General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 22 West End Street, NORWICH, Norfolk, NR2 4JJ

Pharmacy reference: 1035370

Type of pharmacy: Community

Date of inspection: 24/11/2022

Pharmacy context

This community pharmacy is opposite a medical centre in a largely residential area. Its main service is dispensing NHS prescriptions, some of which are delivered to people's homes. It also supplies some medicines in multi-compartment compliance packs to people living at home who need help managing their medicines. The pharmacy provides seasonal flu vaccinations and hepatitis B immunisation. It has a considerable number of people who receive instalment supplies on a daily and weekly basis, including for substance misuse treatment. It operates a needle exchange scheme. And it receives some referrals through the Community Pharmacy Consultation Service.

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	Standards met	1.8	Good practice	The pharmacy's team members proactively follow-up with vulnerable people, or with people who support them, to make sure people's health and welfare is protected.
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 manages the risks associated with its services effectively. It shows particular care when providing services to more vulnerable people. And liaises with other agencies to protect people's welfare. It has up-to-date procedures which tell staff how to work safely. It generally makes the records it needs to by law within the required timescales. And it protects people's information. The pharmacy team members learn from their mistakes so they can make their services safer.

Inspector's evidence

The pharmacy had written procedures for staff to support safe ways of working. There was evidence that staff had read procedures that were relevant to their roles. And staff were seen to follow procedures relating to dispensing; items were signed by the people who dispensed and checked them to create an audit trail. The pharmacy's team members were aware of when they needed to refer queries to the responsible pharmacist (RP) and were seen doing so during the inspection. They understood what they could and couldn't do if there was no RP at the pharmacy. And they could explain the restrictions on sales of some products, including medicines containing codeine. The pharmacy did not sell codeine linctus or Phenergan and the team was aware of the abuse potential of these medicines. Staff could be identified by members of the public as they wore uniforms and most had name badges.

The dispensers recorded mistakes they made and corrected during the dispensing process (near misses). The records seen had limited information about why mistakes had happened and what was being done to try to prevent similar events happening again. The team accepted the records could be improved to make more of the opportunity to learn and improve from these events. The team members could explain how a dispensing mistake which had reached a patient was dealt with. This included correcting the mistake and looking after the patient, making a record of the incident, reporting it to head office, and reviewing the error to understand how it had happened and how to prevent a similar occurrence in the future. To prevent common selection errors, the team had separated products which looked or sounded similar. They had also focussed on making sure part-used boxes were clearly marked to prevent mistakes happening. Details about common mistakes made at this pharmacy and elsewhere in the company were shared through regular team briefings.

Staff were able to explain how a complaint should be handled and would refer to the pharmacist on duty when needed. There was some information about the pharmacy's complaints process displayed in the pharmacy. And staff would also refer to this if people wanted to escalate an issue.

The pharmacy had professional indemnity and public liability insurance in place. There was a notice displayed for the public showing details of the current RP on duty. A paper record about the RP was available but only for very recent dates. The RP explained there had been a misunderstanding about how the record should be kept and wasn't sure the electronic version was complete. So, the pharmacy had very recently reverted to keeping the paper record. Private prescriptions were recorded in a book, and these were up to date. Records viewed about controlled drugs (CDs) were up to date and were mostly complete though some headers were not filled in. Running balances were recorded and checked regularly. The recorded stock of an item chosen at random agreed with physical stock. CDs returned by people for destruction were recorded as soon as they were received. There was an audit trail for

destroyed CDs.

When asked, staff understood the need to keep people's information private. There were written procedures to protect people's information, and these had been read by the staff. Computer screens containing patient information could not be seen by the public. Confidential waste was separated from normal waste and disposed of securely.

The RP had completed level 2 safeguarding training and team members had a very good understanding of their role in protecting vulnerable people. Information about local safeguarding agencies was displayed in the dispensary. The team members gave several examples of following-up with people if they didn't collect their medicines as expected or if a person did not take delivery of their regular medicines. They had, on occasions, liaised with police and other agencies to make sure a welfare check was made. And they had raised concerns with other healthcare professionals where they had concerns about possible coercion or abuse to make sure a person was supported appropriately.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to cope with its workload. The pharmacy’s team members work closely together and communicate well with each other, sharing information appropriately to make the pharmacy’s services safer. And they have the right training for the roles they undertake. The team members complete ongoing training to keep their skills and knowledge current.

Inspector's evidence

The RP on duty during the inspection provided most of the pharmacist cover at the branch and was employed by the company. He was supported by a non-pharmacist pharmacy manager who was not present. There was also two dispensers and a trainee medicine counter assistant on duty. Two further members of the team were on days off; a trainee dispenser and a trained dispenser who worked at a few local branches. Prescription deliveries were made through a courier service.

The team members were coping with their workload during the visit. This was said to be a relatively quiet day and gave the team members chance to catch up. The trainee medicine counter assistant was serving customers promptly and referred queries to more experienced members of the team when needed. Dispensing and checking activity was prioritised and some work, such as dispensing and checking monitored dosage compliance packs, was left until quieter times of the day to reduce risks. The team members were seen discussing queries with each other throughout the visit and referring issues to the RP where needed. The team members had an electronic messaging group to share relevant information and pass on messages to other team members when needed.

There were training certificates for some of the support staff, showing the pharmacy qualifications they had achieved. And there were arrangements in place for new starters to be enrolled onto suitable courses for their role. The staff received ongoing training materials from the company and had individual training records to keep track of completing these. They completed regular training updates about safeguarding vulnerable people, health and safety, and pharmacovigilance.

The RP explained how, as a newly qualified pharmacist, he was very well supported by the company and had the opportunity to network with his peers at training events held over four days per year. He said he felt able to exercise his professional judgement to act in people’s best interest. And he provided examples about how he acted to safeguard vulnerable people receiving instalment supplies. Other team members said they had team meetings where they discussed safety incidents and updates and could make suggestions about how to improve the pharmacy’s services. They said they would feel comfortable about raising any concerns with their branch manager or more senior management.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the safe provision of pharmacy services and are maintained adequately. People can use a separate room to have a private conversation with members of the pharmacy team.

Inspector's evidence

The entrance to the pharmacy was at street level and the door was wide enough to accommodate prams or wheelchairs. The shop floor area was reasonably clear of clutter and there were no trip hazards. Medicines stock was kept off the floor. Access to the dispensary was restricted. Members of staff had good visibility of the medicine counter and pharmacy-only medicines were stored out of reach of the public. The pharmacy could be secured against unauthorised access.

The dispensary was sufficiently spacious for the work undertaken. There was adequate storage space for stock and dispensed items. The premises were fitted out to a basic standard. Public-facing areas and the dispensary were generally clean. A small part of the dispensary ceiling had yet to be repaired following previous water leaks which had been resolved. And some lighting in a storeroom wasn’t working. The consultation room was a good standard and provided a private place for people to have conversations and access pharmacy services.

The room temperature was appropriate for storing medicines and could be controlled. Lighting was adequate for safe dispensing. People’s information on dispensed items waiting to be collected could not be easily seen by members of the public. There was a WC and separate hand washing facilities available for staff. The sink in the dispensary used for reconstituting medicines was clean. Soap and hot and cold running water were available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages its services effectively. The pharmacy's team members prepare compliance packs and other instalment supplies safely. And the pharmacy stores its medicines appropriately. The pharmacy's team members generally know the checks to make with people when supplying higher-risk medicines. But the prescriptions for these items are not always highlighted. So, the pharmacy may sometimes miss out on making sure people get all the information they need to take their medicines safely.

Inspector's evidence

The pharmacy's opening hours were displayed at the entrance; these included advance information about Xmas opening hours. There was some health information literature about self-care displayed in the retail area. And there were notices about the services the pharmacy offered displayed. The pharmacy delivered medicines to some people. There was an audit trail for this service to show that medicines had reached the right people. Baskets were used to keep prescriptions for different people separate. Prescriptions that were waiting to be accuracy checked were placed on a shelf below the dispensary workbench so they could be checked at quieter times. A dispenser said the pharmacy had adopted a new approach to bagging these prescriptions and this had made the process more efficient.

The pharmacy supplied medicines in multi-compartment compliance packs to people who lived in their own homes. The dispensers prepared these packs in a separate, quieter part of the dispensary to reduce risk. They had individual records for the people receiving these packs and added notes to these records when there were changes or other interventions. The packs seen were labelled with the dose and a description of the medicines added. There was an audit trail on the packs to show who had dispensed and checked each pack. More than one dispenser knew how to prepare these packs so there was continuity of service for holidays. Patient information leaflets were supplied every four weeks. The pharmacy also supplied daily and weekly instalments of tablets in separate pouches to a large number of people who needed assistance managing their medication. These instalments were prepared in advance where possible to reduce errors and relevant information about the medicines, including the original container, was kept with the part-prepared supplies so it could be readily referred to.

The pharmacy had the current safety literature about pregnancy prevention and the RP had read recent communications from the GPhC about what the pharmacy needed to do when supplying valproate-containing medicines to people in the at-risk group. The RP said the pharmacy didn't currently supply to anyone in the at-risk group. The pharmacy highlighted prescriptions for CDs so that members of staff could check they were still valid when handing the medicines out. The team members understood most of the types of checks they should make when supplying higher-risk medicines such as warfarin so that people were given advice about possible side-effects and to make sure that people were taking the right dose. But they didn't know about checking for symptoms of a sore throat when supplying methotrexate. And prescriptions for these higher-risk medicines weren't highlighted. So, the pharmacy could have been missing opportunities to give advice to people. The team members said they would start using alert stickers to highlight these prescriptions in future.

Medicines were obtained from licensed suppliers, but the pharmacy was having difficulties ordering quite a few medicines currently. Medicines subject to supply problems were listed on a white board in

the dispensary so members of staff could let patients know quickly if they couldn’t supply these medicines. Information about medicine shortages were shared across branches and the RP signposted people to other pharmacies who he knew used different suppliers when he couldn’t dispense a prescription. Medicines were generally stored tidily on shelves in the dispensary though medicines on higher shelves were a little disorganised and some medicines were kept in plastic totes on the floor under the shelves. Waste medicines were stored in designated bins. When stock was spot-checked, there were no out-of-date medicines found. There was some evidence that medicines with short shelf-lives were highlighted and there was a rota to make sure all parts of the dispensary and shop areas were date-checked regularly. Staff understood the need to keep medicines in appropriately labelled containers so they could date-check effectively and respond to drug recalls efficiently. There were a small number of packs found to contain mixed expiry dates and batches. The team members said they would stop this happening again. Following previous incidents, the team paid particular attention to marking part-used boxes to prevent dispensing errors. Medicines that required refrigerated storage were kept in one of two pharmacy fridges. Maximum and minimum fridge temperatures were monitored and recorded for both fridges and had remained within the required range. There was enough storage capacity in the fridges and no evidence of ice build-up. A dispenser was able to confidently explain how the pharmacy received and responded to medicine recalls and drug alerts, making sure affected medicines were removed from stock, quarantined, and returned to suppliers when needed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. It checks its measuring equipment is working correctly on a regular basis. And it keeps sensitive information on its equipment out of view of the public.

Inspector's evidence

The electronic patient medication record system was only accessible to pharmacy staff and computer screens could not be viewed by the public. Members of the team used smartcards to access electronic NHS prescriptions but not all members of the team could use their own smartcards to do this. The pharmacy was trying to remedy this. The pharmacy had cordless phones, so staff could move to private areas to hold phone conversations out of earshot of the public and computer screens could not be seen from the shop area. Staff had a range of reference sources to use, including online resources, so advice provided to people was based on up-to-date information. The equipment used for measuring liquids, was of an appropriate standard and was clean. Some measures were used solely for measuring CDs to prevent cross-contamination. And there were good processes in place to make sure the Methameasure device was cleaned and calibrated regularly. The pharmacy had the appropriate sundries available for providing the vaccination service safely.

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.