General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 118-120 Bloomfield Road, BLACKPOOL, Lancashire, FY1 6JW

Pharmacy reference: 1075293

Type of pharmacy: Community

Date of inspection: 23/10/2019

Pharmacy context

This is a community pharmacy inside a medical centre. It is situated in a residential area south of Blackpool town centre. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides seasonal flu vaccinations. A number of people receive their medicines in multi-compartment compliance aids.

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	Members of the team record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again.
2. Staff	Standards met	2.2	Good practice	Members of the pharmacy team complete regular training modules to help them keep their knowledge up to date.
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 team follows written procedures, and this helps to maintain the safety and effectiveness of the pharmacy's services. Members of the team record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again. They are given training so that they know how to keep private information safe. And they keep the records that they need to by law.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which were regularly updated by the head office. The pharmacy team had signed training sheets to say they had read and accepted the SOPs. The pharmacy had implemented the company's "safercare" programme to help identify any shortcomings in their procedures. Each month audits were completed to ensure compliance in various areas. This included the environment – ensuring the premises were tidy and stock appropriately stored, and process – to ensure regular housekeeping tasks were carried out such as near miss records and fridge temperatures. The previous audit had identified a shortcoming in the date checking process which the pharmacy team were in the process of bringing back up to date.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). The pharmacy team were able to explain the process to record errors, and the forms used to investigate them. Near miss errors were recorded on a paper log and the records were reviewed monthly by the pharmacist to identify any patterns or trends. The pharmacist discussed the review with the pharmacy team every month as part of a 'safercare briefing'. The pharmacist would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. The pharmacy team gave examples of action they had taken to manage risks they had identified from near miss reviews, such as segregating different strengths of amlodipine tablets. The company shared learning between pharmacies on the intranet. For example, they shared case studies about when things have gone wrong or professional matters. The pharmacy team would discuss the information when it was received.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The trainee dispenser was able to describe what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms and had badges identifying their names and roles. The responsible pharmacist (RP) had their notice displayed prominently. The pharmacy had a complaints procedure. This was described in a separate leaflet and it advised people they could give feedback to members of the pharmacy team. Any complaints were recorded to be followed up by the pharmacist or the head office. A current certificate of professional indemnity insurance was seen.

Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded in a separate register. Records of the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

An information governance (IG) policy was available. The pharmacy team received IG training and had signed confidentiality agreements. When questioned, the dispenser was able to describe how confidential waste was segregated and removed by a waste carrier. A privacy notice was on display

which described how patient information was handled by the pharmacy. GP surgery staff were seen to enter part of the dispensary throughout the day. This meant they might see confidential information, but the pharmacy team confirmed that GP staff had not signed confidentiality agreements.

Safeguarding procedures were in place, and the pharmacy team had received in-house safeguarding training. The pharmacist had completed level 2 safeguarding training. The dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. Members of the pharmacy team complete regular training modules to help them keep their knowledge up to date. And they get regular feedback from their manager to help them improve.

Inspector's evidence

The pharmacy team included a pharmacist, a pharmacy manager – who was dispenser trained, five dispensers and a new starter. The pharmacy team were appropriately trained or on accredited training programmes. The normal staffing level was a pharmacist, and six other staff. There was a high footfall into the pharmacy from the adjoining surgery. There appeared to be enough staff to cope with the workload. But, other than the pharmacist, there were no other accuracy checkers. This caused a bottleneck which sometimes made the dispensing operation less efficient. Staffing levels were maintained by using part-time staff and a staggered holiday system.

The pharmacy team had access to a structured e-learning training programme. The training topics appeared relevant to the services provided and those completing the e-learning. And training records were kept showing that ongoing training was up to date. Staff were allowed learning time to complete training.

The trainee dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said she felt able to exercise her professional judgment and this was respected by the pharmacy team. The trainee dispenser said she received a good level of support from the pharmacist and felt able to ask for further help if needed.

Appraisals were conducted by the pharmacy manager. A dispenser said she felt the process was a good chance to receive feedback on her work. And she felt able to discuss any concerns she may have. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or SI. The pharmacist said she was set service-based targets. She said she did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was generally clean and tidy. It appeared adequately maintained. The size of the dispensary was sufficient for the workload. A sink was available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by the position of the counter. The temperature was controlled by the use of an air conditioning unit. Lighting was sufficient. The staff had access to a kettle, microwave, separate staff fridge, and WC facilities.

A consultation room was available. The space was clutter free with a computer, desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. The pharmacy team carry out additional checks before they supply higher-risk medicines to make sure they are suitable, and that people know how to take them.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was also wheelchair access to the consultation room. Pharmacy practice leaflets gave information about the services offered. There was also information available on the website. Pharmacy staff were able to list and explain the services provided by the pharmacy. The pharmacy opening hours were displayed and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and logged onto an electronic delivery management system. An electronic device was used to obtain signatures from the recipient to confirm delivery. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. CDs were recorded on a separate delivery sheet for individual patients and a signature was obtained to confirm receipt.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were kept on a collection shelf using a numerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out. A number of bags were stored on the floor, which may increase the risk of the medicines becoming damaged.

Schedule 3 and 4 CDs were highlighted so that staff could check prescription validity at the time of supply. High-risk medicines (such as warfarin, lithium and methotrexate) were also highlighted and patients were referred to the pharmacist for counselling. The staff were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said she would speak to any patients who were at risk to make them aware of the pregnancy prevention programme, and this would be recorded on their PMR.

Some prescriptions were dispensed by an automated hub as part of the company's off-site dispensing (OSD) programme. Patients gave consent when they signed up to the repeat prescription service. Prescriptions for the hub were labelled electronically at the pharmacy by staff who had been specifically trained to label OSD prescriptions. The pharmacist was then required to complete accuracy check of the labels and a clinical check on the items. The information was then transmitted to the hub for the medicines to be dispensed. Some items could not be dispensed by the hub, including items out of stock, not stocked, or CD and fridge items. The process was auditable by use of a personal log in to identify

who had labelled the prescription and who performed the accuracy check.

Dispensed medicines were received back from the hub within 48 hours. They were delivered in sealed totes that clearly identified that they contained dispensed medicines. The medicines were packed in sealed clear bags with the patient's name and address the front. These did not need to be accuracy checked by the pharmacy unless they opened the bag, in which case the responsibility for the final accuracy check fell to the pharmacy rather than the hub. When the dispensed medicines were received in branch, they were matched up with the prescription forms, any other bags from the OSD and any exception items that had been dispensed and checked by the branch.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacy would refer them to their GP to complete an assessment about their suitability. A record sheet was kept for each patient, containing details of their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge sheets were sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail. But patient information leaflets (PILs) were not routinely supplied. So people may not always have all of the information they need.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine safety checks of medicines. Stock was date checked on a 3-month rotating cycle and it appeared up to date. But there were historical gaps which indicates there may be gaps in this process. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker and liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use. There were clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had been in range for the last 3 months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the head office. Alerts were printed, action taken was written on, initialled and signed before being filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's team members have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. According to the stickers attached, electrical equipment had been PAT tested in January 2019. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy. The consultation room was used appropriately; patients were offered its use when requesting advice or when counselling was required. Substance misuse clients were directed to the use of the consultation room to provide privacy.

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.