General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 127 High Street, EPSOM, Surrey, KT19 8EF

Pharmacy reference: 1036557

Type of pharmacy: Community

Date of inspection: 06/11/2019

Pharmacy context

A community pharmacy set in a pedestrianised area of Epsom town centre. The pharmacy opens six days a week. It sells a range of over-the-counter medicines. And it dispenses NHS and private prescriptions. It provides multi-compartment compliance packs (blister packs) to help people take their medicines. And it delivers medicines to people who can't attend its premises in person. The pharmacy also offers winter influenza (flu) vaccinations and a paid-for health check 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 not all met	1.1	Standard not met	The pharmacy doesn't identify and manage its risks adequately. And it operates in a way which increases the chances of mistakes happening.
		1.2	Standard not met	Members of the pharmacy team record the mistakes they make. But they don't always review them to try and stop them happening again.
		1.6	Standard not met	The pharmacy doesn't keep all the records it needs to by law.
		1.7	Standard not met	The pharmacy team doesn't do enough to make sure people's private information is disposed of safely.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy doesn't have enough team members. Staff are under pressure. And they struggle to cope with the pharmacy's workload and complete all the tasks and training they're expected to do.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy's premises are poorly maintained. And pose potential health and safety risks to people who work at the pharmacy. The pharmacy doesn't have the workspace and storage it needs for the services it provides. And it doesn't present a professional image.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy doesn't do enough to make sure all its medicines are stored appropriately and securely. The pharmacy's team members don't make sure spent sharps are stored securely.
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 identify and manage its risks adequately. And it operates in a way which increases the chances of mistakes happening. It has appropriate insurance to protect people if things do go wrong. But it doesn't keep all the records it needs to by law. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They record the mistakes they make. But they don't always review them to try and stop them happening again. They understand their role in protecting vulnerable people. But they don't do enough to make sure people's private information is disposed of safely.

Inspector's evidence

Several pharmacy (P) medicines, such as pseudoephedrine-containing decongestants and opiate-containing pain killers, were stored on open shelving. And people could self-select these without staff being able to intervene. The responsible pharmacist (RP) continued to vaccinate people who had made prior flu vaccination appointments despite the pharmacy being busy and not having enough support staff. The RP was also busy trying to clear a dispensing backlog of three to four days and deal with people's urgent requests. The pharmacy team was under pressure to do all the things it was expected to do. And team members were often interrupted during the dispensing process to help people. A dispensing assistant stopped assembling some blister packs, which were due to be collected that morning, to serve at the counter as no other team member was available. Queues of people quickly developed at the pharmacy counter throughout the inspection. And they were told that the waiting time for prescriptions was about an hour. People wanting to be vaccinated were asked to wait unattended in the pharmacy's consultation room. But some prescription medicines and some waste receptacles containing spent sharps were stored in the consultation room. And staff didn't secure these before allowing people to use the room. The pharmacy team hadn't had chance to unpack the 18 boxes of stock it had received from the pharmacy's wholesalers.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, through the National Pharmacy Association (NPA). It had written standard operating procedures (SOPs) for the services it provided. And these have been reviewed since the last inspection. The pharmacy's team members were required to read, sign and follow the SOPs relevant to their roles. The team members responsible for making up people's prescriptions used plastic baskets to separate people's prescriptions and to help them prioritise the dispensing workload. But they reported that they were regularly interrupted by their colleagues working at the counter to check if people's prescriptions had been received or if the pharmacy had an item in stock. There were several stacks of baskets containing assembled or partly assembled prescriptions which the RP needed to check. The assembly of some of the pharmacy's repeat prescriptions had been transferred to an off-site dispensing hub. But the pharmacy team didn't always have the time to effectively utilise this service due to a backlog in the pharmacy's workload. The pharmacy had systems to record and review dispensing errors and near misses. The pharmacy team recorded its near misses. But it didn't always get time to identify and record its learning from them. And periodic reviews of the team's mistakes weren't always done. The pharmacy team could not provide evidence of any recent near miss reviews but could show examples from over six months ago.

The pharmacy displayed a notice that identified the RP on duty. And its staff were required to wear

name badges which identified their roles within the pharmacy. Members of the pharmacy team explained what they could and couldn't do, what they were responsible for and when they might seek help; for example, a member of the pharmacy team explained that repeated requests for the same or similar products were referred to a pharmacist. A complaints procedure was in place and patient satisfaction surveys were undertaken annually. Details on how people could provide feedback about the pharmacy were published within the 'Customer Charter Standards of service' pamphlet. The results of last year's patient satisfaction survey were published online.

The pharmacy's controlled drug (CD) register, its emergency supply records and its RP records were adequately maintained. The pharmacy team checked the CD register's running balance regularly. The pharmacy maintained a record of the destruction of patient-returned CDs. But several patient-returned CDs, which were recorded as received at the pharmacy but not destroyed, couldn't be accounted for. The pharmacy team needed to investigate the matter further and report its findings to the CD accountable officer if it couldn't resolve it. The pharmacy's private prescription records weren't kept up to date and the prescriber's details weren't always included in them. Entries within the prescription-only medicine (POM) register weren't always in chronological order. Private prescription transactions made several weeks ago hadn't been entered in the POM register at all. And supplies weren't routinely recorded on the day they were made, or the following day as required by law. The date an unlicensed medicinal product was obtained wasn't routinely included in the pharmacy's 'specials' records.

An information governance policy was in place. And staff were required to read and sign it. A privacy notice was displayed within the public area of the premises to tell people how the pharmacy and its team gathered, used and shared personal information. Arrangements were in place for confidential waste to be collected and sent to a centralised point for secure destruction. But people's details weren't always removed or obliterated from patient-returned pharmaceutical waste before disposal. And some confidential waste, such as labels with people's names and addresses on them, was being disposed of in the general waste bin. A safeguarding policy was in place and contacts for safeguarding concerns were available. The pharmacy's team members were required to complete safeguarding training. And they understood what they should do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

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

Summary findings

The pharmacy doesn't have enough of the right people working at the right time to deliver its services safely and effectively. And it's not well-led. Members of the pharmacy team are under pressure. They struggle to cope with the pharmacy's workload and complete all the tasks and training they're expected to do. But they make appropriate decisions about what is right for the people they care for. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy opened for 59½ hours a week. It dispensed about 6,500 NHS prescription items a month. The pharmacy team consisted of a full-time pharmacist (the RP), a full-time store manager, a full-time accuracy checking pharmacy technician, two part-time dispensing assistants, a full-time trainee dispensing assistant and a part-time medicines counter assistant. The pharmacy had a vacancy for a part-time member of staff. The RP had recently been assigned to the pharmacy shortly after qualifying as a pharmacist and following her predecessor's move to another pharmacy. The store manager has worked at the pharmacy for some time. Members of the pharmacy team were required to complete accredited training relevant to their roles.

The RP and a trainee dispensing assistant were on duty at the beginning of the inspection. And they were joined by another dispensing assistant after the pharmacy had been open for an hour. There should have been other members of staff on duty, including the store manager, but they were absent. There were inadequate contingency plans in place to cover these absences despite team members raising their concerns about the level of staff cover to deliver the pharmacy's services with people in management positions. The pharmacy team were under pressure and struggled to cope with the pharmacy's workload and serve people throughout the inspection. And staff found they had little time to do all the things they were expected to do. They rarely got time to train, date-check, keep the pharmacy clean and tidy, answer the telephone and complete operational tasks. They were a few days behind with the dispensing workload and assembling people's blister packs. An experienced member of staff had recently resigned and another member of staff was going to be absent for the foreseeable future. The inspector notified the superintendent pharmacist's office of the pharmacy's current staffing issues during the inspection. And two members of staff from nearby branches arrived towards the end of the inspection to provide some additional support. The RP reported that she couldn't open the pharmacy for about an hour one day recently as no staff were available to support her.

The RP supervised and oversaw the supply of medicines and advice given by staff. A member of the pharmacy team described the questions she would ask when making over-the-counter recommendations and when she would refer people to a pharmacist; for example, requests for treatments for infants, people who were pregnant or breastfeeding, elderly people or people with long-term health conditions. Staff performance and development needs were discussed informally throughout the year. Members of the pharmacy team were encouraged to ask questions and familiarise themselves with new products. And they tried to complete training and read company newsletters when they could. Team meetings were held when the pharmacy wasn't busy to update staff and share learning from mistakes or concerns. Staff felt they could make suggestions about how to improve the pharmacy and its services. And they knew how to raise a concern if they had one. Their feedback led to the introduction of a bespoke date-checking recording system.

Members of the pharmacy team felt the targets set for the pharmacy could be challenging at times. But they didn't feel their professional judgement or patient safety were affected by these. Medicines Use Reviews and New Medicine Service consultations were only provided by a suitably qualified pharmacist when it was clinically appropriate to do so and when the workload allowed.

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

Summary findings

The pharmacy has a room where people can have private conversations with members of the pharmacy team. But the pharmacy's premises are poorly maintained. And pose potential health and safety risks to people who work at the pharmacy. The pharmacy doesn't have the workspace and storage it needs for the services it provides. And it doesn't present a professional image.

Inspector's evidence

The pharmacy was located within a listed building and was subject to strict planning conditions. The company gave assurances that the pharmacy would be fully refurbished following the last inspection. But this wasn't done. And structural issues with the premises remained unresolved. The general decorative state throughout the building required attention. An intermittent water leak into the dispensary above an area where medicines were stored hadn't been fully addressed. And some other ceilings and walls within the premises were showing signs of water damage. The pharmacy team reported that a puddle could develop next to the fire exit in the dispensary during torrential rainfall. The stairwell and some corridors within the premises were partially blocked. And this was a potential hazard to people who worked in the pharmacy. The pharmacy's shop front was in a poor state of repair. And some of its window frames had started to rot. Some plaster was missing from the walls in the dispensary. And the flooring in the dispensary was worn in places. Some areas of skirting and door architraves were damaged. And the dispensary fixtures and fittings were dated. A deposit of dried pigeon excrement was found in one of the upper rooms of the premises. And this posed a health risk to people who needed to access the area.

The public area of the premises was tidy and adequately lit. But several plastic screens used to prevent people self-selecting P medicines were missing. The pharmacy team was responsible for keeping the premises clean and tidy. The pharmacy was partially air-conditioned. But its dispensary had limited workbench and storage space available for its current workload. And the pharmacy team struggled to keep the dispensary tidy. A suitably sized consultation room was available if people needed to speak to a team member in private. But its contents were not kept secure when it wasn't being used. The pharmacy's sink had a supply of hot and cold water. And the pharmacy also had appropriate handwashing facilities for its staff.

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

Summary findings

The pharmacy doesn't always manage its services effectively. But it tries to help people access them. The pharmacy delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources. But it doesn't do enough to make sure all its medicines are stored appropriately and securely. The pharmacy's team members usually check stocks of medicines to make sure they are fit for purpose. But they don't do enough to make sure spent sharps are stored securely.

Inspector's evidence

The pharmacy's services were advertised in-store and were included within the pharmacy's practice leaflet. Staff were helpful and knew where to signpost people to if a service wasn't provided. The pharmacy offered a delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery. And people were asked to sign an electronic delivery record to say they had received their medicines.

The pharmacy offered a substance misuse treatment service. And the pharmacist could supervise the consumption of some substance misuse clients' treatments. The pharmacy provided a winter flu vaccination service. And it had appropriate anaphylaxis resources in place for this service. Some people chose to be vaccinated at the pharmacy rather than their doctor's surgery for convenience or because they were not eligible for the NHS service. People could make an appointment for a flu vaccination. But the pharmacy didn't always have enough staff to manage its workload effectively. So, people sometimes had to wait a long time for their prescriptions to be made up or to talk to a pharmacist. Some people's prescriptions were made up at an off-site dispensary and returned to the pharmacy for them to collect. But the pharmacy team didn't routinely tell people about this. The pharmacy used a disposable and tamper-evident system for people who received their medicines in blister packs. The pharmacy team checked whether a medicine was suitable to be repackaged into a blister pack. The pharmacy kept an audit trail of the person who had assembled each blister pack and who had checked it. The pharmacy team provided a brief description of each medicine contained within the blister packs. And staff were required to supply patient information leaflets each time they dispensed a medicine. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. Prescriptions were highlighted to alert the team member handing the medication over that these items had to be added or if extra counselling was required. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. Valproate educational materials were available at the pharmacy.

The pharmacy used recognised wholesalers, such as AAH and Alliance Healthcare, to obtain its pharmaceutical stock. It stored its stock, which needed to be refrigerated, appropriately between two and eight degrees Celsius. It also kept its medicines and medical devices within their original manufacturer's packaging. Its stock was subject to date checks and its team documented these. But a few out-of-date medicines were found on the dispensary shelves amongst in-date stock. These were quarantined during the inspection. So, they weren't supplied to people by mistake. People could self-select some P medicines. And some prescription medicines and spent sharps were left unattended and

unsecured within the consultation room. The pharmacy stored its CDs, which were not exempt from safe custody requirements, securely. The pharmacy team was required to keep patient-returned and out-of-date CDs separate from in-date stock. But out-of-date CDs have been allowed to accumulate and needed to be destroyed in the presence of an authorised witness. Staff were aware of the Falsified Medicines Directive (FMD). They could check the anti-tampering device on each medicine was intact during the dispensing process. But they weren't decommissioning stock at the time of the inspection despite the pharmacy having the appropriate equipment to do so. The pharmacy's SOPs hadn't been revised to reflect the changes FMD would bring to the pharmacy's processes. And the pharmacy team didn't know when the pharmacy would become FMD compliant.

Procedures were in place for the handling of patient-returned medicines and medical devices. Patient-returned waste was emptied into a plastic tray and was checked for CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. Pharmaceutical waste receptacles were available and in use. But the pharmacy didn't have a receptacle for the disposal of hazardous waste, such as cytostatic and cytotoxic products. And some methotrexate tablets were found in a waste receptacle intended for non-hazardous waste. The pharmacy had a process in place for dealing with alerts and recalls about medicines and medical devices. And staff described the actions they would take and the records they would make when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment and the facilities it needs to provide its services safely. And, its team makes sure its equipment is kept clean.

Inspector's evidence

The pharmacy had a range of clean glass measures. It had equipment for counting loose tablets and capsules too. And this equipment was routinely cleaned after each use. The pharmacy team had access to up-to-date reference sources. And it could contact the superintendent pharmacist's office to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the refrigerators' maximum and minimum temperatures. The pharmacy provided blood pressure (BP) checks on request. And the pharmacy team needed to replace the BP monitor regularly. The pharmacy's diagnostic equipment used in its health check service needed to be calibrated regularly. Access to the pharmacy computers and the patient medication record system was restricted to authorised team members and password protected. The computer screens were positioned so only staff could see them. A cordless telephone system was installed at the pharmacy to allow staff to have confidential conversations when necessary. The team members responsible for the dispensing process each had their own NHS smartcard. And they made sure it was stored securely when they weren't working.

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.