General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Courthouse Medical Centre, Heol Browen, CAERPHILLY, CF83 3GH

Pharmacy reference: 1088693

Type of pharmacy: Community

Date of inspection: 23/06/2023

Pharmacy context

This is a pharmacy inside a medical centre. 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.

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 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 keeps people's private information safe. And its 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 risks, including the recording and regular analysis of dispensing errors and near misses. Members of the pharmacy team were able to give several examples of instances where action had been taken to reduce risks that had been identified. For example, highlight stickers had been used to alert staff to the risk of selection errors with different strengths of primidone, different pack sizes of prochlorperazine and different forms of ramipril and tamsulosin. A poster describing the process to follow in the event of needlestick injury was displayed in the consultation room.

A range of standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. A trainee dispensing assistant was able to describe the activities which could and could not take place in the absence of the responsible pharmacist. The accuracy checking technician (ACT) was able to accuracy check all prescriptions that had been stamped and initialled to show that they had been clinically checked by a pharmacist, except for prescriptions for methotrexate 10mg tablets. Methotrexate is a high-risk medicine and errors are often associated with serious adverse outcomes for patients.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, but these had been suspended during the pandemic and had not yet resumed. The pharmacist said that feedback about the customer service provided by the pharmacy was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in the pharmacy's practice leaflet which was displayed at the medicines counter. Leaflets available in the consultation room also advertised the NHS complaints service: 'Putting Things Right'.

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, unlicensed specials, and controlled drug (CD) records. However, two different pharmacists had made an entry in the RP register between 9am and 1pm on 16/6/23 and it was unclear who had taken ultimate responsibility for the safe and effective running of the branch during this time. This meant that it might not be possible to identify the pharmacist accountable in the event of an error or incident. The branch manager explained that no emergency supplies had been made in recent months and so no current records were available. Some records of private prescriptions did not include dates, and some were missing details of the prescriber, with prescriptions written by the company's private prescribing service marked only as 'online doctor'. This meant that there might not be enough information to provide a clear audit trail in the event of queries or errors.

Members of the pharmacy team 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. A privacy notice displayed at the medicines counter gave information about the ways in which personal data was used and managed by the company and included the details of the company's data protection officer.

The pharmacist had undertaken formal safeguarding training and all team members had read and signed the company's internal safeguarding policy. Staff had access to guidance and local safeguarding contact details that were displayed in the dispensary. A copy of the chaperone policy was displayed on the consultation room door, with a summary of the policy displayed nearby. Posters advertising the 'Ask for Ani' domestic abuse scheme were displayed in the staff room and the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough staff to manage its workload safely. But it relies heavily on temporary pharmacists. This lack of continuity means that the team sometimes has to work under pressure. Pharmacy team members understand their roles and responsibilities. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

A regular locum pharmacist worked at the pharmacy every Wednesday and different locum pharmacists worked at the pharmacy on most other days. A dispensing assistant (DA) was employed as the full-time branch manager. The support team consisted of two more DAs, a trainee DA and an accuracy checking technician (ACT). A part-time untrained member of staff who worked on the medicines counter was also present. She was employed on a temporary ten-week contract which was due to finish on 21 July. Two other part-time DAs were absent. The branch manager explained that the trainees always worked under the supervision of a pharmacist or another trained member of staff. The staffing level appeared adequate for the services provided. However, the branch manager said that the team sometimes struggled to keep on top of the workload, especially when members of the pharmacy team were absent, as there was no regular pharmacist to provide continuity. She explained that the pharmacy had also recently lost 40 staff hours which had not been replaced.

The member of staff working on the medicines counter referred all requests for medicines or advice to the pharmacist. Other staff members were observed to use appropriate questions when selling over-the-counter medicines and referred to the pharmacist on several occasions for further advice on how to deal with transactions.

Staff had access to an online learning platform, but the ACT said that there had been no new training modules issued for many months except for mandatory health and safety and safeguarding modules. The lack of a structured training programme increased the risk that individuals might not keep up to date with current pharmacy practice. However, informal training materials such as articles in trade magazines and information about new products from manufacturers were available. The trainee DA was allowed four hours of protected study time each week. The ACT understood the revalidation process and based her continuing professional development entries on situations she came across in her day-to-day working environment. There was no formal appraisal system in place and so there was a risk that training and development needs might not always be identified or addressed. But all staff could informally discuss performance and development issues with the pharmacists, pharmacy manager or area manager whenever the need arose.

There were no targets set for the services provided. Staff worked well together and had an obvious rapport with customers. Staff members said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist or area manager. Details of a confidential helpline for raising concerns outside the organisation were included on a poster displayed in the staff area. Another notice in the staff area advertised a support service for healthcare colleagues in Wales that offered free wellbeing resources including counselling sessions.

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 clean, tidy and well-organised. Some stock and dispensed prescriptions awaiting collection were being temporarily stored on the floor, but these did not pose a trip hazard. The sinks had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use. A consultation room was available for private consultations and counselling, and it was advertised appropriately. A semi-private screened area at the end of the medicines counter was used for quiet conversations and counselling. 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 safe and effective. It stores medicines appropriately and carries out checks to help make sure that they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. However, some locum pharmacists were unable to provide the whole range of services. There was wheelchair access into the pharmacy and consultation room and a hearing aid loop was available. The pharmacy team signposted people to other nearby pharmacies or other providers such as the adjacent surgery or the local council for any services they could not provide, such as the council's sharps collection service.

Dispensing staff used a colour-coded basket system to help ensure that medicines did not get mixed up during dispensing and to differentiate between different types of 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 bags of dispensed medicines 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. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

Prescriptions for high-risk medicines such as warfarin, lithium and methotrexate were sometimes, but not always, marked to identify counselling opportunities. The branch manager said that the pharmacy team usually asked people about relevant blood tests and dose changes and there was evidence to show that this information was recorded on the patient medication record (PMR). The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacy did not currently have any patients prescribed valproate who met the risk criteria, but the branch manager said that any such patients would be counselled and provided with information at each time of dispensing. A poster that listed actions to be taken by the pharmacist when dealing with valproate prescriptions was displayed in the dispensary. Another poster was displayed as a reminder to staff that valproate should only be dispensed in original packs which carried warnings about the risks of valproate use in pregnancy. 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, and to flag up areas where risk reduction could be improved within primary care.

Medicines were supplied in disposable compliance aid trays for a number of people. Trays were labelled with descriptions of the medicines they contained, so that individual medicines could be easily identified, and patient information leaflets were routinely supplied. A list of compliance aid patients was displayed in the dispensary for reference. Each patient had a clear plastic wallet that included their personal and medication details, collection or delivery arrangements and details of any messages or changes.

The pharmacy offered a range of services. Uptake of the emergency supply of prescribed medicines service was very low, as the pharmacy was situated close to the local surgery and kept similar opening hours, so people were usually able to obtain a valid prescription from a GP in an emergency. There was a steady uptake of the common ailments service, the smoking cessation service (supply only), the EHC service and the seasonal influenza vaccination service. The pharmacy also provided a blood pressure measurement service for a charge.

The pharmacy provided a prescription collection service from seven local surgeries. It also offered a free prescription delivery service. Signatures were not always obtained for prescription deliveries as an audit trail, but the team gave assurances that the delivery driver confirmed the identity of the recipient before each prescription was supplied. Signatures were obtained for deliveries of controlled drugs. In the event of a missed delivery, the driver put a notification card through the door and brought the prescription back to the pharmacy.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. However, some medicines that had been removed from their original packaging were not adequately labelled either as stock or named-patient medication, increasing the risk of errors. The branch manager disposed of these appropriately as soon as this was pointed out. Medicines requiring cold storage were stored in two well-organised drug fridges. Maximum and minimum temperatures were recorded daily and were generally within the required range. Some discrepancies had been recorded but evidence showed these had been monitored appropriately. CDs were stored appropriately in two well-organised CD cabinets and obsolete CDs were segregated from usable stock.

Stock was subject to regular documented expiry date checks, although the team had fallen behind with these over the last few weeks as they had been short-staffed. Some out-of-date medicines were found present in the dispensary. However, stickers were used to highlight short-dated stock and pharmacy team members explained that they included a date check as part of their dispensing and checking procedures. Date-expired medicines were disposed of appropriately, as were waste sharps and patient returns. The pharmacy received drug alerts and recalls via the pharmacy's intranet system. The branch manager described how the team would deal with drug recalls by contacting patients where necessary, quarantining affected stock and returning it to the supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities it needs to provide the services. And it makes sure these are always safe and suitable for use.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Triangles, a calibrated tablet counter and capsule counters were used to count loose tablets and capsules. 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. Dispensed prescriptions could be seen from the retail area but no confidential information was visible.

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.