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: 15/06/2022

Pharmacy context

The pharmacy is located on a parade of shops in a largely residential area. It received most of its prescriptions electronically. And it provides a range of services, including dispensing NHS prescriptions and the New Medicine Service. The pharmacy supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to some people.

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	1.6	Standard not met	The pharmacy does not always keep all the records it needs to by law. It has not kept its private prescription records up to date since March 2022.
		1.7	Standard not met	The pharmacy does not always protect people's personal information properly. It stores its bags of dispensed medicines in a way that other people using the pharmacy can see people's personal details.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough staff to manage its workload effectively. It is behind on dispensing and other necessary tasks are not being done.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy does not ensure that all areas are safe for people to use. There are tripping hazards and not all controlled drugs and prescription only medicines are stored securely. This could meant that unauthorised people can access these medicines.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not store all of its medicines securely. And it has many date-expired medicines in stock, which could increase the chance of someone receiving medicine which is out of date.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy cannot demonstrate that it keeps the records it needs to by law, particularly its records of dispensed private prescriptions. And it doesn't properly protect people's personal information. The pharmacy has issues with its staffing levels and medicines storage. But otherwise it adequately manages the risks associated with its services. People using the pharmacy can provide feedback about the pharmacy services. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs). Near misses, where a dispensing mistake was identified before the medicine had reached a person were rectified at the time. But the near misses were not being recorded as team members did not have the time to do this. This meant that mistakes were not able to be reviewed for patterns and the team were not always able to make improvements to help minimise the chance of similar mistakes. The company had a framework for clinical governance which was called 'Safer Care'. But Safer Care meetings had not been held for several months and the pharmacy was without a Safer Care champion. Dispensing errors, where a dispensing mistake had reached a person, were recorded on the pharmacy's computer system. But this was not done in a timely manner due to the current workload. A recent error had occurred where the wrong medicines had been supplied to a person. And this was due to the people having a similar name. The dispenser confirmed that the dispensing incident report form had not been completed for this error yet.

Workspace in the dispensary was cluttered, but the checking area for the pharmacist was clear. There was an organised workflow which helped staff to prioritise tasks. And baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The dispenser explained that the pharmacy would remain closed if the pharmacist had not turned up. He said that if this happened, the drug and alcohol team would be notified that some people would not be able to collect their medicines. And the pharmacy would notify the area manager and the company's rota office. The pharmacy's computer system would not allow dispensing labels to be generated if there was no responsible pharmacist (RP) signed in. And team members knew which tasks they could and should not carry out.

The pharmacy had current professional indemnity and public liability insurance. The RP notice was clearly displayed and the RP record help on the pharmacy's computer was largely completed correctly. But the pharmacist's registration number was not always recorded in the RP record. The dispenser said that the computer system would sometimes not allow it to be added to the record. He said that this would be reported to the pharmacy's head office. The dispenser said that the pharmacy's computer system had the facility to record the private prescriptions the pharmacy had dispensed, but team members were not able to retrieve the record during the inspection. The private prescription records were made in a book and most had been completed correctly. But the date on the prescription and the date the medicines were supplied was not always recorded. Team members were unable to demonstrate that the records of supplies made against private prescriptions had been recorded since

March 2022. There were a large number of private prescriptions which had been dispensed but not recorded. The dispenser said that team members had not had time to carry out this task. The pharmacist explained that there had not been any emergency supplies made recently. Previous records of emergency supplies were at the back of the private prescription book. Labels had been used instead of writing details and the ink on most of the labels seen had faded, so this information could not be read. This could make it harder for the pharmacy to show which medicines had been supplied and who they had been supplied to if there was a query. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not always recorded. And the physical stock of one CD checked at random did not match the balance in the register. The pharmacy's area manager said that this would be fully investigated and the Controlled Drugs Accountable Officer would be informed.

Confidential waste was removed by a specialist waste contractor, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely when not in use. Some team members did not have their own smartcards during the inspection. Team members had completed training about data protection. The pharmacy stored its nags of dispensed medicines in a way that other people using the pharmacy could see people's personal details on them.

The dispenser said that the pharmacy had carried out yearly patient satisfaction surveys before the pandemic but had not carried out one since 2020. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The dispenser said that there had been several complaints recently about the pharmacy not being open. Team members explained that they displayed a notice if there was no pharmacist and explained to people.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy's head office. The dispense could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The dispenser said that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

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

Summary findings

The pharmacy does not have enough team members to manage its workload effectively. For example, it is behind on dispensing, and staff do not have the time they need to undertake various other tasks that need doing. Team members do the right training for their roles. Team members get some ongoing training, but this is not regular, and this could make it harder for them to keep their knowledge and skills up to date. Team members can raise concerns about the pharmacy or other issues affecting people's safety. But the pharmacy does not always address the concerns its pharmacy team raise promptly. So, it may be missing opportunities to improve.

Inspector's evidence

There was locum pharmacist, one pharmacy technician and three trained dispensers working during the inspection. The pharmacy had been employing locum pharmacists for around one year. And the non-pharmacist manager had been tasked to another role around six months ago. During the inspection, one of the dispensers checked on the pharmacy's locum booking schedule to see if there was a pharmacist booked to work the day after the inspection. There was not one showing as booked for tomorrow, nor for the following two days. Or for Friday and Saturday the following week. The dispenser said that this was a regular occurrence and the pharmacy's head office was aware.

During the inspection, team members were frequently having to take a break from their task in hand, to serve people at the medicines counter. This was adding distractions and potentially increasing the chance of mistakes.

A team member said that people's details for the needle exchange service had not been uploaded onto the computer system for several months as team members did not have time to do this. They also said that the number of prescriptions substance misuse medicines had reduced due to the number of days the pharmacy had been closed recently. The pharmacy had not been able to provide this service on the days it was closed.

The team members said that they did not have time to undertake any training or carry out some managerial checks. One of the team members said that they had not undertaken any structured ongoing training for several years, and team members said that most training they had done previously had to be completed at home in their own time.

The team worked well together and communicated effectively to ensure that tasks were prioritised. But the team were around five days behind with the dispensing and were assembling multi-compartment compliance packs which were due to be delivered the following day. This was due to a reduction in staffing levels recently for various reasons.

Team members appeared confident when speaking with people. One of the dispensers when asked, explained the restrictions on sales of products containing pseudoephedrine. They said that they would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. And they used effective questioning techniques to establish whether the medicines were suitable for the person.

The pharmacist and pharmacy technician were aware of the continuing professional development requirement for the professional revalidation process. The pharmacist had undertaken some recent training about hormone replacement therapy and alternative medicines. The pharmacist felt able to make professional decisions.

One of the dispensers could not recall when their last appraisal or performance review had been carried out. They thought it had been over two years since their last one. And another one of the dispensers said that they had not had one carried out since starting work at the pharmacy around one year. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. The pharmacy's area manager visited the pharmacy during the inspection. She had been in post for around three weeks and was trying to help resolve some of the ongoing issues. Targets were not set for team members.

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

Summary findings

The pharmacy has tripping hazards, so it is not always a safe place for team members and people who use the pharmacy. Some areas if the pharmacy are cluttered, which increases the risks of mistakes happening. People can have a conversation with a team member in a private area. But the light in this area is not working, which makes it less available for people using the pharmacy.

Inspector's evidence

The pharmacy could be secured from unauthorised access when it was closed. There was nothing to restrict access behind the medicines counter or into the dispensary. The pharmacy's fixtures and fittings had not been replaced for some time, although they were suitable for their intended use. The dispensary work surfaces were cluttered with baskets and medicines. This left very little clear space for team members to use while dispensing. There were several delivery boxes stacked high in the shop area and dispensary and these were posing trip hazards to the team and people using the pharmacy. Pharmacy-only medicines were kept behind clear plastic screens in the shop area and behind the medicines counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air-conditioning was available and the room temperature was suitable for storing medicines.

There were several chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

The consultation room was located behind the medicines counter, and it was accessible to wheelchair users. The light in the room was not working and the room was dark. Team members said that this had been reported several months to the pharmacy’s head office. The area manager said that she would chase this. The room was suitably equipped and well-screened. Team members could see the door to the room from the dispensary, so they would see if someone entered the room. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

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

Summary findings

The pharmacy does not always store its medicines securely, and it has many date-expired medicines in stock. The staffing issues are having an impact on its ability to provide its services safely. For example, it is behind on dispensing and other tasks that need to be done. People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. It responds to drug alerts and product recalls. And this helps make sure that its medicines and devices are safe for people to use. The pharmacy doesn't always highlight prescriptions for higher-risk medicines. And this may mean that it misses opportunities to speak with people when they collect these medicines.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised, and a variety of health information leaflets was available. Team members did not always have time to answer the pharmacy's phone as they were busy dispensing and carrying out other tasks.

Bags of dispensed medicines were stored to the side of the dispensary counter. A team member said that people frequently approached the side of the dispensary counter where these were accessible. There were several unsealed boxes on the shop floor containing prescription-only medicines which were accessible to people using the pharmacy.

The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin when available. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not always highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 and 4 CDs were not always highlighted. And an expired prescription was waiting collection. This could increase the chance of these medicines being supplied when the prescription is no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. And team members checked CDs and fridge items with people when handing them out. The dispenser said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. And the pharmacy had the relevant patient information leaflets available. Warning cards were attached to the packs of valproate-containing medicines and team members knew not to cover the warnings with dispensing labels.

Stock was stored in an organised manner in the dispensary. The dispenser said that the last date check he could recall for the dispensary was round November 2021. He said that according to the pharmacy's SOP for this activity, this should be done every three months, but team members had not had time to do this task. On a random check of the stock medicines, there was a large number of date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked daily. 'Owings' notes were provided when prescriptions

could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. There was a large number of part dispensed prescriptions on the day of the inspection. The dispenser said that this was due to several issues, including the new computer ordering system and team members not having time to update the stock levels. As well as some ongoing supply issues which were outside the pharmacy's control.

Uncollected prescriptions had been recently checked. Items remaining uncollected after around three months were returned to dispensing stock where possible and the prescriptions were returned to the NHS electronic system or to the prescriber.

Multi-compartment compliance packs were assembled in a room upstairs to help minimise distractions. The pharmacy provided these packs to a large number of people in the community. There was one team member undertaking this task during the inspection. And on the day of the inspection, she was in the process of assembling packs which were due to be delivered the following day. She explained that on several occasions she had been rushing to assemble packs which were due to be delivered the same day. And this added pressure to her already increased workload. She explained that people had assessments carried out by their GP to show that they needed their medicines in the packs. The pharmacy kept a record for each person which included any changes to their medication, and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

CDs requiring safe storage were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned were recorded in a register and destroyed with a witness, and two signatures were recorded. There were several date-expired CDs with dispensing stock, this could increase the chance of these medicines being handed out. The area manager said that these would be kept separate in future.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for CD deliveries where possible, and these were recorded in a way so that another person's information was protected. This made it easier for the pharmacy to show that the medicines were safely delivered. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The dispenser explained the action the pharmacy took in response to any alerts or recalls. But no record of any action taken was kept, which could make it harder for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And its equipment largely allows team members to protect people's personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. And separate measures were marked for use with certain liquids. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only which helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The weighing scales were in good working order. The phone in the dispensary was not portable so it could not be taken to a more private area if needed. The dispenser said that the phone had been recently changed from a portable one to the new one and it had made assisting people on the phone more difficult. The pharmacy had personal protective equipment available for team members, including gloves, masks, and hand sanitiser.

Fridge temperatures were checked daily with the maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. And the fridges were suitable for storing medicines and was not overstocked.

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.