General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 1 Pisgah Street, Kenfig Hill, BRIDGEND, Mid Glamorgan, CF33 6BY

Pharmacy reference: 1043518

Type of pharmacy: Community

Date of inspection: 28/08/2019

Pharmacy context

This is a village pharmacy next door to a doctors' surgery. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a 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	Good practice	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.
		4.2	Good practice	The pharmacy has robust systems in place to ensure that patients prescribed high-risk medicines are appropriately counselled.
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 mistakes. And they take some action to stop them from happening again. But they do not record and review everything that goes wrong. So they may miss some opportunities to learn. The pharmacy keeps the records it needs to by law. It asks people to give their views about the services it provides. And it keeps 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

The pharmacy had systems in place to identify and manage risk, including the recording and monthly analysis of dispensing errors and near misses. A root cause analysis had been conducted following a recent dispensing error. However, very few near misses had been recorded in recent months and as a consequence, reviews of these were not very detailed. Some action had been taken to reduce risks that had been identified: for example, a caution sticker had been used to alert staff to the risks of picking errors with labetalol 100mg tablets and lamotrigine 100mg tablets. And these had also been separated on dispensary shelves. Caution stickers had been used to highlight some 'Look-Alike, Sound-Alike' or 'LASA' drugs. A poster describing the process to follow in the event of needlestick injury was displayed in the consultation room.

The pharmacist said that the regional 'safer care champion' e-mailed regular patient safety bulletins to all branches which included examples of similar packaging to be aware of. A recent bulletin from the superintendent's office that had been read and signed by all staff focused on the legal changes and patient safety issues involving pregabalin and gabapentin. The pharmacist said that monthly briefings on patient safety issues were drawn up in branch and were passed to all staff to read individually. She explained that it was difficult to hold a team meeting to discuss the issues as most staff worked on a part-time basis. The briefings included dispensing incident case studies provided by the superintendent's office as well as issues that had occurred in branch.

A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Staff were in the process of reading and signing new versions of some SOPs. The Responsible Pharmacist notice displayed was incorrect. The pharmacist remedied this as soon as it was pointed out to her.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. Staff said the results of the most recent survey were 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.

Evidence of current professional indemnity insurance was available. All necessary records were kept and properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. CD running balances were typically checked weekly.

All staff had signed confidentiality agreements apart from a newly-recruited trainee pharmacy assistant,

who was absent. The pharmacist said she had discussed confidentiality with this staff member as part of her induction training. Staff 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. A privacy notice displayed at the medicines counter advertised the way in which data was used by the pharmacy and gave details of the pharmacy's Data Protection Officer.

The pharmacists 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. They were able to identify different types of safeguarding concerns and said they would refer these to the pharmacist, who confirmed that she would report concerns via the appropriate channels where necessary. A summary of the company's chaperone policy was advertised in a poster displayed on the consultation room door and inside the room itself. A poster and leaflets advertising a charity and support group for people affected by dementia were displayed in the retail area.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members complete regular training and have a good understanding about their roles and responsibilities. They feel comfortable speaking up about any concerns they have.

Inspector's evidence

Two pharmacists oversaw all professional activities as part of a job-share. There were enough suitably qualified and skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. The support team consisted of four dispensing assistants who worked well together. Another dispensing assistant and a trainee dispensing assistant were absent. Staff members had the necessary training and qualifications for their roles. The trainee pharmacy assistant worked under the pharmacists' supervision.

Targets were set for MURs but these were managed appropriately and the pharmacist said that they did not affect her professional judgement or patient care. The pharmacy served a close-knit community and staff had an obvious rapport with customers. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists and the Lloyds cluster manager for the area. A poster advertising a confidential helpline for reporting concerns outside the organisation was displayed in the staff area.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients and referred to the pharmacist on several occasions for further advice on how to deal with a transaction. Staff undertook online training provided by the organisation on new products, clinical topics, operational procedures and services, completing monthly self-assessments to reinforce this training. They had recently completed training on EllaOne and valproate and were about to complete annual pharmacovigilance training. Online modules could be accessed from home. All staff had recently completed training provided by NHS Wales on improving the quality of services provided. Two of the dispensing assistants were trained to provide the blood pressure measurement service. All staff were subject to annual performance and development reviews. They could informally discuss issues with the pharmacist whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and secure. It has enough space to allow safe working and its layout protects people’s privacy.

Inspector's evidence

The pharmacy was housed in an old building and the décor was in need of refreshment. The dispensary was clean, tidy and well-organised. It was small, but there was enough space to allow safe working. A separate room at the rear of the pharmacy was used for the assembly of compliance aid trays. A locked shipping container outside the back door of the pharmacy was used for storage of sundries and waste medicines. The sinks had hot and cold running water and soap and cleaning materials were available. A consultation room was available for private consultations and counselling although it was not easily visible from the main retail area. 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. The pharmacy's working practices are safe and effective. It generally stores medicines appropriately and carries out some checks to help make sure that they are in good condition and suitable to supply. And it supports people taking higher-risk medicines by making extra checks and providing counselling where necessary.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. A hearing aid loop was available. A signposting file provided by the local health board was available in the consultation room. Staff said that they would signpost patients requesting services they could not provide to nearby pharmacies or other providers such as the local council, which offered a sharps collection service. The pharmacists had recently visited the local surgery to discuss and promote services as part of a health board-funded collaborative working initiative. Visits had involved discussions around the repeat dispensing service, the smoking cessation service, high-risk medicines audits, the influenza vaccination service and the common ailments service.

Dispensing staff used a colour-coded basket system to ensure 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. Stickers were used on prescriptions awaiting collection to identify patients eligible for an MUR and to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding, or that the pharmacist wished to speak to the patient or their representative at the point of handout. Stickers were also 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. Prescriptions awaiting collection were marked with four different coloured pens that corresponded to specific weeks. They remained on the shelf for four weeks before the patient was contacted and the medicines were returned to stock after a further two weeks if not collected or required.

Stickers were used to routinely identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate so that they could be counselled. Information about blood tests and dosage changes was recorded on the patient medication record (PMR). The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that patients prescribed valproate who met the risk criteria had been counselled and provided with patient safety information. A record of this had been added to the patient's PMR. An 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.

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.

Disposable compliance aid trays were used to supply medicines to a number of patients. Trays were labelled with descriptions and a dispensing assistant said that patient information leaflets were routinely supplied. Each patient had a section in a dedicated file that included their personal and medication details, collection or delivery arrangements, contact details for representatives where appropriate, details of any messages or queries and any relevant documentation, such as discharge summaries.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, storage space was limited, and some different products and different strengths of the same product were stored very closely together, increasing the risk of error. Medicines requiring cold storage were stored in a large, well-organised drug fridge. Maximum and minimum temperatures were usually recorded daily and were consistently within the required range. However, there were occasional gaps in the records and so there was not always a clear audit trail to show that the medicines were safe and fit for purpose. CDs were stored appropriately in two well-organised CD cabinets and obsolete CDs were segregated from usable stock. Patients supplied substance misuse treatments against instalment prescriptions were allocated a section in a dedicated file which included their prescription, signed contract and notes of any messages or changes.

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 email. The pharmacist described how she would deal with medicines or medical devices that had been recalled as unfit for purpose by contacting patients where necessary and returning quarantined stock to the relevant 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 in a position 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 makes sure these are always safe and 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. Triangles were used to count tablets and a separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. 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.