General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 4 Strawberry Place, Morriston, SWANSEA, West Glamorgan, SA6 7AG

Pharmacy reference: 1092641

Type of pharmacy: Community

Date of inspection: 15/06/2023

Pharmacy context

This is a pharmacy next door to 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. Substance misuse services are also available.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	Members of the pharmacy team are not all suitably trained for the tasks that they carry out.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all 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 some of their mistakes so they can learn from them. And they take some action to help stop mistakes from happening again. But they do not always record or review all of their mistakes, so they may miss some opportunities to learn and improve. The pharmacy keeps the records it needs to by law. 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 risk, including the recording and analysis of dispensing errors. A member of the pharmacy team who had recently been involved in a dispensing error had completed a reflective account of the incident with associated learning points. Near misses had not been recorded for several months but the pharmacist said that there had been very few of these. He explained that he tended to discuss near misses with relevant staff at the time of each occurrence and that any patterns or trends that emerged were discussed with the whole team. Some action had been taken to reduce risks that had been identified. For example, a highlight sticker had been used to alert staff to the risk of selection errors with the 'look-alike, sound-alike' drugs amitriptyline and amlodipine, and these two products had been distinctly separated on dispensary shelves. Olanzapine and omeprazole had also been distinctly separated at the direction of head office after dispensing incidents had been reported by other branches. 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 member of the pharmacy team who worked on the medicines counter was able to describe which activities could and could not take place in the absence of the responsible pharmacist.

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 from people using 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 displayed in the retail area.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials, and controlled drug (CD) records. CD running balances were typically checked weekly.

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 behind 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 contact

details that were available in the SOP file. A summary of the chaperone policy was displayed on the consultation room door. Information leaflets for people affected by dementia were available in the retail area, as was a poster that included contact details for an Alzheimer's support group.

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

Summary findings

The pharmacy has enough staff to manage its workload. But one member of the team is not suitably trained for the tasks that they do. Pharmacy team members understand their roles and responsibilities. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

A regular pharmacist worked on most days and his absences were covered by locum pharmacists. A dispensing assistant (DA) was employed as the branch manager, but was absent during the inspection. The support team consisted of three other full-time DAs and a part-time member of staff who had worked on the medicines counter for about two years but had not yet undertaken any formal training. The assistant explained that they had received some internal training and always worked under the supervision of a pharmacist or another trained member of staff. The staffing level appeared adequate for the services provided and pharmacy team members were able to comfortably manage the workload.

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 pharmacist said that there had been no new training modules issued for many months. Informal training materials such as articles in trade magazines and information about new products from manufacturers were available and members of the pharmacy team said that much of their learning was via informal discussions with the pharmacist. The pharmacist explained that a formal appraisal process had been in place at the branch for many years, but was no longer being supported by the company following its decision to sell the branch. The lack of a structured training and development programme increased the risk that individuals might not keep up to date with current pharmacy practice and that any training needs might be missed.

Some targets were set for the services provided but these were managed appropriately, and the pharmacist said that they did not affect his professional judgement or compromise patient care. Staff worked well together and had an obvious rapport with customers. They atmosphere in the pharmacy was calm and professional. 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 available on the pharmacy's intranet system.

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. A poster demonstrating hand-washing techniques was displayed above the sink in the dispensary. Hand sanitiser was available for staff use. A consultation room was available for private consultations and counselling and was advertised appropriately. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy is good at promoting the services it provides so that people know about them. But the pharmacy entrance is not suitable for wheelchairs. So some people may not be able to access all of the pharmacy's services. If the pharmacy 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 some 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, which were appropriately advertised. There were steps up to the pharmacy entrance which were not accessible to wheelchair users or others people with limited mobility. An external lift next to the steps had been decommissioned several years previously. The pharmacist explained that the team would go out to patients who were unable to access the pharmacy and help them where possible. Or they would signpost them to other nearby pharmacies or other healthcare providers, such as the adjacent surgery, for any services they could not provide. A hearing aid loop was available in the consultation room. Some healthcare information was displayed in the retail area. The pharmacist had recently visited the local surgery to discuss and promote services as part of a health board funded collaborative working initiative.

About 95% of the pharmacy's prescription business came from the adjacent medical centre. The pharmacy team had a good relationship with the surgery team, which meant that queries and problems were usually dealt with efficiently and effectively. Dispensing staff used a colour-coded basket system in branch to help ensure 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. Prescriptions for Schedule 2 and 3 controlled drugs (CDs) were double-checked and counter-signed by a third member of the pharmacy team to reduce the risk of errors. 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. The clear bags were then put into paper bags at the point of supply to ensure that patient confidentiality was not compromised.

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. Stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was invalid and could no longer be supplied. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

Prescriptions for patients prescribed high-risk medicines such as warfarin, lithium and methotrexate were sometimes, but not always, marked with stickers to identify the patient for counselling. The pharmacist said that he asked 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. A valproate patient information pack was available in the dispensary, as was a poster that listed actions to be taken by the pharmacist when dealing with valproate prescriptions. The pharmacist knew of only one patient prescribed valproate who met the risk criteria, and confirmed that they were counselled and provided with information at each time of dispensing. 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 large number of people. Trays were usually labelled with descriptions of the medicines they contained so that individual medicines could be easily identified. However, some descriptions were missing so there was a risk that patients might not always be able to make informed decisions about their own treatment. Patient information leaflets were routinely supplied. Each patient had a clear plastic wallet that included their personal and medication details and collection or delivery arrangements. Some individual sheets listing medication details were quite untidy. For example, some dosage changes had been altered by obliteration and were difficult to read, which may increase the risk of errors.

There was a steady uptake of the common ailments service and of the emergency supply of prescribed medicines service. The pharmacist was a qualified independent prescriber but said that he did not currently have the time to provide any prescribing services as the pharmacy was too busy. He explained that the pharmacy provided a discharge medicines review service, but local hospitals did not always send electronic copies of discharge letters to the pharmacy through the Choose Pharmacy software platform. So the pharmacy team was often reliant on patients bringing paper copies of their discharge letters to the pharmacy. This meant that uptake of the service was relatively low. The pharmacy currently provided a supervised consumption service to two clients. It also provided a smoking cessation service (supply only), an EHC service and a seasonal influenza vaccination service. The pharmacy provided a prescription collection service from four local surgeries. It also offered a free prescription delivery service. 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 stored appropriately. Medicines requiring cold storage were stored in a large, well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were usually within the required range. Records showed that the maximum temperature had been exceeded on a few occasions, but pharmacy team members had made notes to show that they had managed this appropriately by resetting the thermometer and rechecking temperatures until they were within the required range. CDs were stored appropriately in a well-organised CD cabinet and obsolete CDs were segregated from usable stock. Two dispensed prescriptions awaiting collection in the CD cabinet were no longer valid, as more than 28 days had elapsed from the date marked on the prescription. The pharmacist said that this was an oversight and dealt with the prescriptions appropriately. The pharmacy stored some P medicines in glass cabinets in the retail area, which were marked ‘Please ask for assistance with these medicines’. The cabinets were not locked, but there was always a member of staff at or near the medicines counter who could intervene if a member of the public attempted to self-select a medicine.

There was some evidence to show that regular expiry date checks were carried out, but the frequency and scope of these checks were not currently documented. This created a risk that out-of-date medicines might be overlooked, and some out-of-date medicines were found present in the dispensary. However, these were highlighted with stickers and the pharmacist said that he always included an expiry date check as part of his final accuracy check. Date-expired medicines were disposed of appropriately, as were sharps and patient returns. The pharmacy received drug alerts and recalls via email. The pharmacist described how he would deal with a drug recall by contacting patients where necessary, quarantining affected stock and returning it to the supplier. Drug recalls were filed electronically and marked with the name, registration number and electronic signature of the registrant

responsible for actioning them.

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 and separate measures were used for methadone. Triangles were used to count loose tablets and a separate triangle was available for use with 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. Staff had access to personal protective equipment such as face masks and gloves. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the phamacy 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.