General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 13-15 Bewick Road, GATESHEAD, Tyne and Wear, NE8 4DP

Pharmacy reference: 1037448

Type of pharmacy: Community

Date of inspection: 23/05/2019

Pharmacy context

This small Lloyds pharmacy is situated in Gateshead, Tyne & Wear. It dispenses NHS and private prescriptions sells over-the-counter medicines. The pharmacy offers a prescription collection service from local GP surgeries. And it delivers medicines to people's homes. It supplies medicines in multi-compartmental compliance packs, to help people remember to take their medicines. And it provides NHS services such as flu vaccinations, Emergency Hormonal Contraception (EHC) and a minor ailments scheme.

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	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 identifies and manages risks to its services. But sometimes changes made following a dispensing incident are not maintained. This may mean that the same or a similar mistake happens again. The pharmacy has up-to-date procedures for pharmacy team members to follow. And it has systems for people using its services to feedback their views. The pharmacy keeps the records it needs to by law. And the pharmacy team members know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy and retail area were small. The pharmacist checked prescriptions at the small bench to the front. Pharmacy team members made the best use of the space available. There was a small area next to the retrieval shelves. And people's multi-compartmental compliance packs were prepared there.

The pharmacy had a set of up-to-date standard operating procedures for the team to follow these included SOPs for dispensing controlled drugs (CDs), responsible pharmacist (RP) and services provided from the pharmacy. There was a record of competence for each member of staff. And these were signed to indicate that team members had read and understood SOPs. The Superintendent (SI) had authorised the SOPs. Pharmacy team members had only signed the SOPs relevant to their level of expertise. Pharmacy team members demonstrated understanding of the contents of SOPs observed to be working to these.

The pharmacy had a paper log to record near miss incidents. The pharmacist, on picking up an error, hands prescription back to the dispenser responsible to enter the details and include details such as contributory factors and how the incident had occurred. The accuracy checking technician (ACT) was the allocated safer care champion. She talked the inspector through the process. The near misses for April and the safely care review were looked at in detail. The actions taken for April were more about the processes. No changes made relating directly to the near misses recorded. The ACT explained that they had made changes. But these were not documented.

Dispensing errors were recorded and reported to the superintendent's team via an electronic system, pharmacy incident management system (PIMS). The ACT described an error that the taken place in December. Ropinirole 2mg immediate release formulation was supplied, instead of the modified release preparation required. The ACT indicated that because of the error the items were separated on the shelf and banded. This was found not be the case. Pharmacy team thought that the warning and the band must have been removed when a staff member cleaning was cleaning the shelves.

The pharmacy had an SOP relating to complaint handling there was also a pharmacy leaflet in the shop detailing how to provide feedback, so people in the shop could see it. The community pharmacy questionnaire was prominently displayed on the outside of the consultation room wall. This indicated that 94 per cent of people thought the pharmacy service they received was excellent or good. One of the areas noted for improvement was the lack of somewhere to have a private conversation. Pharmacy team members thought that this related to the fact that when the pharmacy was quiet conversations in the consultation room, could sometimes be overheard in the shop. The area manager was aware of

this. But no solution had been offered to remedy this. This may mean that private conversation could be overheard.

The pharmacy had appropriate professional indemnity insurance.

A sample of the CD register entries checked met legal requirements. Pharmacy maintained the register with running balances. And these were audited weekly. Headers were completed in the CD register. And any incorrect entries were annotated at the bottom of the page.

The private prescription records looked at were complete, including the reason for emergency supply.

Pharmacy staff had completed information governance training. A statement that the pharmacy complied with the Data Protection Act and the NHS Code of Confidentiality was found in the pharmacy's practice leaflet. Confidential waste was segregated. The team said that the waste was collected and destroyed off site. Team members confirmed that they had their own NHS smartcards to access electronic prescriptions.

The pharmacy's team members had completed training about safeguarding vulnerable adults and children. The contact details for local safeguarding organisations were available. The team described a previous incident which had been escalated appropriately. Team members said that they would escalate incidents to the pharmacist and pharmacy's head office.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team are knowledgeable and skilled. The pharmacy team members keep their skills up to date through regular training. And they work well together in an open and honest environment. The pharmacy provides regular feedback to team members about their performance and helps to identify any training needs. They are confident in providing feedback and show how this feedback improves service delivery. Pharmacy professionals are not put under undue pressure to meet targets.

Inspector's evidence

The pharmacy team, on the day consisted of the RP who was a locum. And an ACT, one dispenser and one trainee healthcare partner. The pharmacy team thought that they usually managed with the current staffing levels. At busy times it was sometimes difficult. And this had been mentioned to the cluster manager. Pharmacy team members said that when staff were on holiday or off sick, they were allowed to cover half of the hours as overtime. Sometimes they got cover from local stores.

Training was provided through the MyLearn system. Each month was a different topic the training. MyLearn was also used to provide induction training for a new member of staff. Pharmacy team had completed CPPE for oral health. And a copy of the certificates was uploaded onto the My learn system. There was an area coach who reminded pharmacy team members when they were behind with their training. The trainee was happy with the support she was given with her learning.

Performance reviews were done annually and recorded on the system. The pharmacy team members had last received a performance review in April 2018. Pharmacy team members said that they discussed any development or training needs. One member of the team had expressed an interest in completing training so that she could become a smoking cessation advisor. Following this she was registered on a course is now qualified to provide the service.

The pharmacy team, in the manager’s absence, offered evidence during the inspection and spoke in a confident open manner.

The pharmacy team thought that the manager was approachable and reported that they worked as a team. They felt able to make suggestions at the regular team huddles.

The pharmacy team were aware that there was a whistle blowing policy. One team member described the process they would follow if they had a concern. They would approach the RP first and then the cluster manager. If the issue was unresolved they would then use the anonymous telephone number to share their concern.

Targets were in place for the services offered such as MURs which were achievable.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are suitable to provide its services safely. The pharmacy’s team members appropriately manages the available space. The pharmacy is secure when closed.

Inspector's evidence

The pharmacy was tidy and well organised. The pharmacy was small. The team made the best use of the space available. The consultation room door doesn’t lock. But no confidential information was stored there. The pharmacy’s premises were appropriately safeguarded from unauthorised access. The store was alarmed.

There was adequate heating and lighting. Running hot and cold water was available. Maintenance issues were reported to Head Office. The pharmacy premises were clean. Space in the dispensary was restricted. This meant that benches could easily become cluttered. The team used a small area near the retrieval area to assemble multi-compartment compliance packs. This helped to prevent the rest of the pharmacy from becoming cluttered.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The services are generally well managed. The pharmacy may not always record advice given to people who get higher-risk medicines. So, it may not be able to refer to this information in the future if it needs to. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. And it makes sure that its medicines and devices are safe to use. It adequately sources and manages its medicines, so they are safe for people to use.

Inspector's evidence

Access to the pharmacy was via step-free entrance which was suitable for wheelchairs. Practice leaflets were openly available and listed the pharmacy's services. These were on display in the retail area and in the consultation room.

The pharmacy supplied medicines in multi-compartment compliance packs. The pharmacy usually receives monthly prescriptions. And these are normally ordered a week in advance. The pharmacy-maintained records of medicines administration times, and changes to medicines. Descriptions were supplied which allowed individual medicines to be identified. Patient information leaflets were supplied with the packs. Pharmacy team had a good working relationship with the local surgery and usually dealt with one receptionist. This made sorting out any queries and arranging prescription changes much easier.

A sample of invoices showed that medicines and medical devices were obtained via licensed wholesalers. Stock requiring refrigeration was stored at appropriate temperatures. And paper records were maintained to ensure temperatures were within the appropriate ranges.

Controlled drugs cabinets were available for the safe custody of controlled drugs. The cabinets were appropriately secured. There were a lot of out of date CDs and patient returned CDs which require destruction. These were segregated. And were appropriately marked in the CD cabinets.

Dispensed controlled drug or fridge items such as insulin were stored in clear plastic bags which provided the opportunity for additional accuracy checks when being collected by the patient.

The pharmacy had a process of date checking and rotating stock to ensure medicines were still safe to use and fit for purpose. The pharmacy's procedures indicated that this should take place quarterly. The pharmacy team had been completing this process less frequently. The pharmacy team said that this was because could not find the time to complete these as often as required. This may have increased the risk of expired medicines being supplied. A box of sinemet was found in stock which had expired in May 2019. Other medicines were checked at random and were found to be in date.

Opened bottles of liquid medications were marked with the date of opening to ensure they were still safe to use when used for dispensing again. Some out of date Oramorph and trimethoprim liquid were found on the shelf and these were removed for destruction.

The dispensers were observed using baskets to ensure prescriptions were prioritised and assembled

medication remained organised. Computer-generated labels included relevant warnings and were initialled by the pharmacist and dispenser which allowed an audit trail to be produced.

The shelving system enabled enough storage and retrieval of dispensed medication for collection. People collecting were routinely asked to confirm the name and address of the patient to ensure that medication was supplied to the correct patient safely.

The pharmacy team were aware of the guidance that was provided to people who may become pregnant who received sodium valproate. The pharmacy had completed an audit and identified one person who was provided with advice. The leaflets and sodium valproate cards were on the shelf with the stock. And there was a sticker to remind the team what needed to be provided when dispensing sodium valproate.

Prescriptions for higher-risk medicines were highlighted using the pharmacist sticker. So that appropriate counselling could be provided. It was usual practice to counsel patients. But the pharmacy team did not usually make a note of these conversations on the patient's medication record.

Out of date stock and patient returned medication were disposed of in pharmaceutical waste bags for destruction. These were stored securely and away from other medication.

The pharmacy team members said that the pharmacy had not yet adjusted to meet the Falsified Medicines Directive. The pharmacy did not have working scanners to verify barcodes. SOPs had not been adjusted. This may have reduced the ability of the pharmacy to verify the authenticity of its medicines.

The head office had a system of sending messages to the pharmacy when drug alerts or recalls of medicines or medical devices were necessary. These were printed out. And the pharmacy had a folder of collated alerts which had been signed and dated to confirm they had been completed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Equipment required for the delivery of pharmacy services is readily available, stored appropriately and used in a way that protects the privacy and dignity of patients.

Inspector's evidence

The pharmacy’s equipment appeared safe and fit for purpose. Maintenance issues were reported to the pharmacy’s head office.

The sinks provided hot and cold running water. There were a good range of Crown-marked measuring cylinders were available. These were clean and stored in baskets next to the sink.

Computers and labelling printers were used in the delivery of services. Information produced by this equipment was not visible to the public due to their positioning within the premises. Computers were password-protected to prevent unauthorised access to confidential information. Other patient identifiable information was kept securely away from the visibility of the public.

Up-to-date reference sources were available in paper and online formats. Such as BNF and BNF for children.

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.