General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 128 Battle Road, Hollington, ST. LEONARDS-ON-SEA, East Sussex, TN37 7AN

Pharmacy reference: 1036268

Type of pharmacy: Community

Date of inspection: 08/01/2020

Pharmacy context

This is a busy community pharmacy on a main road in St Leonards-on-Sea. Two local pharmacies owned by the same company have closed down in December 2019. The pharmacy mainly dispenses NHS prescriptions and offers a substance misuse service for some people. It dispenses medications into multi-compartment compliance packs for a large number of people in their own homes who need help managing their medicines. And it also supplies these packs to several care homes.

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	1.7	Standard not met	The pharmacy doesn’t protect people’s personal information properly. Some people's personal information is not stored securely. And the pharmacy doesn't always dispose of confidential waste appropriately.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy doesn’t have enough staff to manage its workload effectively. The pharmacy is significantly behind on dispensing prescriptions, and it can take some time to provide people with their medicines.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy is untidy and there are tripping hazards for staff in the dispensary. Non-public facing areas are messy and cluttered.
		3.4	Standard not met	Although the premises themselves are secure, the pharmacy does not sufficiently protect access to some areas of the pharmacy.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy is behind on dispensing and is not providing its services effectively.
		4.3	Standard not met	The pharmacy doesn’t keep all its medicines securely, which means they are less protected from unauthorised access. And it can’t show that medicines that require cold storage have always been stored at the right temperatures.
		4.4	Standard not met	The pharmacy can’t show how it has responded to recent drug alerts and recalls. This could increase the risk that people are supplied medicines or medical devices that are not safe to use.
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 protect people's personal information properly. And there are some issues including staffing levels and with medicines storage. But otherwise the pharmacy adequately manages the risks associated with its services. It largely keeps the records it needs to so that it can show medicines are supplied safely and legally. Team members know how to protect vulnerable people. And people who use the pharmacy can provide feedback and raise concerns. Team members respond appropriately when mistakes happen during the dispensing process. But they do not always record and regularly review mistakes that happen. And this may mean that they miss out on opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

The inspection was undertaken over two consecutive days, due to how busy the pharmacy was. The report relates to what was observed over both days, unless specified differently in the text.

A range of standard operating procedures (SOPs) was available. Several team members had signed to indicate that they had read and understood them, but many of these people had since stopped working at the pharmacy. Not all the newer staff had signed the SOPs, but many had transferred from other branches of the same pharmacy so were familiar with them. The manager said that he would ensure all team members went through the SOPs and would get them to sign to indicate this.

A book was available for recording near misses, where a dispensing mistake was identified before the medicine was supplied to a person. But near misses had not been recorded since 19 December 2019, and there had been 13 near misses recorded that day. Team members accepted that it was likely that some near misses had happened since then and had not been recorded. A dispenser said that the locum pharmacists had been highlighting near misses to team members as they occurred. She gave an example of a near miss where the wrong strength of phenytoin had been dispensed, and this had been discussed in the team to make everyone aware. Dispensing errors, where a dispensing mistake was made and it had been supplied to a person, were recorded on the company's electronic system. The manager was not aware of any recent errors which had been reported directly to the pharmacy, but he was aware of some that had been reported via the pharmacy's head office. The dispenser said an error had been reported where the wrong strength of amoxicillin had been dispensed, and as a result they had separated each strength into a different place in the dispensary.

The company used a system called 'Safer Care' to review near misses and dispensing errors and to check that the pharmacy's procedures were being followed. But the regular Safer Care reviews were not being done, and the last recorded one found was from July 2019. Team members said that the pharmacy been too busy for them to undertake the regular monitoring and checks.

The dispenser could explain what she could and couldn't do if the pharmacy had not turned up in the morning. Team member's roles and responsibilities were described in the SOPs.

The pharmacy undertook an annual patient survey. Results from the most recent survey in 2019 were largely positive with 94% of respondents rating the pharmacy as very good or excellent overall. Some respondents had made comments about the waiting time and not having all their items in stock. No

leaflets or signs were found in the public area to explain how people could provide feedback or raise concerns. And this could make it harder for people to know how to do this. The pharmacy had a complaints procedure, but as not all team members had signed it, it was not clear if they were fully familiar with it.

There was a copy of the current indemnity insurance certificate displayed. The right responsible pharmacist (RP) notice was displayed and the RP log had been completed correctly. Private prescription records, emergency supply records, and controlled drug (CD) registers seen complied with requirements. CD running balances were maintained. Records of unlicensed medicines supplied were seen to have been completed correctly. But the most recent records found were from November 2019. The manager said that unlicensed medicines had been supplied since this date and would locate the more recent records. The recent records were not available during the inspection.

Separate bins were available for the destruction of confidential waste, but some of these bins were next to the bins for general waste. On both days of the inspection labels containing people's personal information were found in with general waste; these were immediately removed. Some prescriptions containing people's personal information were found to be not stored securely. Team members said that this was due to a lack of storage space. Computer terminal screens were turned away from the public and the terminals were password protected. Some team members had individual smartcards to access the NHS electronic systems. But on the second day of the visit there was some sharing of smartcards as the team members from other stores could not use them in this pharmacy. And some staff had recently transferred from other branches and their smartcards did not work in this pharmacy yet. The manager said that regular team members working at the pharmacy had working smartcards but would check this. Team members from other branches said that they had completed training on confidentiality and safeguarding at their other branch. Annual training was provided by the company for areas such as confidentiality and safeguarding, but only team members could access their own records, and this could not be examined during the inspection. This was due to the computer terminals being in constant use and most team members present were from other branches.

There was a safeguarding policy but only a few team members had signed to indicate they had read it. The manager said that he would ensure that the regular team members were familiar with the policy. However, when asked team members were clear about what they would do if they had any concerns about a vulnerable person. The locum pharmacists confirmed they had completed the level 2 safeguarding course and could describe how they would deal with a concern.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy doesn't have enough staff to manage its workload effectively. The pharmacy is significantly behind on dispensing, and it can take some time to provide people with their medicines. However, team members have done the right training for their roles and they feel comfortable about raising concerns. They do some ongoing training to keep their knowledge and skills up to date. But the pharmacy is very busy, and they usually do not get time to complete this at work.

Inspector's evidence

On the first day of the inspection there were two pharmacists (one relief and one locum), one locum dispenser, and two dispensers from a local branch. On the second day, there was a locum pharmacist, three pharmacists from other branches, three dispensers from other branches, one locum dispenser, a trainee dispenser, and a part-time dispenser who left part-way through the inspection. The manager was also a dispenser and he was present on both days. The pharmacy also employed two part-time dispensers, and a part-time pharmacy technician accuracy checker. Several team members had been off sick during the inspection and at the end of 2019. Team members present during the inspection were able to explain what accredited training they had completed or were undertaking. The manager confirmed that other staff not present during the inspection were on the required training courses or had completed them. But there was one member of staff who he was unsure if they were training or trained and said that he would confirm this.

The pharmacy was very busy during the inspection. Most of the time there was a queue of people at the counter, often up to seven people in length. Staff were observed taking a while to find people's dispensed prescriptions, and this was not helped due to the untidiness in the dispensary. They also needed to search through the baskets containing part-dispensed prescriptions. Piles of these baskets were found where the prescriptions dated from the end of December 2019, and several were found where the prescriptions were from the middle of December 2019. Team members said that dispensing was around two weeks behind and it usually took them at least five minutes to find people's prescriptions when they came in. Staff said that they sometimes reprinted the person's prescription if they were unable to find it. The phone rang almost constantly during the inspection and team members were too busy helping other people to answer it most of the time. Some people using the pharmacy angrily complained to the staff during the inspection about the amount of time it took to receive their medicines. Team members were seen to be clearly under a lot of pressure during the inspection although they were working well together. The pharmacy had not had a regular pharmacist for many months and had been running on locum and relief pharmacists. Team members had worked overtime to try and help get the workload up to date, and some staff were due to come in on a Sunday when the pharmacy was closed.

The pharmacy dispensed a large number of multi-compartment compliance packs to around nine care homes and around 500 people in their own homes. Some of these people had been transferred from the branches that had closed; team members estimated around 100 people had transferred in this manner. Most of the staff who dispensed these packs were part-time and team members said that it was often a struggle to get the packs out on time.

A dispenser working on the counter was able to explain what she would do if someone requested to

buy more than one packet of a medicine. Team members were observed referring queries to the pharmacist during the inspection as appropriate, but this caused more interruptions for the pharmacist who was trying to check the previously dispensed items.

Staff had access to the company's 'MyLearn' system which let them undertake ongoing training. But due to how busy the pharmacy had been, they had been unable to access it recently and had not received any time set aside in work to do it. They had access to the system at home, but team members said that they had not managed to undertake much ongoing training in the last few months. The manager said that this would be addressed once the pharmacy was up-to-date with its workload.

Staff felt comfortable about raising concerns and had previously raised concerns about the staffing levels in the pharmacy. This had included contacting the pharmacy's superintendent's office. Regular staff meetings no longer occurred, but team members said that they raised any issues as they came up during the day. And team members were observed communicating well with each other.

The pharmacy had targets such as the number of Medicines Use Reviews (MURs) and items dispensed. The manager said that they had achieved their MUR target and he did not feel under undue pressure to achieve the rest. The pharmacists spoken with felt able to take professional decisions to make sure people were kept safe.

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

Summary findings

The pharmacy is untidy and there are tripping hazards for staff in the dispensary. Not all areas of the pharmacy are sufficiently protected from unauthorised access. However, the premises themselves are kept secure. And people can have a conversation with a team member in a private area.

Inspector's evidence

The dispensary was untidy, with baskets containing medicines and prescriptions on the worktop and floor of the dispensary. However, there were small areas of worktop which were kept clear for dispensing or checking. There were also boxes containing stock on the dispensary floor and this was a tripping hazard. This had improved by the second day of the inspection, but there were still tripping hazards on the floor. In the non-public areas upstairs, there were several rooms which were full of fixtures and fittings and stock from the branches which had closed. Some of these rooms were messy. There appeared to be a lack of storage space in the pharmacy, which had been exacerbated by the local branches closing and sending items to this pharmacy. A separate room upstairs was used for the preparation of multi-compartment compliance packs to care homes and people in their own homes.

The room temperature was suitable for the storage of medicines and was maintained with air conditioning. Handwashing facilities were available. The consultation room was untidy, and not all items inside were secured properly. However, the room was accessed behind the pharmacy counter and team members said that people were always escorted and not left in the room alone. They said that the items would be removed if anyone wanted to use the room. The room allowed a conversation to take place inside which would not be overheard. The premises themselves were secured from unauthorised access. But access to non-public areas was not sufficiently restricted.

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

Summary findings

The pharmacy doesn't keep all its medicines securely, which means they are less protected from unauthorised access. And it can't show that medicines that require cold storage have always been stored at the right temperatures. It can't show how it has responded to recent drug alerts and recalls. This could increase the risk that people are supplied medicines or medical devices that are not safe to use. The pharmacy is behind on dispensing and is not providing its services effectively. However, people with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access from outside via an automatic door. The pharmacy had wide aisles and enough space to help people with wheelchairs and pushchairs to manoeuvre. Staff were aware of the local health services and explained how they signposted people.

Dispensed multi-compartment compliance packs seen were labelled with a description of the medicines inside to help people and their carers identify the medicines. The packs were labelled with the required warnings, and patient information leaflets were routinely supplied. And they had an audit trail to show who had dispensed and checked the packs. People were assessed by their GP to see if the packs were suitable for them, but team members were not sure if this had occurred for the people who had been transferred from the other branches. Records were maintained when medicines were stopped or changed, and a date was recorded of when this had occurred. But several records seen did not detail who had initiated the change, which could make it harder for people to find out this information if there was a query.

Team members explained how they highlighted prescriptions for higher-risk medicines (such as warfarin or methotrexate) so that they had an opportunity to speak with people taking these medicines when they collected them. They could explain which medicines they would do this for. No dispensed higher-risk medicines were found on the shelves. Dispensed CDs were highlighted with stickers, and the sticker included the date when the prescription would no longer be valid. Team members were aware of the additional guidance to be give about pregnancy prevention for some people taking valproate medicines. But they were not aware of any people the pharmacy had who took valproate and were in the at-risk group. The pharmacy had the educational literature for people taking valproate, such as cards and stickers.

Although the dispensary was very busy and untidy, there were sufficient clear dispensing and checking areas and there was an organised workflow through the dispensary for when items were dispensed. However, dispensing for previous prescriptions was around two weeks behind.

Drivers delivered medicines to people in their own homes. Team members said that the driver's hours had been reduced and it was sometimes hard to get all the deliveries out on time. The driver explained how he got electronic signatures from recipients to show that the medicines had been safely delivered. And he brought back any undelivered items to the pharmacy. A separate paper audit trail was kept for CD deliveries, where recipients signed individual paper sheets.

The pharmacy had the equipment to comply with the Falsified Medicines Directive (FMD) but team

members were not aware of how to use it and had received no training. The manager said that he would check with head office to see if there was any FMD training.

Medicines were obtained from licensed wholesale dealers and specials suppliers. Medicines storage in the dispensary was generally tidy, but there were boxes of stock which had arrived in from the wholesaler which were not stored securely. Team members said that they had been too busy to put away the stock. Some other medicines in non-public areas were also not stored securely.

Some individual packs of medicines contained mixed batches which could make it harder to effectively date-check them or to respond to drug alerts or recalls. One pack found contained mixed batches and some loose tablets which were outside the foil strip; this pack was removed. Team members were unsure where the date-checking records were, and there were three date-expired medicines found in with stock. This could increase the chance that people were dispensed medicines which were past their 'use-by' date. Bulk liquids were marked with the date of opening, which helped staff know if they were still suitable to use. Medicines people had returned were separated from stock and placed into designated bins and sacks.

CDs requiring safe custody were stored securely. The pharmacy had three fridges for storing items which required cold storage. Two of them had their temperatures recorded on the first day of the inspection and their current temperatures were within the required range. But there were some gaps in the records, and the most recent record before them were from 27 and 28 December respectively; however, these records had been within the required range. The third fridge was in the dispensary on a worktop. On the first day of the inspection the current range was showing as 3 and 16 degrees Celsius; no temperature records were found for this fridge and there were medicines stored inside. On the second day of the inspection the temperature range of this fridge had been reset and had started to be recorded; the temperatures were then seen to be within the required range.

There was a folder containing records of drug alerts and recalls. The action taken in response had been recorded, but the most recent recall found was from November 2019; several recalls were known to have been issued since this date. A dispenser who had worked at the branch a lot recently had seen the more recent recalls at her other branch but not at this one. Documentation for more recent recalls could not be found during the inspection and it was not clear if any action had been taken in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

A range of calibrated glass measures was available for use with liquids. Separate measures were used for liquid methadone and these were marked as such during the inspection. Tablet and counting equipment was clean, and a separate marked triangle was used to count cytotoxic medicines. This helped avoid cross-contamination.

Team members had access to up-to-date reference sources including the internet. The fax machine was away from the shop area, and the phone could be moved to somewhere more private to protect people's personal information.

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.