

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 111 Reading Road, Yateley,
CAMBERLEY, Surrey, GU46 7LR

Pharmacy reference: 1036426

Type of pharmacy: Community

Date of inspection: 19/07/2019

Pharmacy context

A community pharmacy in the village of Yateley, owned by Lloyds pharmacy multiple. As well as the NHS Essential Services, the pharmacy provides medicines in multi-compartment compliance aids for approximately 60 people. Other services include, Medicines Use Reviews (MURs), New Medicines Service (NMS), seasonal flu vaccinations, emergency hormonal contraception (EHC) and drug misuse support services including the supervised consumption of methadone. The pharmacy has a prescription delivery service for the elderly and housebound.

Overall inspection outcome

✓ **Standards met**

Required Action: None

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	N/A	N/A	N/A
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's working practices are safe and effective. Its team members understand their roles and responsibilities. They listen to people's concerns and keep people's information safe. They discuss any mistakes they make and share information on what could go wrong to help reduce the chance of making mistakes in future. But they are not always thorough enough in the way they use information to learn and improve.

Inspector's evidence

Staff worked under the supervision of the responsible pharmacist (RP), whose sign was displayed for the public to see. Staff had standard operating procedures (SOPs) to follow and team members had read those relevant to their roles. The pharmacy had a 'safer care' process for managing risks in the dispensing procedure, whereby all incidents, including near misses, were discussed at the time and recorded. The regular RP then reviewed the records each month to help prevent the same mistakes being repeated. She then produced a safer care report. Near miss records indicated that mistakes were made when staff were rushing, felt hot or were busy. Follow up action was for staff to take more time when dispensing and on several occasions to check their own dispensing before it was accuracy checked. But, records did not provide details of how this was to be achieved. In addition, records did not give a clear indication that staff had reflected enough on what had gone wrong so that they could prevent similar mistakes in future. And, repetition of the same learning points indicated that follow up actions were not always sustained and may need closer monitoring.

But, it was clear that the team identified risk and made changes to prevent reoccurrence in other ways. Monthly patient safety reports advised the team to take more care with look-alike-sound-alike drugs (LASAs). Consequently, staff had placed stickers on the front edges of shelves containing LASAs such as amitriptyline and amlodipine, and atenolol and allopurinol. The dispenser, who was the safer care champion, had taken photographs of similarly packaged drugs to alert staff. These had been placed on the notice board for staff to see and included photos of the very similar packs of Requip 1mg tablets and Requip 2mg tablet and packs of prednisolone 30mg tablets and prednisolone 5mg tablets.

The pharmacy team had a positive approach to customer feedback. The most recent survey indicated a high level of customer satisfaction. But, a small number of people had commented on the overall cleanliness of the pharmacy and medicines availability. In response to these comments staff now swept the floor daily and mopped it weekly. And shelves were dusted regularly. The availability of some medicines had been affected by manufacturers' shortages, so staff would contact neighbouring pharmacies with different suppliers to try to obtain stocks for people. Where no stock was available they would contact the patient's GP for an alternative.

The pharmacy had a documented complaints procedure. A standard operating procedure (SOP) for the full procedure was available for staff to refer to. Customer concerns were generally dealt with at the time and more formal complaints were recorded on the Lloyds on line one-portal reporting system. And details of the local NHS complaints advocacy service and PALs could be provided on request. The pharmacy had professional indemnity and public liability arrangements so, they could provide insurance protection for staff and customers. Insurance arrangements were in place until 30th June 2020 when they would be renewed for the following year.

All the necessary records were kept and were generally in order including controlled drug (CD) registers, and records for, private prescriptions, unlicensed 'specials', the responsible pharmacist and emergency supplies. The pharmacy had records for patient returned CDs. Records of returned CDs were kept for audit trail and to account for all the non-stock CDs which RPs had under their control.

Staff understood the importance of protecting people's private information. They had received information governance training through the Lloyds on-line training programme. Discarded dispensing labels and prescription tokens were shredded to protect people's details. The pharmacist had completed level 2 CPPE safeguarding training. Staff had also completed the Lloyds on-line training module and dementia friends training but had not had any concerns to report.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team manages the workload safely and effectively and team members work well together. They are comfortable about providing feedback to employers and are involved in improving the pharmacy's services.

Inspector's evidence

In general pharmacy services were managed by two regular RPs. Support staff consisted of an MCA who was also a dispensing assistant (healthcare partner) and supervisor (part-time), two dispensers (one full-time, one part-time), three healthcare partners (all part-time), and a part-time medicines counter assistant (MCA). On the day of the inspection the pharmacy was run by a regular RP, a dispenser, a pharmacy student, on a month's placement, and a healthcare partner.

Staff had regular performance reviews and were able to raise any concerns either during reviews or day to day while they worked. The dispenser and healthcare partner described how they had discussed ways of keeping the healthcare partners dispensing skills up to date when most of her time was spent working at the pharmacy counter. Consequently, they had put a plan in place where the healthcare partner was to be more involved in the dispensary, particularly when it was quieter. This was so that she could improve her skills and be more aware of what was happening when dispensing staff went on leave. She was also due to work with one of the regular RPs all day on a Saturday when no other dispensing staff were around, so that she could have more one-to-one coaching and support.

Staff kept their knowledge up to date through the Lloyds on-line training modules. Recent topics included Flexiseq gel for arthritis. Team members could also all recall receiving training on hay fever at the start of the summer season. The team was up-to-date with the daily workload of prescriptions and customers were attended to promptly. The team felt supported in their role and could raise concerns. Team members described having regular informal discussions with the pharmacists and colleagues.

The pharmacist was set targets for Medicines Use Reviews (MUR)s. She aimed to provide MURs for people who needed them but would not compromise her attention to the remaining workload. She said she tried to do MURs whenever she could. Her aim was to complete more MURS out of flu season to free up time for flu vaccinations over the winter months. She aimed to provide a good service by ensuring that people's medicines were dispensed on time and the day's workload completed.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are clean, tidy and organised. They provide a safe, secure and professional environment for people to receive healthcare services. But there was a lack of clear work surface which meant that it did not look as tidy as it could.

Inspector's evidence

The pharmacy was on a small parade of local shops on the village green. The pharmacy's premises had a traditional appearance, with two large windows across the front and a recessed door in between. The pharmacy was bright and professional looking. The shop floor area was organised and uncluttered. The consultation room was situated to the side of the counter. The pharmacist used the room for MURs, and other services. If customers wished to talk in private, they were asked if they wanted to use the room. The pharmacy had a seating area for anyone waiting.

The dispensary was situated behind the counter. The main dispensing area had three separate areas of bench space forming a general U-shaped area of work surface. There was a further small bench with a sink and a workspace which staff used for general administrative tasks. The majority of dispensing was done on the U-shaped workspace and the checking area overlooked the counter and shop floor. This was where the main pharmacy computer was, allowing the dispensing staff to easily see people at the counter. Dispensing surface was taken up with several baskets of prescriptions waiting to be dispensed, part dispensed prescriptions and repeat prescriptions to be checked. Remaining workspace was being used for dispensing multi-compartment compliance aids leaving not much free space. Most of the dispensing and checking took place on the longest area of bench space. Once checked prescriptions were bagged and stored ready for collection or delivery. Dispensed prescriptions for delivery were placed on the draining board. So, although work surfaces were cluttered, the dispensary was clean and organised with clean sinks, floors, shelves, worktops. There was a sign above the dispensary entrance stating that there was authorised access only. In general, access to the dispensary was restricted to authorised individuals only, and at the discretion of the pharmacist.

The pharmacy stocked a variety of goods including items for health and personal care as well as a range of cosmetics, perfumery, gift items, baby care and household items. Overall, the pharmacy was adequately lit and ventilated with temperature control systems in place. It was suitable for the provision of healthcare services.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services safely. In general staff give people the advice and support they need to help them use their medicines safely and properly. The pharmacy manages its medicines safely and effectively and it carries out most of the checks that help make sure that its medicines are fit for people to take. But not everyone can access its services easily.

Inspector's evidence

The pharmacy had three steps up to the entrance. Therefore, wheelchair users could not enter the premises and could not access services such as MURs. But the pharmacy had a bell outside, and when customers rang the bell staff would go to serve them outside. There was also a repeat prescription collection service and a prescription ordering service for a small number of patients who needed help to manage their prescriptions. Services were advertised at the front window for people to see and there was a variety of information leaflets available for customer selection. Information leaflets were placed in a rack on the shop floor and in the consultation room.

In general services were delivered in accordance with SOPs. CDs were audited on a regular basis as per the SOP. A random sample of CD stock was checked during the inspection (Zomorph 30mg capsules) and the quantity checked was as stated in the register. Dispensing labels were initialled by the person dispensing and the person checking, to provide a dispensing audit trail, as per the SOP.

Multi-compartment compliance aids were provided for patients who needed them. Medicines summary sheets were created for each person and checked against prescriptions each time. Staff would pursue discharge letters after being informed that people had been in hospital. Patient information leaflets (PILs) were offered with new medicines and on a regular basis thereafter. Compliance packs also contained a description of the medication, including colour and shape, to help people to identify them. They also gave the required BNF advisory information to help people take their medicines properly. However, the print on the labelling was very faint. This meant that all this information was difficult to read.

The pharmacy had procedures for targeting and counselling all patients in the at-risk group, taking sodium valproate. The pharmacist described supplying valproate warning cards with relevant prescriptions and referred to the purple MHRA pack which was to hand. The pack contained a guidance sheet for pharmacists, warning cards and information booklets. All patients in the at-risk group had been identified and counselled. Packs of sodium valproate in stock bore the updated warning label and additional warning stickers were available for split packs.

Medicines and Medical equipment were obtained from established wholesalers; Alliance Healthcare, AAH, and Sigma. Unlicensed 'specials' were obtained from AAH. All suppliers held the appropriate licences and stock was generally stored in a tidy, organised fashion. Two CD cabinets and fridge were available for storing medicines for safe custody, or cold chain storage as required. Fridge temperatures were read, recorded and monitored to ensure that the medication inside was kept within the correct temperature range. The pharmacy team had the equipment in place but were not yet scanning products with a unique barcode in accordance with the European Falsified Medicines Directive (FMD).

Stock was regularly date checked and records kept. Short-dated stock was identified and highlighted using a yellow dot sticker. It was then listed so that it could be removed easily when the time came. Waste medicines were disposed of in the appropriate containers for collection by a licensed waste contractor. A list of Hazardous waste had been placed on the cupboard door next to the waste container, so staff could dispose of all hazardous waste properly. Drug recalls and safety alerts were responded to promptly and records were kept. Staff could recall responding to the recent recalls for Clexane injections, Dovobet gel and Incruse inhalers and the earlier patient level recall for Emerade injections. The pharmacy had not had any of the affected stock.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And, it uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had all the necessary facilities and equipment for the services offered. Equipment was generally clean and in good order. There was a range of crown stamped measuring cylinders and tablet and capsule counting equipment. But one of the measures was sticky on the outside and the Methadone measure contained a watery residue of Methadone liquid. Methadone measures had a red CD sticker placed at the bottom to identify them and prevent their use for measuring other liquids. Amber dispensing bottles had been stored with their caps on to prevent contamination with dust and debris.

There were three computers with a patient medication record (PMR) facility, two in the dispensary and one in the consultation room. There was an additional computer for general management and administration. This appeared to be adequate for the workload.

The pharmacist had access up-to-date information sources such as the BNF, a BNF for children and the drug tariff. Pharmacists also had access to a range of reputable online information sources such as EMC, the BNF 'app', and the NHS website. They also used the NPA advice line.

Confidentiality was maintained through the appropriate use of equipment and facilities. Computer terminals were password protected and were out of view of patients and the public. Computer screens could not be viewed by customers and were switched off when not in use. Patient sensitive documentation was generally kept out of public view and confidential waste was set aside in a basket and shredded daily. Staff were observed using their own smart-cards when accessing patient records.

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.