General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 16-17 Bush Row, St Thomas Green, HAVERFORDWEST, Dyfed, SA61 1RJ

Pharmacy reference: 1043252

Type of pharmacy: Community

Date of inspection: 15/10/2019

Pharmacy context

This is a pharmacy situated near two medical centres on the outskirts of a rural town. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. Some NHS prescriptions are assembled off-site at another pharmacy owned by the company. The pharmacy provides medicines in multi-compartment compliance aids to a large number of patients who live in the surrounding area. It offers a wide range of services including emergency hormonal contraception, smoking cessation, treatment for minor ailments and a seasonal 'flu vaccination service for NHS and private patients. Substance misuse services are also available.

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	2.2	Good practice	Staff have the appropriate skills, qualifications and competence for their role and are supported to address their learning and development needs
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures to help make sure the team works safely. Its team members record and review their mistakes. But they do not always take action to stop them from happening again. The pharmacy keeps the records it needs to by law. It asks people to give their views about the services it provides. And its staff receive training so that they know how to keep people's private information safe. The pharmacy's team members understand how to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

A range of written standard operating procedures (SOPs) underpinned the services provided. These were regularly reviewed, and staff were in the process of reading and signing new versions of some SOPs. The pharmacy had systems in place to identify and manage risk, including the recording and analysis of dispensing errors and near misses. Monthly 'Safer Care' briefings were held to discuss patient safety issues, including learning points from bulletins provided by the Professional Services Manager. Staff were unable to cite any specific action that had been taken to reduce risk but said that the team had recently discussed the risks of picking errors with different strengths of similarly-packaged bisoprolol tablets. Observation showed that olanzapine and omeprazole had been separated on dispensary shelves. The team said that this was at the direction of the superintendent's office after incidents had been reported by other branches. The risks associated with the influenza vaccination service had been assessed and posters describing the process to follow in the event of needlestick injury were displayed in the dispensary and consultation room.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed in the retail area showed that this was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in a Customer Charter leaflet displayed in the retail area.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. However, some entries in the CD registers had been amended by obliteration which did not comply with legal requirements and there was no audit trail to show who was responsible for the amendments. CD running balances were typically checked weekly. The pharmacist was investigating a discrepancy in the oxycontin 30mg MR tablet register following the most recent balance check. The register showed the balance to be 112 tablets when the stock holding was in fact 168 tablets. The error could not be resolved during the inspection, but on subsequent investigation the pharmacist reported that it had been the result of a duplicate entry.

Staff had signed confidentiality agreements. They were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. Individual staff members had unique passwords to access the pharmacy computer that the system prompted them to change at regular intervals.

Some dispensing baskets were piled up on the dispensary riser and patient information on bag labels could be seen from the retail area. Staff re-arranged the baskets as soon as this was pointed out to

ensure that this information was not visible.

The pharmacist had undertaken level two safeguarding training and had access to guidance and local contact details that were displayed in the dispensary. Staff had received in-house training and were able to identify different types of safeguarding concerns. They said that they would refer these to the pharmacist, who confirmed that he would report concerns via the appropriate channels where necessary. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door and inside the room itself.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. But it does not always have enough cover when key staff members are away. This means the pharmacy team might not be able to provide services as effectively as usual. Pharmacy team members complete regular training and have a good understanding about their roles and responsibilities. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The regular pharmacist worked on most days of the week. Locum pharmacists covered his role on alternate Saturdays. He was usually assisted in the day-to-day operation of the pharmacy by the branch manager, who was a qualified dispensing assistant. During the inspection the support team consisted of two dispensing assistants and two trainee dispensing assistants. A pharmacy technician, the branch manager and another dispensing assistant were absent. Staff members had the necessary training and qualifications for their roles. The trainee dispensing assistants worked under the supervision of the pharmacist and other trained members of staff.

There were enough suitably qualified and skilled staff present to manage the workload safely during the inspection. However, it was clear that the workload could have been managed more effectively if another member of dispensing staff had been present. The pharmacy was busy, and the pharmacist was frequently away from the dispensary providing services in the consultation room. One person who had waited several minutes for their prescription to be checked eventually left the pharmacy as they were unable to wait any longer.

Targets were set for MURs but these were managed appropriately and the pharmacist said that they did not affect his professional judgement or compromise patient care. Staff worked well together. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists, cluster manager or Area Manager. A whistleblowing policy was available on the intranet.

The member of staff working on the medicines counter gave a coherent explanation of the WWHAM questioning technique and gave appropriate examples of situations she would refer to the pharmacist. Staff undertook online training on new products, clinical topics, operational procedures and services. They completed monthly self- assessments to reinforce this training. Recent modules had covered topics such as hay fever, CBD oil, smoking cessation and valproate. All staff were subject to annual performance and development reviews. They could informally discuss issues with the pharmacist or pharmacy manager whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. But it is not very tidy, and this might increase the risk of mistakes. It has enough space to allow safe working and its layout protects people’s privacy.

Inspector's evidence

The pharmacy was clean. Some of its fixtures needed to be repaired: the staff toilet door did not shut properly and a door to the cupboard under the sink had broken off and was propped against the wall. Staff said that these problems had been reported. Dispensary work surfaces were cluttered but there was enough clear bench space for safe working. Large quantities of stock and prescriptions were being temporarily stored on the floor and posed a potential trip hazard. Staff said that these had built up as they had recently been short-staffed and the pharmacy had been busy. They said they planned to clear them later in the day when the pharmacy became quieter. The sink had hot and cold running water and soap and cleaning materials were available. A consultation room was available for private consultations and counselling and its availability was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes the services it provides so that people know about them and can access them easily. If it can't provide a service, it directs people to somewhere that can help. It stores most medicines appropriately and carries out some checks to help make sure that they are in good condition and suitable to supply. Its working practices are generally safe and effective. But members of the pharmacy team do not always know when higher-risk medicines are being handed out. So they might not always check that medicines are still suitable, or give people advice about taking them.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised in the retail area. Stickers advertising the influenza vaccination service were attached to prescription bags. There was a small step up to the pharmacy entrance, but staff said that the team would go out to people in wheelchairs and help them into the pharmacy if necessary. There was wheelchair access into the consultation room. A hearing aid loop was available. Staff said that they would signpost people requesting services they could not provide to other nearby pharmacies. Some health promotional material was on display in the retail area. The pharmacist said that he had recently visited the local surgeries and had a telephone conversation with a nearby optician to discuss and promote services as part of a health board funded collaborative working initiative. Recent visits had involved discussions around the smoking cessation service and the Choose Pharmacy common ailments service.

The pharmacy team said that about 30% of repeat prescription items were assembled at the company's hub pharmacy. Dispensing staff used a colour-coded basket system to help make sure that medicines did not get mixed up during dispensing and to differentiate between different prescriptions. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Controlled drugs requiring safe custody and fridge lines were dispensed in clear bags to allow staff members to check these items at all points of the dispensing process and reduce the risk of a patient receiving the wrong medicine.

Prescriptions awaiting collection were annotated to identify patients eligible for an MUR. Stickers were attached to prescription bags to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. Stickers were used to identify dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was invalid and could no longer be supplied. However, one prescription for diazepam was present that was not marked in this way.

Staff said that stickers were usually, but not always, used to identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate so that they could be counselled. One prescription for methotrexate was present that had not been marked with a sticker. The pharmacist said that he always asked walk-in patients prescribed warfarin for information about blood tests and dose changes and demonstrated that he recorded this on the patient medication record (PMR). The pharmacy team were aware of the risks of valproate use during pregnancy. A poster that included information about the valproate pregnancy prevention programme was displayed in the dispensary. Staff said that one patient prescribed valproate who met the risk criteria had been counselled and provided with information. The information pack for valproate patients was available in the dispensary. The pharmacy carried out regular high-risk medicines audits commissioned by the local health board. These audits were used to collect data about the prescribing, supply and record-keeping associated

with high-risk medicines to flag up areas where risk reduction could be improved within primary care.

Prescription bags awaiting collection were marked with four different coloured pens that corresponded to specific weeks. They remained on dispensary shelves for two weeks before the patient was contacted as a reminder. A second reminder was sent after another week. After four weeks the medicines were returned to stock if not collected or required.

The delivery service was managed electronically. Patients or their representatives signed a handheld electronic device to acknowledge receipt of delivery and were required to sign a paper form on receipt of a CD delivery. In the event of a missed delivery, the delivery driver put a notification card though the door and brought the prescription back to the pharmacy.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a large number of patients. Trays were labelled with descriptions to enable identification of individual medicines. The pharmacist said that patient information leaflets were routinely supplied. Each patient had a section in one of four dedicated files that included their personal and medication details, collection or delivery arrangements and details of any messages or queries. People receiving weekly compliance aids also had individually-labelled baskets that contained their stock medicines. Warfarin was included in one patient's compliance aid at the request of his GP. Staff explained that the warfarin clinic faxed through documentation that included INR results and current dosages before each tray was assembled. These faxes were stored in the patient's file for reference.

Uptake of the influenza vaccination service was high and the pharmacist carried out several vaccinations during the inspection. He said that the pharmacy received a lot of referrals from local surgeries and a nearby optician for the Choose Pharmacy minor ailments service. The pharmacy was about to begin providing a private travel vaccinations service in association with MASTA, a travel health company. The pharmacist said that the pharmacy was also soon to begin providing the local health board's sore throat test and treat service.

Medicines were obtained from licensed wholesalers. Poor stock management had led to large quantities of medicines being stored in a limited space. Some were well-organised, but others such as external creams and eye preparations were stored untidily, with different products and different strengths of the same product jumbled together on dispensary shelves. Stock was also stored untidily in some of the drug fridges and CD cabinets. This increased the risk of errors. P medicines were stored behind Perspex screens in cabinets marked 'These Products Are Not For Self-selection. Supervised Sales Only. Please Ask For Assistance' that were accessible from the retail area. Medicines requiring cold storage were stored in three drug fridges. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in three CD cabinets and obsolete CDs were segregated from usable stock.

Stock was regularly checked and date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist was able to describe how he had dealt with a drug recall for Emerade injections by contacting patients to check for affected stock. He explained that any affected stock would have been quarantined and returned to the supplier. Drug recalls were printed, filed and signed to show that they had been actioned. The pharmacy had the necessary hardware to work in accordance with the Falsified Medicines Directive, but the software had not been installed and so the pharmacy was not yet able to comply with legal requirements.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services. It generally makes sure that these are suitable for use. The pharmacy's team members use equipment and facilities in a way that protects people's privacy.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Separate measures were used for methadone. A triangle was used to count loose tablets. It was dusty but staff said that they would clean it before use. A dispensing assistant said that loose cytotoxic tablets were counted by using tweezers to transfer them from the stock pot into a medicine bottle. The pharmacy had a range of up-to-date reference sources.

Most equipment was in good working order and appropriately managed. Evidence showed that it had recently been tested. However, staff said that only one of the pharmacy's two prescription scanners was working. They said they had reported the problem to head office. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the pharmacy software system was protected with a password and the consultation room was used for private consultations and counselling.

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.