General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 76 Warwick Road, CARLISLE, Cumbria, CA1 1DU

Pharmacy reference: 1087638

Type of pharmacy: Community

Date of inspection: 08/10/2019

Pharmacy context

This is a community pharmacy next to a large health centre close to the town centre of Carlisle, Cumbria. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including seasonal flu vaccinations, medicines use reviews (MURs) and the NHS New Medicines Service (NMS). The pharmacy delivers medicines to people's homes and supplies medicines in multi-compartment compliance packs to help people take their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy is not adequately identifying and managing the risks with some of its services. The pharmacy doesn't regularly complete some processes it should. Such as regularly checking its fridge temperatures and the expiry dates of its medicines. And so, there is a risk that the medicines people receive are not fit for purpose.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not always have enough staff to manage its workload. And the team members work under pressure to make sure people get their medicines when they need them. This can increase the risks of mistakes. And the team members don't always complete other less urgent tasks. And so, the pharmacy gets behind with its workload.
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 not all met**

Summary findings

The pharmacy is not adequately identifying and managing the risks with some of its services. The team members are struggling to regularly complete some of the processes they should to make sure medicines are fit for purpose. The pharmacy team members do not regularly record or analyse the near miss errors they make while dispensing. But they sometimes briefly discuss and learn from the errors at the time. And they take some basic steps to make sure they don't repeat these errors. The pharmacy has written procedures to help the team protect the safety and wellbeing of people who access its services. But the team members have not read the most up to date versions. It mostly keeps the records it must have by law. And it keeps people's private information secure. The pharmacy team members have some tools available to them to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy was busy at the time of the inspection, with a constant flow of people bringing prescriptions to be dispensed. Most of the prescriptions were from the adjacent health centre. The dispensary was cluttered with many baskets containing prescriptions and medicines awaiting a final check. The pharmacy team members were working under pressure to complete the dispensing workload. This could increase the risk of error. But they weren't recording the near-miss errors due to the pressure. So, they couldn't identify the risks. Other tasks had not been completed such as date checking and monitoring the fridge temperatures. This increased the risk that medicines were not fit for purpose. The pharmacy wasn't adequately identifying these risks or managing them.

The pharmacy had a set of standard operating procedures (SOPs). And they were kept in a ring binder with an index. So, it was easy to find a specific SOP. There were SOPs for procedures such as taking in and handing out prescriptions, responsible pharmacist regulations and dispensing. Each team member had read the SOPs that were relevant to their role in the pharmacy. A team member said she would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with. But the SOPs that were being used had been due for review in August 2019. The pharmacy had been provided with a new set of SOPs to replace the ones being used. And these had a review date of July 2021. But the team had not yet started reading and complying with them.

The pharmacist highlighted near miss errors that were spotted during dispensing. And the pharmacist discussed the error with the team member. Occasionally, the team members recorded the details of any errors they made into a near miss log. But they didn’t use the log regularly. And they had not recorded any near miss errors in the last two months. The team members talked about the errors and why they happened. They identified rushing or misreading the prescription were the most common errors. The pharmacist encouraged the team members to take more time when dispensing prescriptions, even when the pharmacy was busy. The team were encouraged to formally analyse the near miss errors every four weeks as part of the company’s ‘Safercare’ process. The findings would then be documented and discussed with the team during a Safercare briefing. And the team were encouraged to consider and implement changes to the way they work to help prevent near miss errors from happening. But the team had not completed the process for several months. A SafeCare notice board was fixed to a wall and its purpose was to highlight the key findings from the last briefing. But it

had not been used for several months. The team members explained they discussed the near miss errors at the time of the incident and tried to involve each other in thinking of ways they could improve. For example, alert stickers were attached to the shelves where simvastatin was stored. The alert stickers reminded the team that simvastatin had been involved in some picking errors. And they should take extra care when dispensing. The pharmacy had a process to record dispensing errors that had been given out to people. And to keep a copy of the report in the pharmacy for future reference. The reports template included the details of who was involved, what happened, why it happened, and what actions the pharmacy intended to do to prevent a similar error happening again. The team members described some examples, but they were unable to locate any completed reports.

The pharmacy advertised how people could make comments, suggestions and complaints in a leaflet in the retail area which people could take away with them. It obtained feedback from people who used the pharmacy each year through a customer satisfaction survey. The results of the latest survey were displayed in the retail area. And they were generally positive. One area for improvement was the time people were required to wait while their prescriptions were being dispensed. The team members were observed trying to manage people's expectations and dispense prescriptions within a reasonable time. A team member described how she would manage and escalate any potential complaints or concerns.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. But they were not always completed fully, as some headers were missing. This is not in line with requirements. The pharmacy team checked the running balances against physical stock each month. A physical balance check of Mezolar 12mcg patches matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor. The pharmacy outlined to people using the pharmacy how it stored and protected their information. The team members understood the importance of keeping people's information secure. Each team member discussed how they had completed various training modules on information governance, but no evidence was available for inspection.

The pharmacist on duty and a pharmacy technician had completed training on the safeguarding of vulnerable adults and children up to level 2 via the Centre for Pharmacy Postgraduate Education. The team members gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. A team knew to discuss their concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had written guidance on how to manage or report a concern and the contact details of the local safeguarding team affixed to a dispensary wall.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy team members struggle to manage the pharmacy's workload. And they work under pressure to make sure people get their medicines when they need them. This means the team members don't always complete other less urgent tasks. The pharmacy has training arrangements in place for its team members. But they don't always get the opportunity to complete ongoing training to help them keep their knowledge and skills up to date. The team members support each other well and talk together informally about how to make improvements to the pharmacy's services. But they are unable to do this regularly.

Inspector's evidence

At the time of the inspection the responsible pharmacist was the pharmacy manager who worked full time. And she was supported by a full-time pharmacy technician, a part-time pharmacy assistant and a full-time pharmacy assistant. Another full-time pharmacy assistant and the pharmacy's delivery driver were not working on the day of the inspection. The team members appeared under pressure during the inspection and were struggling to manage the dispensing workload. A local Lloyds branch had permanently closed in August 2019 and many of the people who had used the branch had started using the pharmacy. And so, the pharmacy's dispensing workload had significantly increased. One team member from the closed branch had been transferred to work at the pharmacy. The team members explained they were behind with their dispensing workload and were struggling to dispense prescriptions in accordance with people's expectations and needs. There were many prescriptions that had been received by the pharmacy around four weeks ago but had not yet been labelled or dispensed. The team said they often felt under pressure to dispense medicines for when people needed them. On some Fridays only one team member supported the pharmacist. And so, it was often difficult for the team to achieve the high standards of service that they wanted to achieve. The team was also behind with the dispensing workload for the multi-compliance packs and the team members often had to dispense the packs while people waited in the retail area. And so, the risk of making an error was increased. They often worked more than their contracted hours to ensure they were able to complete the workload to the best of their ability. For example, the pharmacist occasionally came in to the pharmacy on days she was not contracted to work to complete tasks such as CD balance checks. The team had asked the company's head office for some support with staffing and locum dispensers had occasionally been booked in to support the team, but the bookings had often been changed or cancelled.

The team members had access to an online training system called Mylearn. The system contained several modules, some of which were mandatory to complete, and some could be accessed voluntarily or in response to an identified training need. Each team member had personal electronic log of the training they completed. There was usually a short quiz at the end of each module which the team members were required to pass to indicate they had understood the module and were competent in following it. The team members were scheduled to receive 30 minutes of protected training time each

week. The time was protected to allow the them to work without distraction. But the team had struggled to find time to regularly take the protected training time since August 2019 due to the pressures of the dispensing workload and had therefore been unable to complete several modules. The pharmacy had an appraisal process in place for its team members. The appraisals took place every year. And the pharmacy was up to date with the process. The appraisals were an opportunity for the team to discuss which aspects of their roles they enjoyed, where they wanted to improve and if they wanted to give any feedback to improve the services the pharmacy offered. For example, following a supply problem with clopidogrel, the team discussed how they could make sure people prescribed clopidogrel were managed appropriately. This included speaking with people's GP practices to make them aware of the supply problem and recommending alternative treatments.

The team held ad hoc meetings and discussed topics such as company news, targets and patient safety, if the pharmacy was quiet. But this was rare, and the team had not held a meeting for several months. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members were observed attempting to acknowledge people who were waiting to be served as soon as they arrived at the retail counter. But this was not always possible. They informed people of the waiting time for prescriptions to be dispensed and took time to speak with them if they had any queries. The team members were able to discuss any professional concerns with the pharmacist or senior management. They had recently raised some concerns about staffing levels but were unaware of a plan to help them solve their concerns. The pharmacy had a whistleblowing policy. And so, the team members could raise concerns anonymously. The team was set various targets to achieve. These included the number of prescription items they dispensed and the number of services they provided, for example, medicine use reviews. The team members said they were not able to consistently achieve the targets and felt some pressure to do so. But they were unable to focus on achieving the targets while they were behind with the dispensing workload.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and suitably maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members. Overall, the pharmacy is professional in appearance. But the staff area of the pharmacy is reasonably untidy and so there may be a risk of trips and falls.

Inspector's evidence

The pharmacy was clean, professional in appearance and well maintained. It had a limited amount of bench space available for the volume of dispensing being completed. And some of the benches were cluttered and several baskets containing medicines and prescriptions were kept on the dispensary floor. The risk of trip hazards and medicines being mixed up due to the clutter, was discussed with the team. The pharmacy held stock in rooms on the upper floors. The rooms were untidy and were difficult to walk through safely. Several items were stored on the floors. And so, there were some significant trip hazards. The risks were discussed with the team members.

There was a clean, well-maintained sink in the dispensary for medicines preparation. There was a WC and sink available for staff use. And it was well maintained. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities and a computer system. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. And the pharmacy helps make these services accessible to people. The pharmacy has controls in place to help deliver some of its services effectively. It manages the risks associated with supplying medicines in multi-compartmental packs with suitable processes. But it doesn't always regularly complete other processes it should. The team don't always regularly check fridge temperatures or check the expiry dates of its medicines. This means there is a risk that some of its medicines are not fit for purpose.

Inspector's evidence

The pharmacy had steps up from the pavement. And there was a ramp, so people using wheelchairs and prams could easily access the pharmacy. The pharmacy advertised its services and opening hours in the main window. Seating was provided for people waiting for prescriptions. Large print labels were provided on request to help people with a visual impairment. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer.

The team members regularly used various stickers during dispensing and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people's prescriptions from getting mixed up. At the time of the inspection, there was a backlog of around 30 baskets containing prescriptions that needed dispensing. They recorded the date that CD prescriptions expired on CD alert stickers, which they attached to medication bags. This system helped prevent team members from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy had a system to contact people who had not collected their medication for four weeks. If people were uncontactable or they no longer required their medicines, the medicines would have their dispensing labels removed and if appropriate, the medicines put back onto the dispensary shelves. But the team was behind with this process, and so the medication retrieval area was overflowing. The pharmacy kept records of the delivery of medicines from the pharmacy to people. And the records included a signature of receipt. And so, there was a complete audit trail in place that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

Some of the pharmacy's prescriptions were dispensed at an offsite dispensing hub. The team was not up to date in completing checks for the service. The team members had completed training on providing the service. The pharmacist demonstrated how she checked that the prescriptions were both clinically appropriate and the data entered accurate before the prescription was released to the hub to be dispensed. The dispensed medicines were received by the pharmacy after around three days. The medicines were returned in sealed bags which were clear on one side. This allowed the team members to complete a visual check against the prescription to ensure the medicines were accurate.

The pharmacy supplied medicines in multi-compartmental compliance packs for around 30 people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the prescriptions. And they did this around a week in advance. But they were often behind with the process. They cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The packs had backing sheets which listed the medicines in the packs and the directions. The pharmacy supplied information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs. The team members recorded the details of any changes such as dosage increases or decreases. They kept the details of when the change was authorised and who had authorised it.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used alert stickers attached to people's medication bags to remind them that the bag contained a high-risk medicine. They then brought the bag to the attention of the pharmacist. The pharmacist gave the person collecting the medicine additional advice if there was a need to do so. But due to the current workload issues, the pharmacist currently had to keep the conversation short to minimise the time she was away from the dispensary. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. One person had been identified. And the person was provided with advice about the programme. The pharmacy used clear bags to store dispensed insulin and controlled drugs. This allowed the team member and the person collection to undertake a final visual check of the medicine before the person collected the medicine.

Pharmacy medicines (P) were stored in Perspex boxes in the retail area. The boxes had an instruction for people to ask for assistance if they wished to choose a product in the box. The boxes could be easily opened, and some were out of view of the pharmacy counter. The pharmacy counter was often unmanned as all team members were working to complete the workload in the dispensary. The team realised there was a risk that people may self-select a P medicine. And the team member or pharmacist may not realise during the sale. The pharmacy stored its medicines in the dispensary tidily and they were easy to find. Every three months, the team members were required to check the expiry dates of its medicines to make sure none had expired. But the records seen showed that the team had not fully completed the checks since May 2019. The pharmacy used stickers to highlight stock that was within six months of expiring. Some short-dated stickers were seen on items on the dispensary shelves. Two boxes of out-of-date medicines were found following a random check of 20 items. The team were struggling to allocate time to complete any date checking. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received training on how to follow the directive. The team was unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges. But they did not do this every day. The temperature ranges were checked during the inspection. And were within the correct ranges.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and suitable for the services it provides. The pharmacy uses its equipment appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private.

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.