General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Ortongate Centre, Goldhay, PETERBOROUGH, Cambridgeshire, PE2 5TD

Pharmacy reference: 1092889

Type of pharmacy: Community

Date of inspection: 16/02/2023

Pharmacy context

This community pharmacy is based on a retail park on the outskirts of Peterborough. Its team has changed significantly over recent months. Its main activity is dispensing NHS prescriptions, including some instalment prescriptions for substance misuse. It offers a paid-for prescription delivery service, and it supplies medicines in multi-compartment compliance packs to some people who need this support. It offers seasonal flu vaccinations and travel vaccinations when there are suitably trained pharmacists present to provide these. And it also has a needle exchange service.

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 does not manage the risks associated with some of its medicines appropriately. And it does not have effective date-checking processes in place to make sure medicines are of the right quality to supply.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough suitably trained staff to undertake all routine tasks effectively.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	Some medicines are not removed from stock or disposed of at an appropriate time.
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 managing the risks associated with some of its activities effectively, to make sure its services are safe. This includes dealing with patient-returned medicines promptly, having effective date-checking processes and managing uncollected prescription items. It could make better use of the governance tools available to it to identify and manage risks. This includes learning from mistakes. However, the pharmacy's team members understand their roles and responsibilities and they generally keep people's information safe. They also take appropriate action when they have concerns about more vulnerable people.

Inspector's evidence

The pharmacy team had access to written standard operating procedures (SOPs) issued by head office to help deliver services safely and these were reviewed regularly. Team members had read the SOPs relevant to their roles and there was an audit trail to show this had happened.

Prescription labels were initialled at the dispensing and checking stages to create an audit trail showing who had been involved in these tasks. Designated areas of the pharmacy were used for separate tasks such as dispensing and checking prescriptions to reduce the risk of distractions. But these were generally cluttered, and several baskets were stacked on top of each other.

There were record sheets available to write down dispensing mistakes the team members made that were spotted before the medicines were handed out (referred to as near misses). The last records were from November 2022 and the dispenser accepted that more recent mistakes had not been recorded due to staff pressures. The records that had been made contained information about the mistake but did not include any information about why they might have happened or any learnings to prevent similar mistakes happening again.

When asked, the dispenser could explain what the pharmacy should do if a dispensing mistake reached a person (known as a dispensing error). There was a process to record and report these events to head office. And learnings from previous errors had been shared with the team. Some medicines with similar names or similar packaging had been more clearly separated by placing them in designated drawers to prevent picking errors.

Members of the team could explain what they could and couldn't do when a pharmacist was not present. A recently recruited medicine counter assistant (MCA) understood that they should refer requests for advice to more experienced members of staff. And they had a basic understanding of medicines that could be abused and restrictions of their sale. The pharmacy had a complaints procedure and there was a poster displayed in the retail area inviting people to provide feedback about the pharmacy. Delays in dispensing prescriptions and stock availability issues had figured in recent feedback about the pharmacy. And staff reported they had been subject to increasing levels of abuse from some customers.

There were written procedures and staff training about protecting confidentiality. Sensitive information was stored out of the reach and sight of the public and confidential waste was disposed of securely.

There was a data privacy notice poster displayed in the pharmacy. The IT system was password protected. There was some sharing of smartcards to access electronic prescriptions as not all trained staff had their own cards. The team was advised to ensure people obtained and used their own cards.

The pharmacist on duty had completed level 3 training about safeguarding and had some understanding of what to do if they had concerns about the wellbeing of a vulnerable person. There was a chaperone policy for using the consultation room. Other team members had completed company-issued safeguarding training relevant to their roles. The dispenser explained how concerns about a vulnerable person were escalated to their GP and follow-up action had been taken to protect the person.

The pharmacy had current professional liability and public indemnity insurance. Records about controlled drugs (CDs) were kept and generally complied with legal requirements. There were a small number of occasions when the headers had not been completed. CD running balances were kept and checked for accuracy though not as frequently as recommended by the company. This was said to be down to other work pressures and team changes. The stock of three CDs chosen at random agreed with the recorded balance. The pharmacy had a separate register for patient-returned CDs though none had been destroyed for some time. The responsible pharmacist (RP) notice was put up at the start of the visit to show who the RP on duty was. Records about the responsible pharmacist (RP) were kept and the correct RP notice was displayed where members of the public could see it. Private prescriptions were recorded electronically. The records viewed were largely complete though a small number of the entries, largely for dental prescribers, did not have the address of the prescriber. Others had not been set to 'issued' on the system and so were not readily available to view. The dispenser said they would look into this.

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

Summary findings

The pharmacy team is just about managing to keep on top of its dispensing activities. But it is struggling to keep on top of other routine tasks effectively. There is some ongoing recruitment activity to try to address this. The pharmacy's team members work well together and are enrolled on the right training for their roles. However, they do not get time at work to complete training and this may make it harder from team members to keep their skills and knowledge up to date.

Inspector's evidence

There had been a lot of change in the team over recent months with quite a few experienced team members having left and replaced with trainee staff. The team members said they had not had any recent visits from the area manager. The current pharmacy team consisted of two trained dispensers, three trainee MCAs and a delivery driver. There was a dispenser working on the day of the inspection who was based at another branch but was providing extra cover at this pharmacy. The pharmacy had a vacancy for another dispenser but was struggling to fill this with permanent or locum staff. The pharmacy did not have any employed pharmacists in post but did have a few regular locum pharmacists who provided responsible pharmacist cover. The pharmacy had had some difficulty in finding pharmacist cover at times and had needed to close on occasions because of this. Staff said this had been less of a problem more recently.

The team members were doing their best to cope with the workload during the inspection and they worked closely together. They said they had managed to catch up with routine dispensing. But admitted that they didn't have time to complete other routine tasks as they would like. These included date checking, cleaning, and other governance routines covered by the company's 'Safer Care' process. They had not been able to have any 'Safer Care' team meetings recently.

The new members of staff had been enrolled on accredited training courses relevant to their roles. To help keep their skills and knowledge up to date, team members had access to training modules via the company's training portal. They were prompted about any new or mandatory and there was a company process to check this was done. But team members said they didn't get any time at work to do ongoing training and were completing this in their own time. The most recent training module had been on Code of Conduct Retail 2023.

Team members described how information was shared amongst the team and how they had made improvements to handovers by using a whiteboard in the dispensary. This meant that important tasks connected with the supply of multicompartment compliance packs were not overlooked.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are adequate for the safe provision of pharmacy services. They are kept secure when the pharmacy is closed. And people can have a conversation with members of the pharmacy team in a private area and won't be overheard. The retail area is generally well presented. But the pharmacy could do more to make sure the dispensary and sink where medicines are prepared are kept clean and tidy.

Inspector's evidence

Overall, the premises were large enough for the activities currently undertaken. It had just about enough bench space to help with safe dispensing routines though parts of this were cluttered with part-dispensed prescriptions and items waiting a final check. The premises were mostly kept clear of slip or trip hazards. Staff explained they had to do all the cleaning themselves which was a struggle at times. The dispensary sink was badly stained. And some lower shelves were very dusty.

Room temperatures in the premises were controllable, and levels of ventilation and lighting were appropriate for the activities undertaken. The pharmacy had a consultation room just off the retail area which was reasonably large and well kept. People could have a private conversation about their healthcare and receive services such as flu vaccinations in this room. There was also a screened part of the counter used for needle exchange and supervised administration which offered people a greater degree of privacy than the main counter. These areas were kept tidy and there was a range of health promotion literature available to people waiting for services. The pharmacy team members had access to rest areas and hygiene facilities.

The premises could be secured outside of opening hours and were accessible to people with mobility issues or those with prams or wheelchairs. The dispensary was clearly separated from the shop area and access by the public was suitably restricted. Pharmacy-only medicines were kept behind medicines counter or in Perspex display units so their sales could be supervised appropriately. Dispensed medicines were kept away from public view to protect people's private information.

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

Summary findings

The pharmacy team is struggling to carry out date checks of medicines regularly and some medicines are not removed or disposed of at an appropriate time. This increases the chance that people could receive medicines that are not of the right quality. The pharmacy team is aware of the need for extra care when supplying certain medicines which may be higher risk. But prescriptions for these medicines are not always highlighted. So, it may be harder for team members to give people all the information they need to take their medicine safely.

Inspector's evidence

The pharmacy's opening hours were displayed at the entrance. The entrance door to the pharmacy was power assisted and level with the pavement and the aisles were wide enough to accommodate people with prams or wheelchairs. There was an induction hearing loop available.

The pharmacy had had to close on occasions due to the lack of pharmacist cover. To reduce the risks to people receiving daily instalment supplies of certain medicines, there were arrangements to transfer people to other local pharmacies to access this service. The availability of some other services including flu vaccinations was sometimes limited as not all pharmacists had completed the necessary training to provide all the services offered. There were, however, suitable sundries available and in-date adrenaline in the event of an anaphylactic reaction to a vaccination.

The pharmacy team members were about up to date with dispensing activities. They were doing extra hours to achieve this. Dispensing being carried out during the visit was done in an orderly way. All dispensed items were accuracy-checked by the responsible pharmacist. Baskets were used to keep prescriptions for different people separate. The baskets were colour coded to prioritise the workload. But there were several baskets stacked up across the dispensary benches which limited the amount of free space for dispensing. Instalment supplies were made up when the person attended to collect their medicines. There was a record kept of prescriptions that had been delivered to people, and this included the signatures of recipients for some items.

The team members had a basic understanding that prescriptions for valproate needed additional care when supplying to people who might become pregnant. The stock packs available had the warning cards and alert stickers attached. The pharmacy also had spare cards and alert stickers to use if a smaller quantity needed to be supplied in a plain box. The pharmacist explained how they would check that people were using adequate contraception. Other alert stickers to help identify prescriptions for higher-risk medicines where patient counselling was needed were available. However, these were not always used in practice. So, the pharmacy could be missing opportunities to give people important information about their medicines.

When asked, most of the team members knew how long prescriptions for CDs were valid for. Stickers were attached to some in the prescription retrieval system to help staff identify those which were beyond the valid date. But some had not. This increased the chances of medicines being supplied when the prescription was no longer valid. And the team had not been able to go through the retrieval system to return uncollected items to stock in the usual way.

The dispenser could confidently explain the process for preparing multi-compliance packs. There was a rota to prepare these on time. And each person had a record about their medicines which was updated if there were any changes made. The packs viewed included dose and warning information. And descriptions of the medicines included in the packs so people could identify individual items. The pharmacy also supplied patient information leaflets with these packs every four weeks. The dispenser could describe the types of medicines that were not suitable for inclusion in these packs.

Medicines were obtained from licensed wholesalers and specials were obtained from specials manufacturers. Team members described difficulties obtaining some medicines, particularly antibiotics to treat possible Strep A infections. Though stock shortages had started to lessen more recently. Medicines were stored in dispensary drawers and on shelves in the dispensary. Some shelves were rather cluttered, and in some places different strengths of medicines were not clearly separated. Medicines for dispensing were kept in appropriately labelled containers. CDs were stored securely. When two dispensary drawers were checked at random, six different medicines were found to be beyond their use by date. They had not been highlighted to alert staff when dispensing. A member of the team admitted they were struggling to keep on top of certain routine tasks and date checking was one of these tasks. Where detected, out-of-date medicines and patient-returned medicines were moved into designated bins and collected by specialist waste contractors for appropriate disposal. The medicines fridge temperatures were monitored and were kept within the required range for medicines requiring refrigeration. No extemporaneous dispensing was carried out.

The pharmacy had a process to receive and act on drug recalls and safety alerts. It was notified of these by its head office and there was a system in place to make sure these were responded to promptly.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it stores its equipment securely.

Inspector's evidence

The pharmacy had measuring equipment of a suitable standard. Some of the glass measures were reserved for measuring specific types of medicines to prevent cross-contamination. There was evidence of medicine residue in the bottom of a few of these; staff said they were washed thoroughly at the end of each day. The pharmacy had access to online reference sources to assist with clinical checks and other services. It also had the right equipment to assist the safe disposal of medicines and sharps waste and kept these out of reach of the public.

All portable electrical equipment appeared to be in good working order as did the blood pressure meter. The pharmacy had cordless phones so team members could make phone calls out of earshot of waiting customers if needed. The pharmacy's patient medication records and computer screens in the pharmacy could not be viewed from the shop floor.

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.