General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 15 William Street, REDDITCH, Worcestershire, B97 4AJ

Pharmacy reference: 1092950

Type of pharmacy: Community

Date of inspection: 24/06/2019

Pharmacy context

This is a community pharmacy located close to a few GP surgeries in the centre of Redditch in Worcestershire. The pharmacy dispenses NHS and private prescriptions. It provides some services such as Medicines Use Reviews (MURs), the New Medicine Service (NMS), flu vaccinations during the season, Emergency Hormonal Contraception (EHC) and needle exchange. The pharmacy supplies medicines inside multi-compartment compliance aids for some people, if they find it difficult to take their medicines on time. These are prepared from a separate part of the company's premises. And, it supplies medicines to seven residential care homes for their residents.

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 is managing most risks associated with its services. Pharmacy team members deal with their mistakes responsibly. But, they are not always formally reviewing them. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. Team members understand how they can protect the welfare of vulnerable people. But, the pharmacy doesn't always keep its records in accordance with the law. This means that the team may not have all the information needed if problems or queries arise.

Inspector's evidence

The pharmacy's walk-in trade was steady and manageable. Its dispensary was somewhat cluttered in some areas but there was enough workspace to dispense medicines safely (see Principle 3).

Staff described processing prescriptions and carried out three-way checks by using the prescription, medicines and generated labels to ensure accuracy. Some team members ticked details when these checks occurred, the responsible pharmacist (RP) conducted the final check for accuracy in a segregated section on the main workbench and staff recorded their own near misses. They described their mistakes being passed back for them to identify and near misses were reviewed every month.

The company's Safer Care processes were being managed by the team. Medicines that were similar or involved in errors were segregated and highlighted. This included separating olanzapine and quetiapine, look alike and sound alike medicines (LASA) were identified and the Safer Care Board was updated from May 2019. However, there was no information seen recorded about the review of near misses and medicines inside drawers were stored in a haphazard way (see principle 4).

Incidents were handled by pharmacists and documented details of previous incidents were seen. This included the root cause analysis and reflective statements that were completed by staff.

To protect people's confidential information, the team was trained on data protection, this included information on the General Data Protection Regulation (GDPR). Staff separated confidential waste into designated bins before it was disposed of through the company's procedures. Sensitive details on bagged prescriptions awaiting collection could not be seen from the front counter. There was also an information governance policy present that staff had read and signed. However, another member of staff's NHS Smart card was left in the computer slot when they were not present at the pharmacy.

Staff were trained to safeguard vulnerable people, they could identify signs of concern and referred to the RP in the first instance. Staff recalled seeing relevant local contact details, but these were not seen. The team was trained through reading relevant company information and the pharmacist was trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE).

The pharmacy held a range of documented standard operating procedures (SOPs) to support the safe provision of services. Staff declarations were complete. Roles and responsibilities of team members were defined within the SOPs, staff referred appropriately to the RP and they knew which activities were permissible by law, in the absence of the RP. The correct RP notice was on display and this provided details of the pharmacist in charge of operational activities.

The RP record was maintained in full. In general, records for emergency supplies and a sample of registers seen for controlled drugs (CDs) were maintained in line with requirements. Balances for CDs were checked and recorded every week. On selecting a random selection of CDs held, their quantities corresponded to the balance stated in the registers. Occasionally, records for emergency supplies were made using generated labels but these had not faded or become detached. The pharmacy held records of destruction for CDs brought back by people for destruction but there were occasional missing details seen.

Prescriber details were missing from most records of unlicensed medicines, there were dates missing from recent records of private prescriptions and details about some private prescriptions were not being routinely entered into the register. There were also some gaps seen where fridge temperature records had not been routinely checked.

Professional indemnity insurance arrangements for the services provided was through the National Pharmacy Association (NPA) and due for renewal after 30 June 2019.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy provides services using a team with a range of skills and experience. But, the pharmacy's current staffing levels means that they sometimes struggle to manage the workload. And the pharmacy has no contingency plan to cope with staff absence. This could make it more difficult to manage the workload safely. Pharmacy team members in general, understand their roles and responsibilities. And, they are provided with resources to keep their skills and knowledge up to date.

Inspector's evidence

The pharmacy dispensed approximately 13,000 to 14,000 prescription items every month and supplied around five to six people with instalment prescriptions. 128 people were supplied with multi-compartment compliance aids, but they were prepared from another of the company's branches upstairs and supplied from this pharmacy. Medicines were also supplied to around 400 residents within seven care homes.

Staff at the inspection consisted of a recently employed regular pharmacist, a trained full-time dispensing assistant, a part-time dispensing assistant (30 hours), medicines counter assistant (MCA) who worked 23 hours, three dual trained MCA and dispensing assistants, two of whom were full-time, and one was part-time (28 hours). Other staff included a full-time manager technician and three evening members of staff who worked 10 to 15 hours each, two of them were trained dispensing assistants and one was enrolled onto accredited training. However, the latter was described as moving to another one of the pharmacies situated in the building.

The pharmacy was previously dispensing 10,000 prescription items each month last year. According to staff, they were now busier with less staff as their budget for staffing hours had been reduced. The pharmacy had also experienced some upheaval with three different managers leaving employment in the last three years. Before the regular pharmacist, the team was managing without a manager and with locum pharmacists for the past six months.

Staff were somewhat struggling to manage the workload at times. They explained that a pharmacy technician and a trained dispensing assistant who worked 39 hours and 32 hours each week respectively had left and their hours had not been replaced. There was only one member of staff present from 5pm until 10.30pm working alongside the RP who also covered the counter during this period. Staff explained that the pharmacy was busy until 7pm or 8pm and this meant that the RP was self-checking during this period. This was also the case on Sundays.

Staff described only 40% of their annual leave could be covered and there was no contingency cover for sickness. The inspector was told that other than one member of staff who processed and assembled prescriptions for the care homes, no other members of staff fully understood or knew the process to manage this section. This meant that there was no-one available to cover the member of staff responsible for assembling medicines for care homes as contingency for planned or unplanned leave. This member of staff described struggling at times, there could be 80 to 90 interim medicines that required processing and dispensing on the same day and she was responsible for completing these alone.

The team's certificates of qualifications obtained were seen and staff wore name badges. Staff asked a range of questions to determine suitability before selling medicines over the counter and they held a suitable amount of knowledge of these medicines. People requesting excessive amounts of medicines that were prone to abuse were refused sales and the RP was informed. To assist with training needs, staff completed online modules every month to help keep their knowledge current, they described being up to date with this. The team's progress was checked a few times in a year, staff discussed details verbally and were part of a WhatsApp group to help communicate with one another and receive updates.

Principle 3 - Premises ✔ Standards met

Summary findings

In general, the pharmacy's premises are suitable to ensure the effective delivery of its services. But, some parts of it are not clean and untidy. This increases the risk of mistakes happening.

Inspector's evidence

The premises consisted of a spacious retail area and a large dispensary. In general, the former was well presented, professional in appearance and bright. The latter consisted of sectioned areas to manage multi-compartment compliance aids, a segregated unit from where dispensing for the care homes occurred and the front section of the dispensary where walk-in and repeat prescriptions were managed.

There was enough work space for dispensing activity to occur safely, but parts of the pharmacy were cluttered. The floor in the dispensary required a deep clean as it was dirty and the seat in the ‘better life’ area in the retail section was also dirty and stained. Most of the dispensed prescriptions awaiting collection were stored appropriately but there was an overspill with some stored on the floor, but in baskets.

Pharmacy (P) medicines were held within unlocked perspex units that were marked to ask staff for their assistance. Team members stated that people did not normally try to help themselves. There were two signposted consultation rooms, located to one side of the front counter where confidential conversations and services could take place. The rooms were signposted and of a suitable size for the services provided. Both were unlocked at the point of inspection and one contained prescriptions in baskets. As soon as this was highlighted, the RP removed the information and they were instructed to ensure no confidential information was accessible going forward.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from reputable suppliers. But, it doesn't always store them in a suitable way. This increases the chance of mistakes happening. The team makes some checks to ensure that medicines are not supplied beyond their expiry date. But, the pharmacy has no up-to-date written details to confirm this. In general, the pharmacy's services are delivered in a suitable manner. But they don't always record information for people that receive higher-risk medicines. This makes it difficult for them to show that appropriate advice has been provided when these medicines are supplied.

Inspector's evidence

People could enter the pharmacy at street level from a wide double door, there was clear open space and wide aisles inside the pharmacy and this enabled easy access for people with wheelchairs. There were seats available for people waiting for prescriptions.

Multi-compartment compliance aids:
Staff explained that the person's GP initially set up the compliance aids for people and assessed their suitability for this. Prescriptions were ordered by the pharmacy and cross-checked against people's individual records. If changes were identified, staff confirmed them with the prescriber and documented details on records. The records were then scanned to the hub which was in the upstairs portion of the building, once dispensed, they were sent downstairs, booked in by the pharmacy and people either collected the compliance aids or they were delivered. Mid-cycle changes involved retrieving the old compliance aids and supplying people with new ones.

Delivery service:
The pharmacy provided a delivery service and audit trails to show where deliveries occurred were maintained. CDs and fridge items were highlighted and checked prior to delivery. The driver obtained people's signatures when they were in receipt of their medicines using a handheld device. Failed deliveries were brought back to the branch, notes were left to inform people about the attempt made and medicines were not left unattended.

Care homes:
Apart from two of the care homes, the rest ordered their own prescriptions, the pharmacy received a duplicate copy of the medication administration record (MAR) detailing the requests and prescriptions were cross-checked against this to ensure all items had been received. A missing items form was faxed to the care home if medicines were outstanding. Interim or mid-cycle items were dispensed at the pharmacy. The team obtained information about allergies and sensitivities, this information was recorded onto the MAR charts. Patient information leaflets (PILs) were routinely supplied and higher-risk medicines were provided separately.

The pharmacy did not routinely obtain or ask about relevant parameters for residents that were prescribed any of these medicines. This included information about blood test results, such as the International Normalised Ratio (INR) for people prescribed warfarin. Staff had been approached to provide advice regarding covert administration of medicines to care home residents. Documented details were maintained, a three-way conversation and agreement were required between the pharmacy, care home or representatives and the person's GP. Pharmacists used relevant guidelines and

resources to assess suitability here.

During the dispensing process, the team used baskets to keep prescriptions and items separate, these were colour co-ordinated to help highlight priority. Staff used a dispensing audit trail from a facility on generated labels and this helped to identify their involvement in the different processes. A stamp was used to identify when a clinical check had occurred when the accuracy checking technician was working in the pharmacy.

Staff were aware of the risks associated with valproate, they described ordering relevant literature to be able to provide to people upon supply of this medicine and according to the team, no patients at risk were identified, that may have previously been supplied this. Prescriptions for higher-risk medicines were highlighted using stickers, relevant parameters were checked according to staff, but details were not documented. This included checking the International Normalised Ratio (INR) level for people prescribed warfarin.

Dispensed prescriptions awaiting collection were stored with prescriptions attached. Prescriptions requiring counselling or pharmacist intervention, fridge and CD items (schedules 2 and 3) were highlighted with stickers. Clear bags were used to store CDs and fridge items, and this helped assist in identifying their contents upon hand-out. A cyclical calendar system was in place for uncollected items, these were identified and removed every four to six weeks according to staff. However, schedule 4 CDs were not routinely identified and a date-expired prescription for diazepam (dated 17 May 2019) was still present in the retrieval system.

Licensed wholesalers such as AAH and Alliance Healthcare were used to obtain medicines, medical devices and unlicensed medicines. Unlicensed medicines were obtained from the former. Staff were aware of the EU Falsified Medicines Directive (FMD), they described reading information about this, there was equipment present to comply with the process, but this was not yet functioning at the point of inspection.

Staff stated that they date-checked stock for expiry every month and used stickers to help identify short-dated medicines. There were no date-expired or mixed batches of medicines seen. CDs were stored under safe custody, the keys to the cabinet were maintained in a manner that prevented unauthorised access during the day as well as overnight and medicines were stored appropriately in the fridge. Staff received drug alerts by email, they checked stock, and acted as necessary. A full audit trail was available to demonstrate the process. The alerts were also passed to the care homes to check for affected stock.

However, details from the date-checking schedule indicated that staff had last carried out this process in March 2019. Stock in the care home section was not routinely date-checked, the inspector was told that this process occurred when possible because there was only one member of staff here to manage this section. There was no schedule used to demonstrate that the process had occurred here, and some uncapped bottles were seen.

In addition, medicines were not routinely stored in an organised manner. Every drawer that was checked had stock thrown into it or mixed in amongst other stock in a haphazard way. Several medicines were seen stored in this way for example, zopiclone was in with zolmitriptan, trimethoprim and alogliptin were in with trihexylphenidate, Rifadin was mixed in with tamoxifen and risperidone, spironolactone was in with sitagliptin, Losec was in with omeprazole and pioglitazone, Januvia was in with quetiapine, different strengths of pregabalin were jumbled up inside the drawer along with risperidone, instead of being neatly segregated, mesalazine was in with naproxen and Lamictal was in

with glimepiride.

Medicines brought back for disposal were accepted, held in appropriate containers and collected in line with the pharmacy's contractual arrangements. Before collection, the pharmacy was storing them in a lift in the back section, according to staff this was not used. People bringing back sharps for disposal were accepted provided they were in sealed bins. Returned CDs were brought to the attention of the RP and details were documented in a CD returns register prior to storage and destruction.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

There was a range of equipment available for staff to use when providing services. This included current versions of reference sources, crown stamped, conical measures for liquid medicines including designated ones for water and CDs as well as counting triangles. The latter included a separate triangle for cytotoxic medicines. The dispensary sink used to reconstitute medicines was clean and there was hot and cold running water available. There were lockers available for the team to store their personal belongings.

The pharmacy fridges in general were maintained at appropriate temperatures for the storage of medicines and the CD cabinets were secured in line with legal requirements. Computer terminals were positioned in a manner that prevented unauthorised access and staff could use cordless phones to maintain private conversations away from the retail space.

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.