General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 473 Warrington Road, Rainhill, ST. HELENS, Merseyside, L35 4LL

Pharmacy reference: 1034724

Type of pharmacy: Community

Date of inspection: 27/11/2019

Pharmacy context

This is a community pharmacy situated on a major road near two GP surgeries. It is located in Rainhill, near Prescot in Merseyside. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including a minor ailment service, emergency hormonal contraception, seasonal flu vaccinations, and travel vaccinations. A number of people receive their medicines in multi-compartment compliance aids.

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	Good practice	1.2	Good practice	The pharmacy team record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again.
		1.7	Good practice	Members of the team are given training so that they know how to keep private information safe.
2. Staff	Good practice	2.2	Good practice	Members of the pharmacy team complete regular training modules to help them keep their knowledge up to date.
		2.4	Good practice	The pharmacy team routinely discuss things that go wrong and receive feedback about this work.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy provides services safely, and additional checks are carried out for people who take higher risk medicines to ensure they are safe to supply.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Good practice

Summary findings

The pharmacy team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy keeps the records it needs to by law. And members of the team are given training so that they know how to keep private information safe. They record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again.

Inspector's evidence

There was a current set of standard operating procedures (SOPs), some of which were reviewed in July 2019 by the head office. Members of the pharmacy team had signed to say they had read and accepted the SOPs. The pharmacy had implemented the company's "safercare" programme to help review and learn from routine processes and procedures. Each month audits were completed to ensure compliance in various areas. This included the environment – ensuring the premises were tidy and stock appropriately stored, and process – to ensure regular housekeeping tasks were carried out such as near miss records and fridge temperatures.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). A recent error involved the incorrect supply of pantoprazole instead of paroxetine. The pharmacist had investigated the error using a root cause analysis and discussed his findings with the pharmacy team. Action had been taken to help reduce the risk of further errors, such as segregating the medicines away from each other. Near miss incidents were recorded on a paper log. The pharmacist explained that he would highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. The pharmacist said he would also review the near miss records to identify any trends. He gave examples of action which had been taken to help prevent similar mistakes. For example, moving different strengths of bisoprolol tablets away from one another. The company shared learning between pharmacies in a bulletin on the intranet. Amongst other topics they covered common errors and learning topics. The pharmacy team would discuss the information when it was received.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A pharmacy student was able to explain what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms and had badges identifying their names and roles. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure. This was described as part of a customer charter leaflet and it advised people they could give feedback to members of the pharmacy team or to the head office. Complaints were recorded to be followed up by the pharmacist manager or the head office. A current certificate of professional indemnity insurance was on display.

Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available. The pharmacy team received IG training and each member had signed a confidentiality agreement. When questioned, a pharmacy student was able to

describe how confidential waste was segregated to be removed by a waste carrier. The pharmacy's privacy notice was on display which described how the pharmacy handled and stored people's data.

Safeguarding procedures were available. The pharmacy team had completed in-house training and the pharmacist said he had completed level 2 safeguarding training. Contact details to raise safeguarding concerns were on display in the dispensary. A dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Good practice

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete regular training modules to help them keep their knowledge up to date. They routinely discuss things that go wrong and get regular feedback from their manager to help them improve.

Inspector's evidence

The pharmacy team included a pharmacist manager, four dispensers, a pharmacy student, and a medicine counter assistant (MCA). All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist and four other staff. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff could also be requested from the head office. The pharmacy was in the process of recruiting a new member of the team after a dispenser had recently transferred to another branch.

The pharmacy provided the team with a structured e-learning training programme. And the training topics appeared relevant to the services provided and those completing the e-learning. Training records were kept showing that ongoing training was up to date. Staff were allowed learning time to complete the training.

A pharmacy student gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse co-codamol sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said he felt able to exercise his professional judgment and this was respected by the pharmacy team and the head office. A dispenser said she felt a good level of support from the pharmacist and she felt able to ask for further help if she needed it.

Appraisals were conducted annually by the pharmacy manager. A dispenser said she felt that the appraisal process was a good chance to discuss her development in an open manner. The staff held a monthly ‘safercare briefing’ about errors and learning. Details about what was discussed were documented and this was signed by staff who were present. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the head office. There were service-based targets for MURs, NMS and Flu. The pharmacist said he did not feel under pressure to achieve the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. A sink was available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary. Access to the dispensary was restricted by the position of the counter. The temperature was controlled by the use of electric heaters. Lighting was sufficient. The staff had access to a kitchenette and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a computer, desk, seating, and adequate lighting. The patient entrance to the consultation room was clearly signposted and indicated if the room was engaged or available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. Members of the pharmacy team identify patients who take higher-risk medicines. Then they check that the medicines are still suitable and give people advice about taking them.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was also wheelchair access to the consultation room. Pharmacy practice leaflets gave information about the services offered and the opening hours. Information was also available on the website. Pharmacy staff were able to list and explain the services provided by the pharmacy. If the pharmacy did not provide a particular service staff were able to refer patients using a signposting folder. A range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and logged onto an electronic delivery management system. The driver used an electronic device to obtain an electronic signature to confirm receipt. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. CDs were recorded on a separate delivery sheet for individual patients and a signature was obtained to confirm receipt.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied. Dispensed medicines awaiting collection were kept on a collection shelf using a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out.

Schedule 3 and 4 CDs were highlighted so that staff could check prescription validity at the time of supply. High-risk medicines (such as warfarin, lithium and methotrexate) were also highlighted and patients who were counselled on their latest results and this was recorded on their PMR. Members of the pharmacy team were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said he would speak to any patients who were at risk to make sure they were aware of the pregnancy prevention programme, which would be recorded on their PMR.

Some prescriptions were dispensed by an automated hub as part of the company's off-site dispensing (OSD) programme. Patients gave consent when they signed up to the repeat prescription service. Prescriptions for the hub were labelled electronically at the pharmacy by staff who had been specifically trained to label OSD prescriptions. The pharmacist was then required to complete an accuracy check of the labels and a clinical check on the items. The information was then transmitted to the hub for the

medicines to be dispensed. Some items could not be dispensed by the hub, including items out of stock, not stocked, or CD and fridge items. The process was auditable by use of a personal log in to identify who had labelled the prescription and who performed the accuracy check.

Dispensed medicines were received back from the hub within 48 hours. They were delivered in sealed totes that clearly identified that they contained dispensed medicines. The medicines were packed in sealed clear bags with the patient's name and address the front. These did not need to be accuracy checked by the pharmacy unless they opened the bag, in which case the responsibility for the final accuracy check fell to the pharmacy rather than the hub. When the dispensed medicines were received in branch, they were matched up with the prescription forms, any other bags from the OSD and any exception items that had been dispensed and checked by the branch.

Some medicines were dispensed in multi-compartment compliance aids. People were referred to their GP for an assessment about whether they were suitable to receive their medicines in a compliance aid pack. A record sheet was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge sheets were sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

The pharmacy dispensed medicines for a number of patients who were residents of care homes. A re-order sheet was provided by the home with details about the medicines required, medicine changes and any handover notes for the pharmacy. When prescriptions were received from the GP surgery they would be compared to the re-order sheet to confirm all medicines had been received back. Any queries or outstanding medicines were chased up with the GP surgery. Medicines were dispensed into disposable compliance aids and a dispensing and checking signature was written onto the seal. PILs were provided to the care home.

The pharmacy offered a travel vaccine service using various patient group directions (PGD). The pharmacist had completed the necessary training required by the PGDs and the pharmacy was registered as a yellow fever site. Records were kept, and the patient’s GP was informed following the vaccination.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine checks of medicines. Stock was date checked on a 3-month rotating cycle. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker and liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There were clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had been in range. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the head office. Alerts were printed, with the details about the action taken, date and by whom written onto a drug alert log.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. According to the stickers attached, electrical equipment had been PAT tested in November 2019. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required.

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.