General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 347-349 St. Mellons Shopping Centre, St Mellons, CARDIFF, South Glamorgan, CF3 0EF

Pharmacy reference: 1043743

Type of pharmacy: Community

Date of inspection: 25/11/2019

Pharmacy context

This is a pharmacy situated near in a small shopping centre on the eastern edge of Cardiff. 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 some services including treatment for minor ailments and substance misuse services.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 met	1.2	Good practice	Information about risk is reviewed and analysed to improve the safety and quality of pharmacy services
		1.8	Good practice	Safeguarding is an integral part of the culture within the pharmacy
2. Staff	Good practice	2.2	Good practice	Staff have the appropriate skills, qualifications and competence for their roles and are supported to address their learning and development needs
		2.4	Good practice	A culture of continuous improvement through learning exists within the team
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 has written procedures to help make sure the team works safely. Its team members record and review their mistakes so they can learn from them. And they are good at taking action to help stop mistakes 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 it keeps people's private information safe. The pharmacy's team members are good at recognising and reporting 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 analysis of dispensing errors and near misses. The accuracy checking technician (ACT) was able to demonstrate action that had been taken to reduce risks that had been identified: for example, different strengths of co-amoxiclav tablets had been separated following a series of near misses. The ACT had recently attended a company conference about patient safety. She said that as a result of learning from the conference, the team had discussed the risks of picking errors with 'Look-alike, Sound-alike' or 'LASA' drugs. As a result, amitriptyline and amlodipine had been separated on dispensary shelves. Caution stickers stating: 'Stop! Cream or Ointment?' had been used to alert staff to the risks of errors with different forms of external preparations. Caution stickers had also been used to highlight the risks of selection errors with different strengths of quetiapine tablets. The ACT said that many near misses were the result of distractions that interrupted concentration during the dispensing process, such as answering the telephone. The issue had been discussed with the team and as a result all staff agreed that if actively dispensing, they would focus on the task in hand to reduce risk. Conversely, if they were carrying out a less risky task and could see that another member of staff was dispensing a prescription, they would ensure that they answered the telephone promptly themselves.

Monthly 'Safer Care' briefings were held, during which the team discussed relevant patient safety issues that had occurred in branch, as well as case studies and examples of company-wide patient safety issues provided by the superintendent's office. Observation showed that olanzapine and omeprazole had been separated on dispensary shelves at the direction of the superintendent's office after incidents had been reported by other branches. The pharmacy manager and ACT were members of an instant messaging group set up by the company. The group allowed branches to post photographs of similar packaging and descriptions of other patient safety issues they had encountered in order to help reduce risk. Photographs of similar packaging were also displayed in the dispensary. A poster describing the process to follow in the event of needlestick injury was displayed in the consultation room.

A range of written standard operating procedures (SOPs) underpinned the services provided. 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 and the pharmacist remedied this immediately. A list of daily tasks was displayed in the pharmacy. The pharmacy manager said that she had created the list as there had recently been a high turnover of staff and it was a useful reference tool for new staff members. The ACT said that there were no restrictions on the items she was able to check. However, she said that sometimes the pharmacist did not clinically check a prescription until after she had performed the accuracy check. There was a risk that the lack of a clear procedure for clinical checks might result in medicines being supplied without such a check being made. The ACT said that her

accuracy checking practice was subject to monthly spot checks that were undertaken by a pharmacist.

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. Another leaflet in the retail area gave details of the NHS complaints procedure 'Putting Things Right'.

A current certificate of professional indemnity insurance was on display. 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, although one formulation of methadone had not been subject to a balance check since September 2019. There was a risk that this might lead to concerns such as dispensing errors or diversion being missed

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 system.

The pharmacist and ACT had undertaken level two safeguarding training and had access to guidance and local contact details that were displayed in the dispensary. Staff had undertaken level one training and were able to identify different types of safeguarding concerns. They said that one of the dispensing assistants had reported a concern about a vulnerable elderly patient who lived alone and had difficulty looking after himself. The dispensing assistant had noticed that the patient had lost weight and that his health was deteriorating. The patient's family and GP were informed, and a care package was arranged. Staff said that the pharmacy team telephoned the patient every Monday, Wednesday and Friday to check on him and see if there was anything he needed. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door.

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. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacy was run on relief and locum pharmacists. They were 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 an accuracy checking technician (ACT), two dispensing assistants, a trainee dispensing assistant and a medicines counter assistant. Two dispensing assistants and another trainee dispensing assistant were absent. There were enough suitably qualified and skilled staff present to comfortably manage the workload safely during the inspection. Certificates were displayed as evidence that most staff members had the necessary training and qualifications for their roles. The trainee dispensing assistant worked under the supervision of the pharmacists and other trained members of staff. The pharmacy manager said that there was a plan to enrol two of the dispensing assistants on an NVQ level three training course.

Targets were set for MURs but these were managed appropriately and the pharmacy manager said that they did not affect the pharmacists' 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 pharmacy manager, professional standards manager and local cluster manager. A poster advertising a confidential helpline for raising concerns was displayed in the staff room.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients. She referred to the pharmacist on several occasions for further advice on how to deal with a transaction. She said that she would feel confident refusing a sale and had done so in the past when dealing with what she considered to be an inappropriate request for a sedative product. 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 treatment of skin tags, sepsis, smoking cessation, pharmacovigilance and valproate. The ACT said she understood the revalidation process. She said that she based her continuing professional development entries on situations she came across in her day-to-day working environment. All staff were subject to six-monthly performance and development reviews. They could informally discuss issues with the pharmacy manager whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was fairly clean. It was generally tidy and well-organised. Some tote boxes of stock and some prescriptions were being temporarily stored on the dispensary floor and posed a potential trip hazard. 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 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. Its services are generally easy for people to access. But some services are not available every day. If it can't provide a service, it directs people to somewhere that can help. The pharmacy's working practices are generally safe and effective. It stores most medicines appropriately and carries out some checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. The pharmacy manager said that demand for the Choose Pharmacy common ailments service was high. However, not all locum pharmacists were authorised to access the Choose Pharmacy software platform and so the service could not always be provided. She said that in the previous month the service had only been available for 7 out of 31 days. She said that a regular pharmacist was due to begin work at the branch in early 2020, which she hoped would make service provision more consistent.

There was wheelchair access into the pharmacy and consultation room. A hearing aid loop was available. Staff said that they would signpost people requesting services they could not provide to nearby pharmacies or other providers such as the local council which offered a sharps collection service. Some health promotional material was on display in the retail area. The pharmacy manager said that the pharmacists and ACT had recently visited local surgeries and 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 repeat dispensing service, the discharge medicine review service and the Choose Pharmacy common ailments service.

Information for locum and relief pharmacists was displayed in the dispensary to help ensure continuity of service. The pharmacy team said that about 50% of their repeat prescription items were assembled at the company's hub pharmacy. The hub could not dispense split packs, fridge items or controlled drugs and these continued to be dispensed at the branch. 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.

The pharmacy dispensed medicines against some faxed prescriptions from local surgeries. There were mechanisms in place to ensure that Schedule 2 or 3 CDs were only ever supplied against the original prescription. One faxed prescription waiting to be dispensed was found not to be signed by the prescriber. Staff said that medicines would not be supplied against unsigned faxes.

Stickers were attached to prescription bags to identify patients eligible for an MUR or to alert staff to the fact a CD requiring safe custody or fridge item was outstanding. Staff said that stickers were used to identify dispensed Schedule 3 and 4 CDs awaiting collection. They said that this practice helped ensure that prescriptions were checked for validity before handout to the patient.

Staff said that stickers were used to identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate so that they could be counselled. The ACT said that staff asked patients prescribed these medicines for information about blood tests and dose changes and recorded this on the patient medication record (PMR). However, there were no records available as evidence of this practice. The pharmacy team were aware of the risks of valproate use during pregnancy. Staff said that patients prescribed valproate who met the risk criteria would be counselled and provided with information. A poster that listed actions to be taken by the pharmacy team when dealing with valproate prescriptions was displayed in the main dispensary. Information packs for patients prescribed valproate were available in both dispensaries. 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 stored on four separate shelves that corresponded to specific weeks. Prescriptions remained on the shelves for three 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 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. These medicines were assembled in a dispensary on the first floor which had a separate telephone line. The compliance aids were labelled with descriptions although these did not always include enough detail to enable identification of individual medicines. Many descriptions were recorded only as ‘white round tablets’. Patient information leaflets were routinely supplied. Staff said that controlled drugs requiring safe custody were never included in compliance aid trays, although the reasons for this were not clear. Each patient had a section in one of four dedicated files that included their personal and medication details, collection or delivery arrangements, details of any messages or changes and documents such as current prescriptions and discharge letters. A list of patients was included at the front of each file. Some individual sheets listing medication details were quite untidy. For example, some dosage changes had been altered by obliteration and were difficult to read, which may increase the risk of errors.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. Some were well-organised, but medicines in the compliance aid dispensary were stored untidily, with different products and different strengths of the same product jumbled together on dispensary shelves. This increased the risk of errors. Some P medicines were stored in Perspex boxes marked ‘Please Ask For Assistance’ that were accessible from the retail area. During the inspection, a person tried to self-select a P medicine but a member of staff intervened and dealt with the transaction appropriately. Medicines requiring cold storage were stored in two large, well-organised 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 pharmacy team were able to describe how they had dealt appropriately with drug recalls by quarantining affected stock and returning it to the supplier. Drug recalls were printed and filed for

reference. 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 its services. It generally makes sure these are 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 and capsule counters were used to count tablets and capsules. 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 one of the pharmacy's prescription scanners was broken and they had reported the problem to head office. Records showed that the blood glucose monitor was calibrated monthly. 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.