General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 62 Herbert Street, Pontardawe, SWANSEA, West Glamorgan, SA8 4ED

Pharmacy reference: 1043839

Type of pharmacy: Community

Date of inspection: 26/10/2021

Pharmacy context

This is a town centre pharmacy. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. 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 seasonal influenza vaccination, treatment for minor ailments and substance misuse services. This inspection visit was carried out during the COVID-19 pandemic.

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 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 take action to help stop mistakes from happening again. The pharmacy generally keeps the records it needs to by law. But some details are missing, so it may not always be able to show exactly what has happened if any problems arise. 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 know 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 had been read and signed by all staff. Lists of daily tasks were displayed on the main dispensary whiteboard and on the wall in the dispensary on the first floor where compliance aids were assembled. Pharmacy team members understood which activities could and could not take place in the absence of the responsible pharmacist.

The pharmacy had systems in place to identify and manage risk, including the recording and analysis of dispensing errors and near misses. Pharmacy team members were able to demonstrate action that had been taken to reduce risks that had been identified: for example, different strengths of lansoprazole and flucloxacillin had been separated in the dispensary following some near misses. Omeprazole and olanzapine had also been separated in the dispensary at the direction of the superintendent's office after incidents had been reported by other branches. The team were aware of 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 and caution stickers had been used to highlight the risks of selection errors with atenolol and allopurinol. A separate near miss log was available for the compliance aid dispensary. The pharmacist explained that if an incorrect item was identified during an accuracy check, the correct packaging was inserted into the patient's file to reduce the risk of a similar mistake occurring in future. A poster describing the process to follow in the event of needlestick injury was displayed in the consultation room.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, but this process had been paused during the pandemic. During recent months some negative feedback had been received about prescription waiting times. The pharmacy team had acknowledged this and had worked to address the factors involved, such as staff shortages and the team's lack of familiarity with the pharmacy's new computer system. Staff had been recruited and trained and as a result, waiting times had begun to improve. A formal complaints procedure was in place and information about how to make complaints was included in the practice leaflet displayed in the retail area, although details of how to complain to the local health board directed people to NHS Scotland rather than NHS Wales. A Customer Charter leaflet that was also displayed in the retail area gave further detail about the complaints procedure and included the correct contact details for NHS Wales.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply and controlled drug (CD) records. However, there were some gaps in

the responsible pharmacist record and there is a risk that it would not be possible to identify the pharmacist accountable in the event of an error or incident. Some headings were missing from CD registers and there was a risk that a clear audit trail would not be available in the event of queries or errors. CD running balances were checked at the time of each transaction and at least once weekly. Records of unlicensed specials were not available during the inspection, but team members said that the pharmacy dispensed very few of these. They understood that the records should be kept for five years and marked with patient details.

Staff had signed confidentiality agreements as part of their internal information governance training. They were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. The pharmacist and most of the team had undertaken formal safeguarding training. The trainee MCA had completed basic internal training. The safeguarding policy and procedure was displayed in the dispensary, as was the procedure for reporting safeguarding concerns out of hours. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door.

Principle 2 - Staffing ✔ Standards met

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

A regular pharmacist worked at the branch on three days during the week and every other Saturday. Relief pharmacists employed by the company covered her regular days off and any other absences. The pharmacists were assisted in the day-to-day operation of the pharmacy by the pharmacy manager, who was a qualified dispensing assistant. During the inspection the support team consisted of the pharmacy manager, two other dispensing assistants and a newly recruited medicines counter assistant (MCA). Another dispensing assistant who was due to start her pharmacy technician training course in November was absent. All worked on a full-time basis. Most staff members had the necessary training and qualifications for their roles. The trainee MCA had worked at the branch for six weeks under the supervision of the pharmacists and other trained members of staff. She was soon to be enrolled on an accredited training course. The pharmacy manager was currently recruiting for a second MCA to work on Saturdays.

There were enough suitably qualified and skilled staff present to manage the workload safely during the inspection, although it was clear that this was only achievable as the pharmacy manager was able to use her expertise as a dispensing assistant to assist with the workload. She said that she was required to work as a dispenser for most of the day, which prevented her from carrying out her managerial role as effectively as she would like. The pharmacist explained that during the past year the staffing hours and skill mix of the pharmacy team had altered significantly, as two experienced full-time members of the team (the pharmacy technician branch manager and an accuracy checking technician) had left the branch following the challenging implementation of a new pharmacy software system. It had taken time to recruit replacement staff and the team had struggled to manage the new pharmacy system with fewer resources. The workload had consequently built up and had not always been managed effectively. The team had also lost a full-time dispensing assistant during this period and her hours had not been replaced. However, the situation had improved when the current pharmacy manager had joined the team. She had previous management experience, as well as experience of the implementation of new pharmacy systems, and had recruited staff, arranged training and organised systems to help manage the workload more effectively.

Targets were set for the common ailments service 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 and 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 pharmacist, pharmacy manager and area manager. The company's whistleblowing policy was displayed in the dispensary, and a poster advertising a confidential helpline for raising concerns was displayed in the staff room.

Pharmacy team members were observed to use appropriate questions when selling over-the-counter medicines to patients. The trainee MCA referred to the pharmacist for further advice whenever she

received a request or query involving a medicine. Staff undertook online training on a variety of topics. Recent training had covered topics such as the new computer system, the influenza vaccination service and over-the-counter medicines. Some topics were only available on work computers and staff sometimes found it difficult to access these while working as they were often very busy and the computers were frequently in use. All staff were subject to performance and development reviews but had not received a review since before the pandemic began. 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 generally tidy. It is secure, has enough space to allow safe working and its layout protects people's privacy.

Inspector's evidence

The pharmacy was clean. It was fairly tidy and well-organised. However, large quantities of stock were being temporarily stored on the floor and posed a potential trip hazard in the first-floor dispensary. The sinks had hot and cold running water and soap and cleaning materials were available. Staff disinfected work surfaces twice daily. A plastic screen had been installed at the medicines counter to reduce the risk of viral transmission between staff and customers. Markings on the floor in the retail area encouraged people to keep a safe distance from each other. 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's services are easy for people to access. 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 medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply. 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 wide range of services and these were appropriately advertised. There was a small step up to the pharmacy entrance, but a wheelchair ramp was available and the door could be opened using an external push pad. There was wheelchair access into the consultation room. Staff said that they would signpost patients requesting services they could not provide to nearby pharmacies or other healthcare providers such as the local surgery. A range of health promotional material was displayed near the medicines counter. The pharmacist and pharmacy manager 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 common ailments service and the repeat dispensing service.

Services were provided from the main dispensary and a dispensary on the first floor, which was used solely for dispensing medicines in compliance aids. A new pharmacy software system had recently been installed. The system sometimes crashed, leaving pharmacy team members unable to access it to process prescriptions or view patient medication records. The pharmacy manager explained that the team were currently trying to clear a three-day backlog of prescriptions as the system had crashed on the previous Thursday and had not come back on line until Saturday morning. However, staff dealt with all prescription requests and queries promptly, politely and effectively during the inspection and the atmosphere was professional and calm.

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. 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 also used to identify dispensed Schedule 3 and 4 CDs awaiting collection. Staff said that this practice helped ensure that prescriptions were checked for validity before handout to the patient.

Patients on high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified and there was a risk that opportunities for counselling might be missed. The pharmacist said that she asked walk-in patients about relevant blood tests and dose changes but did not record these conversations. The pharmacy team were aware of the risks of valproate use during pregnancy and used stickers to identify valproate prescriptions. This helped ensure that patients prescribed valproate who met the risk criteria were counselled appropriately and provided with information. The pharmacy

carried out regular audits of high-risk medicines, which were 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.

There had been an increase in demand for the delivery service as a result of the pandemic. Prior to this, signatures had been obtained for prescription deliveries. However, to reduce the risk of viral transmission, the procedure had been changed. The driver now placed a package on the patient's doorstep, knocked or rang the doorbell and waited until it was collected, making a note of this on an electronic device as an audit trail. In the event of a missed delivery, a notification card was put though the door and the prescription was returned 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. Each patient had a section in one of five dedicated files that included their personal and medication details, collection or delivery arrangements and details of any messages or changes. A list of patients was included at the front of each file. The pharmacy provided medicines to patients in four care homes. A log for each care home listed the dates on which the team were expected to have completed different stages of the dispensing process. This ensured that they were on schedule to deliver the medication to each home before the required medication start date.

The pharmacy provided a wide range of services. There was a high uptake of the common ailments service, the emergency supply of prescribed medicines service and the influenza vaccination service. The pharmacy also provided smoking cessation services and the All-Wales EHC service. It had recently begun to offer the Welsh Government's COVID-19 lateral flow test supply service and a private COVID-19 lateral flow testing service. It was not currently providing medicines use reviews, as this service had been suspended by Welsh Government in light of the COVID-19 pandemic. It offered blood pressure measurement and blood glucose measurement for a charge and customers were encouraged to book appointments for these services via the pharmacy's website.

Medicines were obtained from licensed wholesalers and were stored appropriately. Some P medicines were stored in the retail area in closed Perspex boxes marked 'Please Ask For Assistance'. Medicines requiring cold storage were stored in two well-organised drug fridges: one was situated in the main dispensary and the other in the MDS room on the first floor. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in two CD cabinets. These were well-organised but large quantities of obsolete CDs were segregated from usable stock and took up a lot of cabinet space. A dispensed prescription for Zomorph that was no longer valid was being stored in one of the cabinets. The pharmacy team was aware of this and said that the Zomorph was shortly to be put back into stock and the prescription sent back to the surgery. The process for reporting a CD discrepancy to the controlled drug accountable officer, including contact details, was displayed in the dispensary.

There was some evidence to show that regular expiry date checks were carried out, but the frequency and scope of these checks were not documented. This created a risk that out-of-date medicines might be overlooked, which was reinforced by the presence of two out-of-date stock medicines in the MDS dispensary. However, the pharmacy team said that they included a date check as part of their dispensing and checking processes to mitigate this risk. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received drug alerts and recalls

via the company intranet, which was checked daily by the pharmacy manager. The pharmacist was able to describe 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 or manufacturer.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its 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. Personal protective equipment was available for staff use. The pharmacy team had access to hand sanitiser and were wearing face masks. 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.