy team members use audit trails effectively to help manage dispensing services. And they provide appropriate information to people when supplying medicines and giving advice.

Inspector's evidence

People accessed the pharmacy through a simple push/pull door at street level. Team members had a clear understanding of the services provided by the pharmacy. But the pharmacy's full range of services was not always available to people due to the frequency of the acute closures. In order to manage dispensing services the team had needed to prioritise the safe delivery of essential NHS services following these closures. Pharmacy team members were aware of how to signpost a person to another pharmacy or healthcare provider if they required a service which the pharmacy could not provide. And they followed guidance to report closures and to make other healthcare providers aware of the closure. On the day of inspection pharmacy team members were observed being attentive to people's needs. And taking the time required to answer queries and provide advice to people on a wide variety of topics related to people's health and wellbeing.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. A team member serving on the medicine counter identified circumstances in which the request for a P medicine would be referred directly to the RP. The pharmacy team identified higher risk medicines by using 'Pharmacist' stickers to prompt additional counselling when handing out these medicines. Team members explained that they made some records of counselling checks such as INR monitoring on people's medication records (PMRs), but examples of recording interventions were not made available. The pharmacy had some tools available to support people taking higher risk medicines. For example, steroid treatment cards and INR monitoring booklets. Pharmacy team members were knowledgeable about the requirements of the valproate pregnancy prevention programme. The pharmacy had patient cards and counselling materials available to support it in supplying valproate. A discussion during the inspection about the appropriate placement of labels on valproate containing medicines prompted the team to add the topic to its next Safer Care briefing.

The RP discussed planning for new services, including the upcoming launch of the NHS hypertension case findings service. Risks associated with the supply of Saxenda through a weight management service were identified and managed. The service involved face-to-face consultations with a pharmacist prior to people commencing treatment and at four weekly intervals. The RP contacted people by telephone for weekly reviews between physical appointments. And kept records of these interventions. The patient group direction used to supply Saxenda included clear information related to record keeping for the service. This included recording a person's BMI at each face-to-face consultation. People using this service also had access to lifestyle support through a smartphone application.

The pharmacy held records associated with the delivery of medicines. This supported the team in answering any queries relating to the service. The pharmacy retained prescriptions for owed medicines,

and dispensed from the prescription when later supplying the owed medicine. The pharmacy made supplies of medicines to the care home in original boxes with medication administration records (MARs) provided. This supported the safe administration of medicines and the re-ordering of prescriptions. The pharmacy managed prescription queries with the care home. And it recorded clinically significant information on PMRs. For example, allergy status. Workload associated with the supply of medicines in multi-compartment compliance packs was generally well managed. The pharmacy used individual patient record sheets to record people's medication regimens. But team members did not use one consistent process for recording changes on these sheets. A discussion took place about the need to follow one process with clear audit trails of the changes made. A sample of assembled compliance packs contained full dispensing audit trails and clear descriptions of each medicine inside the packs. The pharmacy routinely supplied patient information leaflets alongside compliance packs.

The pharmacy sourced medicines from licensed wholesalers. It stored medicines in an orderly manner, within their original packaging, on shelves and in totes. The pharmacy stored CDs appropriately within secure cabinets. It stored assembled CDs and high-risk cold chain medicines in clear bags. This prompted additional checks when handing out the medicine. The pharmacy's fridge was an appropriate size for stock held. The pharmacy's fridge temperature record confirmed that the fridge was operating within the correct temperature range of two and eight degrees Celsius. The team regularly recorded the completion of date checking tasks on a matrix in the dispensary. A random check of dispensary stock found no out-of-date medicines. And the team annotated liquid medicines with details of their shortened shelf-lives once opened. The pharmacy had appropriate medicinal waste bins and CD denaturing kits available. It received and actioned medicine alerts electronically.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the required equipment for providing its services. It generally maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

The pharmacy had up-to-date written and electronic reference resources available. Written reference resources included the British National Formulary (BNF). Pharmacy team members had access to the internet and intranet. The pharmacy protected its computers from authorised access through the use of passwords and NHS smart cards. It stored bags of assembled medicines in a designated area within the dispensary. This protected information on bag labels from unauthorised view. Pharmacy team members used cordless telephone handsets. This meant they could move out of earshot of the public area if the phone call required privacy.

The pharmacy team used crown-stamped measuring cylinders for measuring liquid medicines. Equipment for counting capsules and tablets was also available. There was separate equipment available for counting and measuring higher risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. Equipment used to support the delivery of pharmacy services was generally maintained. For example, the pharmacy's blood pressure machine was replaced at regular intervals. But there was no evidence of recent calibration checks associated with the pharmacy's glucometer. The team did report that due to the backlog of work the pharmacy had not promoted the type 2 diabetes testing service for some time. But this did highlight the need to ensure the pharmacy worked in accordance with NHS point of care testing guidance. Electrical equipment was subject to regular portable appliance testing.

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.