General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 5 Warwick Parade, Kenton Lane, HARROW, Middlesex, HA3 8SA

Pharmacy reference: 1035014

Type of pharmacy: Community

Date of inspection: 03/07/2019

Pharmacy context

A Lloyds pharmacy located in a small shopping parade in Kenton, Harrow. The pharmacy dispenses NHS and private prescriptions, sells a range of over-the-counter medicines and provides health advice. The pharmacy also dispenses some medicines in multi-compartment compliance packs (MDS trays or blister packs) for those who may have difficulty managing their medicines at home and for patients in care homes. The pharmacy provides a supervised consumption service and a local delivery service.

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	1.1	Good practice	The pharmacy team regularly record incidents which occur in the pharmacy, identify ways to make changes and share this learning.
2. Staff	Standards met	2.2	Good practice	The team have regular training and dedicated time to complete this.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy was dated in appearance, had rotten woodwork around the doorframe and a trip hazard in the dispensary due to cracked flooring.
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

Overall, the pharmacy's working practices are safe and effective. Team members record, review and share their mistakes to help reduce the risk of them happening again. The pharmacy keeps all the records that it needs to by law and it keeps people's information safe. Team members help to protect vulnerable people.

Inspector's evidence

A near miss log was present in the pharmacy and was seen to be used by the pharmacy team. The pharmacist explained that as they were a new team, they were trying to encourage everyone to record near misses regularly and to think about them in detail to identify why the near miss occurred and what the team could do to prevent a recurrence. The pharmacist explained that the team would also discuss errors and near miss learning in a Whatsapp group so that even if team members were off, they were aware of what had occurred and any subsequent changes.

The pharmacy team would carry out a Root Cause Analysis following significant dispensing incidents. Examples of previous analyses were seen to be held in the 'Safer Care' logbook. The pharmacist explained that she would always get the person who made the error to enter the analysis information to make them think about what had happened. She gave an example of an error made where a member of the team had missed a patient's title when entering information about a prescription for off-site dispensing. The member of the team then commented later about how the Root Cause Analysis made her concentrate more on how titles should be entered. The team completed a 'Safer Care' checklist on a weekly basis to ensure they have the right environment, people and processes to deliver a safe pharmacy service. Examples of previous 'Safer Care' checklists were seen.

Anything identified in the 'Safer Care' checklists or with the near misses was highlighted on a 'Safer Care' notice board displayed in the dispensary. The current information on the board included the team highlighting the separation of ramipril capsules and tablets on the shelves and using split boxes before new boxes where possible. The pharmacist explained that the team would have a meeting every month to discuss anything in the Safer Care process including near misses, errors and the checklists.

There was an established workflow in the pharmacy where labelling, dispensing and checking were all carried out at dedicated areas of the work benches. Trays for domiciliary patients were prepared on a dedicated dispensing bench. Dispensing labels were seen to have been signed by two different people indicating who had dispensed and who had checked a prescription.

All the SOPs had the roles and responsibilities of each member of staff set out and on questioning, one of the summer placement students explained that they were all clear on their roles and responsibilities and that they would refer to the pharmacist if they were unsure of anything. The SOPs had all been read by the team members and signed off. A certificate of public liability and professional indemnity insurance from the NPA was available and was valid until the end of June 2020.

There was a complaints procedure in place and the staff were all clear on the processes they should follow if they received a complaint. The complaints procedure was detailed in the Customer Charter

Standards of Service leaflet which was available to the public in the consultation room. The leaflet contained the contact information for the company's head office as well as the Patient Advisory Liaison Service (PALS). The previous Community Pharmacy Patient Questionnaire (CPPQ) survey was displayed on the NHS Choices website and in the retail area of the pharmacy and was positive.

Records of controlled drugs and patient returned controlled drugs were all seen to be complete and accurate. A sample of Zomorph 200mg capsules was checked for record accuracy and was seen to be correct. The controlled drug running balance was checked every week by the pharmacist for both the solid and liquid drugs.

The maximum and minimum fridge temperatures for the two pharmacy fridges were recorded by the team. One of the fridges had temperatures in the 2 to 8 degrees Celsius range, but the other one had a maximum temperature recoded of 21.7 degrees Celsius on the day of the inspection. The pharmacist explained that as the fridge still felt cold, the team assumed the thermometer was faulty and so they replaced it and were waiting to re-read the temperature to see if it was in range. The fault and re-reading of the temperature were all annotated on the fridge temperature log.

The responsible pharmacist record was seen as complete and the responsible pharmacist notice was displayed in the pharmacy where patients could see it. The private prescription records were seen to be completed appropriately. Date checking was carried out in a manner which meant the whole pharmacy is date checked four times in a year and records of this were seen to be completed appropriately. The specials records were all held in a file and the certificates of conformity were seen to contain all the required information.

The computers were all password protected and the screens were not visible to the public. Conversations inside the consultation room could not be overheard. There were cordless telephones available for use and confidential waste paper was collected in white confidential waste bags which were removed by the company for destruction. Information Governance (IG) practice was reviewed annually in the pharmacy against the requirements and the team had submitted the latest IG Toolkit.

The pharmacist had completed the Community Pharmacy Post-Graduate Education (CPPE) learning module on safeguarding children and vulnerable adults. The pharmacy team had also been trained on safeguarding children and vulnerable adults and had signed a training matrix to say they had read and understood the training and were competent to safeguard children and vulnerable adults. The contact details for all the relevant safeguarding authorities were seen to be held in a signposting and safeguarding file.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services safely. Team members have access to training materials to ensure that they have the skills they need, and the pharmacy gives them time to do this training. Pharmacy team members make decisions and use their professional judgement to help people. Team members can share information and raise concerns to keep the pharmacy safe.

Inspector's evidence

During the inspection, there was one pharmacist, three pharmacy summer students, one NVQ Level 2 dispenser and one medicines counter assistant. The staff were observed to be working calmly and well together and providing support to one another when required.

Staff performance was monitored formally in a review twice a year. During these reviews, the manager and the staff would have a two-way discussion about performance as well as any improvements which would be required and training and development needs.

The team members completed training online and had a medicines skills assessment every month to assess their knowledge and understanding of products and services. The dispenser explained that each team member is provided with protected training time to complete their learning modules during the pharmacy opening hours.

The staff members recorded their own near miss incidents and explained that they would often discuss with one another the ways in which they could reduce the likelihood of regular near misses from occurring.

The company had an annual staff satisfaction survey which was an opportunity for the staff to feedback any opinions they had about their roles and the company anonymously. The results of this would be published on the company’s intranet. The members of staff also explained that they were more than happy to raise any concerns they had instantly with the pharmacist. There was also a whistleblowing policy in place and a poster of about this was displayed in the staff areas of the building. The team was aware of this and was happy to use it if required.

There were targets in place for MURs and NMS, but the team explained that they did not feel any pressure to deliver these targets and would never compromise their professional judgement to achieve targets.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is clean, but fixtures and fittings are dated, and create a hazard in some areas. Pharmacy team members use a private room for sensitive conversations with people. The pharmacy is secure when closed.

Inspector's evidence

The pharmacy was based on the ground floor of the building and included a retail area, medicines counter, consultation room, dispensary and staff bathroom.

The pharmacy was clean but dated in appearance and cluttered due to a lack of storage space. There was a cleaning rota displayed in the dispensary with different weekly cleaning tasks which the members of staff took ownership of. However, although the pharmacy was cleaned by the team, the effect was limited due to the age of the fixtures and fittings. The woodwork around the front doors was rotting and dirt had collected in the light fixtures causing discolouration. The floor in the dispensary had cracked creating a trip hazard and the retrieval area for completed prescriptions was screened with a curtain.

The pharmacy was presented well and laid out with the professional areas clearly defined away from the main retail area. All the products for sale within the pharmacy area were healthcare related and relevant to pharmacy services.

Medicines were stored on the shelves and in the drawers in a generic and alphabetical manner and the manager explained that the shelves would be cleaned when the date checking was carried out.

The dispensary was screened to allow for the preparation of prescriptions in private and the consultation room was advertised as being available for private conversations. Conversations in the consultation room could not be overheard and the consultation room could be locked when not in use. The consultation room was fit for purpose and included seating, a computer with the PMR and storage.

There was a sink available in the dispensary with hot and cold running water to allow for hand washing and the preparation of medicines.

The ambient temperature was suitable for the storage of medicines but on a hot day, the dispensary could be quite warm. The pharmacist explained they could open the back door and draw a grille over the door to allow for an air flow in the dispensary. Lighting throughout the store was appropriate for the delivery of pharmacy services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people with different needs. Staff members provide the pharmacy services safely and can identify people who require extra counselling. The pharmacy sources and stores medicines appropriately.

Inspector's evidence

Pharmacy services were clearly displayed in the shop window and on posters around the pharmacy area. There was a range of leaflets available to the public about services on offer in the pharmacy near the medicines counter and in the consultation room.

There was step-free access into the pharmacy and seating for patients or customers waiting for services. The pharmacy also had an induction loop available should someone require it. The team explained that they served a diverse population and would use their own language skills where necessary to communicate with patients.

The MDS trays and care home medicines were organised into a four-week cycle. The team used a rota to document which patient and care home would be having their deliveries on each day. The MDS trays were supplied with descriptions of the medicines inside and Patient Information Leaflets (PILs) were provided every month.

The pharmacist explained that the pharmacy had been commissioned to deliver Emergency Hormonal Contraception, but the pharmacists who worked there were not currently accredited. Therefore, the pharmacist explained that she would be attending the training for this in October.

The team explained that they were all aware of the requirements for women in the at risk group to be on a pregnancy prevention programme if they were on valproates and they had checked the PMR to see if they had any patients affected by this. The team also had a folder in place in the dispensary with valproate information cards, leaflets and stickers inside which they would use every time they dispensed valproates.

The dispenser explained that when dispensing prescriptions for warfarin, they would ask patients for their anti-coagulant monitoring books and they would check their INR levels and that they were having regular blood tests. The team would also place 'Pharmacist' stickers on all prescriptions with warfarin to highlight that on hand out, these prescriptions require extra counselling.

The team were aware of the EU Falsified Medicines Directive (FMD) and explained that they were one of the stores which were trialling the decommissioning of medicines for the company. The dispenser demonstrated how they would use the scanners and software to decommission medicines as they worked.

The pharmacy obtained medicinal stock from AAH and Alliance. Specials were ordered from AAH Specials. Invoices were seen to demonstrate this.

There were destruction kits available for the destruction of controlled drugs and doop bins were

available and being used for the disposal of medicines returned by patients. There was also a bin for the disposal of hazardous waste and a list of hazardous waste medicines which need to be disposed of in these bins.

The fridges were in good working order and the stock inside was stored in an orderly manner.

MHRA alerts came to the team electronically through the company's intranet and they were actioned appropriately. The team kept a robust audit trail for the MHRA recalls and recorded when they had received the recall as well as who had actioned it and what action had occurred following the recall. Recently, the team had received a recall regarding stock which had been highlighted due to FMD which they had actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

There were several crown-stamped measures available for use, including 100ml, 50ml and 10ml measures. Some were marked with pink paint to show they should only be used with methadone liquid. They were all seen to be clean.

Amber medicines bottles were seen to be capped when stored and there were counting triangles available as well as capsule counters.

Up-to-date reference sources were available such as a BNF, a BNF for Children and a Drug Tariff as well as other pharmacy textbooks. Internet access was also available should the staff require further information sources.

The fridges were in good working order and the maximum and minimum temperatures were recorded daily.

The pharmacy had two computer terminals with the PMR on it, but the team explained that they struggled with this as the dispenser who prepared the MDS tray could often not get onto a terminal to prepare dispensing the trays.

Doop bins were available for use and there was sufficient storage for medicines. Hazardous waste bins were also available as well as lists of which drugs were hazardous.

The computers were all password protected and conversations going on inside the consultation could not be overheard.

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.