General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Portakabin, Princess Of Wales Hospital, Lynn Road, ELY, Cambridgeshire, CB6 1DN

Pharmacy reference: 1089227

Type of pharmacy: Community

Date of inspection: 17/06/2019

Pharmacy context

This community pharmacy is set in the grounds of a hospital in a largely residential area on the outskirts of Ely. There are a lot of new houses being built in the surrounding area. The pharmacy's main activity is dispensing NHS prescriptions. It also offers a prescription delivery service, Medicines Use Reviews (MURs), the New Medicine Service (NMS), seasonal flu vaccinations, emergency hormonal contraception, and health checks including blood pressure and blood glucose checks. It supplies some medicines in multi-compartment compliance aids to people who need this help taking their medicines.

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	1.2	Good practice	The pharmacy reviews its mistakes so the team can learn and improve from these to make its services safer.
2. Staff	Good practice	2.2	Good practice	The pharmacy's team members are well supported in keeping their skills and knowledge up to date.
		2.4	Good practice	There is a strong culture of openness, honesty and learning in the pharmacy and team members can contribute ideas about how to improve how the pharmacy works.
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's staff generally follow clear procedures to provide services safely. The pharmacy keeps the records it needs to be law. Its team members record their mistakes and review them regularly, so they can learn and reduce risks. And they understand what they can and cannot do when there is no pharmacist present. The pharmacy keeps people's private information safe. And its team members know what to do to protect vulnerable people. It could do more to make sure that the safe practice it follows for higher-risk medicines applies to medicines which are dispensed off-site. So that people always get the advice they need to take their medicines safely.

Inspector's evidence

Some medicines were dispensed at an off-site hub. This relieved some of the pressure on this pharmacy and helped the team cope with the limited space available more efficiently. The pharmacy had needed to complete a sign-off process to demonstrate it could complete the necessary administration tasks safely to support this service before the work was transferred.

Pharmacy services were supported by written standard operating procedures (SOPs) which were subject to regular review. There was an audit trail to show that staff had read the most recent versions of these SOPs. The pharmacy team had other tools available to reduce risks in the dispensing process. Shelf alerts had been placed in front of some medicines which had similar names or appearances to reduce the possibility of selecting the wrong item when dispensing. There were also alert stickers for higher-risk medicines, fridge lines, and controlled drugs (CD). These were generally applied to prescriptions and bags of medicines waiting to be collected so the staff knew when additional care was needed. When some medicines waiting collection were checked, a bag containing warfarin which had been dispensed at the off-site hub did not have an alert sticker applied.

Prescription labels, including those on multi-compartment compliance aids, were initialled at the dispensing and checking stages. Prescription forms were also initialled to show when the pharmacist had completed a clinical check so the accuracy checking technician knew it was appropriate for her to carry out the final accuracy check of the dispensed items. The accuracy checking technician (ACT) said that if there was no pharmacist signature on the prescription, she did not accuracy check the dispensed medicines.

The team members said that the pharmacist or ACT pointed out any dispensing mistakes the staff had made, and which were picked up during the final check of prescriptions. Near misses were recorded and the records seen included information about why or how the mistakes had been made. Some medicines with similar sounding names had been more clearly separated on shelves to prevent selection errors.

Errors which reached patients were recorded and said to be reported to head office. The pharmacist explained how errors had to be reviewed and that any action points were recorded as part of that review. Learning points from incidents were included in the regular safety reviews (known as 'safer care') and were shared with the team.

The roles and responsibilities of the team members were clear. When asked, they could confidently explain what they could and couldn't do in the absence of a responsible pharmacist. They could describe the types of questions to ask when selling medicines and knew which ingredients needed greater care including codeine and pseudoephedrine. They explained that they would refer requests for multiple packs of medicines containing these ingredients to the pharmacist. They also explained that they would not sell footcare products to people who had diabetes.

There was a company complaints procedure. Information about this was included in the pharmacy practice leaflet displayed. The pharmacy sought feedback from people using its services through an annual survey. The results of the most recent survey were displayed in the shop and were very positive overall. Some people had made comments about the lack of privacy and the type of seating available. The pharmacy manager said she was raising these with senior management to try to improve the seats. The team was trying to use the consultation room more often to improve privacy.

There were appropriate insurance arrangements in place for the services provided. The responsible pharmacist (RP) notice correctly showed who the pharmacist in charge was and it was displayed clearly. The RP record and records about controlled drugs (CDs) were complete and running balances were checked regularly. Private prescription records were made in a book complied with requirements. Emergency supplies were infrequent, but the records seen were complete.

The pharmacy protected sensitive information in several ways. Confidential waste was segregated and disposed of securely. Staff had completed training packages on protecting people's information and there were written procedures about information governance. Patient medication records were password protected and staff used their own NHS Smartcards to access electronic prescriptions. There was no confidential material left on display. And there was information for the public about how their data was processed by the pharmacy.

There were procedures in place to help make sure the pharmacy took appropriate action to protect vulnerable people. Staff had read these procedures. The pharmacist and ACT had completed level 2 training about safeguarding. Details for local support agencies were available so concerns could be reported promptly though advice was usually sought from the superintendent's office before this was done.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy's team members are suitably trained for the roles they undertake. They are supported in ongoing learning and development and they have set-aside time at work to training. There is a strong culture of openness, honesty and learning in the pharmacy and team members can contribute ideas about how to improve how the pharmacy works.

Inspector's evidence

At the time of the inspection there was a full-time pharmacist manager (the responsible pharmacist at the time of the inspection), one part-time accuracy checking technician, and two part-time dispensers who were also trained medicine counter assistants. A further two part-time dispensers were not present. Certificates evidencing the pharmacy qualifications achieved by the team members were displayed. The team coped with their workload during the visit and worked closely together, referring queries to the pharmacist where needed.

The staff had records of training they had completed. They were provided with a variety of e-Learning modules by the company, some of which were mandatory. The records seen showed that the staff were up to date with their training. The staff said that they got time at work to do training modules. They had not yet completed any training about the EU Falsified Medicines Directive.

The team members said they could share suggestions about how to improve the way the pharmacy worked. They had reviews with their manager and these looked at how the member of staff was doing, opportunities to develop their skills, and if they needed any additional support with training. As it wasn't always possible to have a team meeting with everyone present, there were arrangements to handover messages between the team members. A member of staff explained that the team had suggested how to improve the handover process between the team and had started using a notebook for this purpose. There was a staff notice in the dispensary which displayed information about monthly safety reviews and highlighted any learning points from these reviews.

The team said they would feel comfortable raising any concerns with the pharmacy manager or more senior management if needed. There was a helpline for staff if they wanted to raise concerns confidentially. The pharmacist explained that she felt able to exercise her professional judgement when delivering services, putting the needs of the patients first. There were targets set for services but she said she did not let these adversely affect the safe running of the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services the pharmacy provides.

Inspector's evidence

The pharmacy was in a portacabin and had been so for many years. There was an external ramp to the entrance so the premises could be accessed by people with wheelchairs, prams or other mobility problems. The pharmacy was equipped with an induction hearing loop and staff could demonstrate how to use this.

Access to the dispensary was restricted. There was very limited dispensing bench space but the team members were trying to keep this as clear as possible. One section of bench was used for dispensing prescriptions and a separate section for checking prescriptions, to reduce risks. Medicines and dispensed items were kept off the floor. A small extension to the original premises had created additional storage space just off the consultation room and this had meant some archived paperwork and other sundries could be moved out of the dispensary. There was also a small office area which was used for paperwork and other management tasks as well as acting as a colleague rest area.

Retail space was very limited, so the range of items kept was comparatively small. There were seats available for people waiting for services. A small consultation room was located just beside the medicine counter and this was used for services and private conversations. It was well-screened and was just big enough to accommodate a wheelchair. The room had a computer terminal to enable access to patient medication records and other information sources.

All areas of the premises were reasonably clean. The sinks in the dispensary and WC were equipped with hot and cold running water. The premises could be secured to prevent unauthorised access. The pharmacy had a mobile air-conditioning unit which was said to help keep room temperatures at a suitable level for working and storing medicines. Ventilation was good during the inspection; the front door and windows at the rear of the premises were kept open.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are undertaken safely and effectively. The pharmacy generally takes care when it supplies medicines which may be higher risk. And its team members are fully aware of what they should do when supplying valproate. To ensure its medicines are safe, the pharmacy gets its stock from reputable sources and generally stores it safely. It can readily demonstrate how it responds to safety alerts about medicines or medical devices to protect people's safety and wellbeing.

Inspector's evidence

Information about the services the pharmacy offered were advertised by way of leaflets and posters displayed in the pharmacy. The team members used local knowledge to direct people to other care providers for services that the pharmacy did not offer. The pharmacy was open Monday to Friday, 9am to 6pm. A prescription delivery service was offered to assist some people to access their medicines. Prescription deliveries were recorded so that there was evidence to show medicines had reached the right person.

For those services offered under Patient Group Directions (PGDs), including emergency hormonal contraception and seasonal flu vaccinations, the pharmacist had completed the necessary training to provide these services and there was evidence kept of this at the pharmacy. Patient consent was recorded and the PGDs had been signed appropriately. The team understood the information that needed to be provided about pregnancy prevention when supplying sodium valproate. The corresponding patient information leaflets, cards, and alert stickers were available. The shelf storage location of these products had been highlighted to prompt the team members to make the necessary checks when supplying these.

When supplying other higher-risk medicines, the pharmacy usually checked and recorded any available results of therapeutic monitoring tests, for example, INRs for people receiving warfarin. On a record checked at random, these results had been recorded for most of the recent supplies. Prescriptions for higher-risk medicines and CDs which were waiting to be collected by people were generally highlighted so that patients could be provided with appropriate advice when these were handed out. The team members knew that prescriptions for CDs were only valid for 28 days and said that prescriptions for all CDs in schedule 2, 3 and 4 would be highlighted. Examples of these were found when checked.

Multi-compartment compliance aids were provided to people who needed additional help with managing their medicines. Compliance aids were prepared in accordance with a planned rota over four weeks. Prescriptions were ordered on behalf of people and missing items or unexpected changes were queried with the person or their GP. The compliance aids were labelled with dose, cautions, and tablet descriptions to allow easy identification of the contents. Information leaflets which came with the medicines were supplied to people routinely. The staff could describe the types of medicines that were not suitable for putting in the compliance aids. They described the process they followed if there were any mid-cycle changes. This included retrieving any old compliance aids a person might still have before supplying the new ones.

The pharmacy got its medicines from licensed wholesalers and unlicensed 'specials' were obtained from

specials manufacturers. No extemporaneous dispensing was carried out. Medicine stock for dispensing was generally stored in an orderly fashion in the dispensary. Pharmacy only medicines were stored out of reach of the public. The pharmacy checked the expiry dates of its stock every quarter. These checks were recorded. Short-dated items were highlighted using an alert sticker. When a sample of medicines were checked at random, there were no date-expired medicines found. All medicines were kept in appropriately labelled containers. The dates of opening were added to the stock bottles of liquid medicines so the staff could assess if the medicines were still suitable to dispense. Out-of-date medicines and patient-returned medicines were transferred to designated bins. These were stored away from other medicine stock and were disposed of through licensed waste contractors. There were processes followed to denature CDs before disposal.

Appropriate arrangements were in place for storing controlled drugs (CD) and access to the CD cabinet was well-controlled. There was enough storage capacity for medicines requiring cold storage. The medicines fridge was equipped with a maximum and minimum thermometer and temperatures were checked daily and recorded. The records seen were within the appropriate range of between 2 and 8 degrees Celsius. The pharmacy had the appropriate scanning equipment to comply with the EU Falsified Medicines Directive. The staff were waiting for training to be able to use the equipment.

The pharmacy had a process to receive drug recalls and safety alerts. The pharmacy kept a record of previous safety alerts and could show that it had checked its stocks to make sure it had none of the affected medicines or medical devices. The pharmacy had been alerted by a customer that a blood pressure meter supplied did not appear to be working correctly. The pharmacy had notified the suppliers about this and had arranged to send the meter back for further checks. The customer had been supplied with a replacement device.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it checks its equipment regularly to make sure it is working correctly.

Inspector's evidence

The pharmacy had measuring equipment of a suitable standard to use when dispensing and providing other services. All medicine measures were clean. The meters used for checking people's blood pressure and blood glucose were stored securely. The blood pressure meter was replaced periodically and the date of first use was recorded to track this. The blood glucose meter was checked using a control solution and results of these checks were recorded to show it was operating correctly.

The pharmacy had a range of up-to-date reference sources available, in hard copy and via the internet. All electrical equipment appeared to be in good working order and was tested regularly. Patient medication records were stored electronically and access to these was password protected. NHS Smartcards to access summary care records and electronic prescriptions were not shared. Screens containing sensitive information were not visible to the public. The staff had access to cordless phones and could move to quiet areas of the dispensary to make phone calls out of earshot of waiting customers.

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.