General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 141 Beaconsfield Street, NEWCASTLE UPON TYNE, Tyne and Wear, NE4 5JP

Pharmacy reference: 1037515

Type of pharmacy: Community

Date of inspection: 20/06/2019

Pharmacy context

The pharmacy is on the corner of a busy road in Newcastle Tyne and Wear. It dispenses NHS and private prescriptions and 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), a minor ailments scheme. And a substance misuse service.

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. 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. But sometimes the near miss review does not highlight appropriate changes.

Inspector's evidence

The pharmacy had a generously sized retail area. The pharmacy was small. Pharmacy team members made the best use of the space available.

The pharmacy had a set of up-to-date standard operating procedures for the team to follow (SOPs). And 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.

The pharmacy had a paper log to record near miss incidents. The pharmacist, on picking up an error, handed the prescription back to the dispenser responsible to enter the details and include details such as contributory factors and how the incident had occurred. The dispenser was the allocated safer care champion. The near misses for May and the safety care review were looked at in detail. The action taken for May was a general comment to ‘take more care’. No changes were made relating directly to the near misses recorded. The safer care board was not up to date.

Dispensing errors were recorded and reported to the superintendent’s team via an electronic system, pharmacy incident management system (PIMS). A member of the pharmacy team described an error that the taken place. Tramadol had been supplied instead of trazadone. The items had been separated on the shelf and these was a warning sticker on the shelf edge.

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. One of the areas noted for improvement was to improve professional practice through additional training. The pharmacy team members were unsure what this referred to or if any actions had been taken.

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. A register was maintained of CDs returned by patients for destruction and was complete and up to date. A sample of records for the receipt and supply of unlicensed products looked at found that they were being kept in accordance with the requirements of the MHRA.

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. Team members said that they would escalate incidents to the manager.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified members of staff to provide safe services. The pharmacy's team members have access to training resources. And have regular performance reviews. The pharmacy team hold meetings to share information. But they do not take notes to share with staff who are unable to attend.

Inspector's evidence

The pharmacy team, on the day consisted of the RP who was a locum. And three dispensers. The pharmacy team thought that they usually managed with the current staffing levels. Part time pharmacy team members covered for each other if necessary.

Training was provided through the MyLearn system. Each month was a different topic for training. Pharmacy team had completed recent product training on a nasal spray last month.

Performance reviews were done annually and recorded on the system. The pharmacy team members had last received a performance review in April 2019. Pharmacy team members said that they discussed any development or training needs. They thought the manager was approachable and they could make suggestions for change to improve services. No specific examples were provided. The team has team meetings to discuss tasks to be completed and mistakes. These was no notes made of these.

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 area supervisor. 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 appropriately manages the available space and the pharmacy is secure when closed.

Inspector's evidence

The pharmacy premises were clean. Space in the pharmacy was restricted. The consultation room was suitable for private consultations and counselling. The consultation room door doesn’t lock. But no confidential information was stored there. There were shutters to the front. The pharmacy’s premises were appropriately safeguarded from unauthorised access. There was adequate heating and lighting. Running hot and cold water was available. Maintenance issues were reported to Head Office.

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 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. 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.

Inspector's evidence

Access to the pharmacy was a small step up into the pharmacy. The dispenser advised that there was a portable ramp available to assist people in 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.

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. There were two occasions in the last month when the temperature had not been recorded. The pharmacy team members thought that the fridge temperature would have been checked but had not been recorded on the sheet.

Controlled drugs cabinets were available for the safe custody of controlled drugs. The cabinet was appropriately secured. There was no patient returned or out of date CDs in the controlled drugs cabinet.

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 shelves were untidy and some medicines such as lisinopril 10mg and 20mg were mixed together on the shelves. This may increase the risk of a picking error. 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 last recorded date check was on 18 April 2019. This may have increased the risk of expired medicines being supplied. A box of Tramquel was found in stock which had expired in June 2019.

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 Zantac liquid were found on the shelf and this was 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. The leaflets were on the shelf with the stock. The sodium valproate cards could not be found in the pharmacy. A dispenser advised that they always put a leaflet in the bag when dispensing sodium valproate.

Prescriptions for higher-risk medicines were highlighted. And there were stickers on a warfarin prescription in the retrieval area. So that appropriate counselling could be provided. It was usual practice to counsel people. A member of the pharmacy team had checked the patients INR. But had not put a note of this on the patients 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. 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.

A range of Crown-marked measuring cylinders were available. These were clean and stored next to the sink. There was equipment for counting tablets and capsules. And there was separate triangle counter for cytotoxic medicines.

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 British National Formulary (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.