General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 52 Earl Street, WARRINGTON, Cheshire, WA2 7PW

Pharmacy reference: 1094701

Type of pharmacy: Community

Date of inspection: 19/06/2019

Pharmacy context

This is a community pharmacy in Warrington, Cheshire. The pharmacy mainly sells over-the-counter medicines and dispenses NHS and private prescriptions. It also provides a range of services such as blood pressure monitoring, diabetes testing and seasonal flu vaccinations. And it supplies medicines in multi-compartmental compliance packs to people in their own homes.

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's team members are good at recording any errors that happen with dispensing. And they analyse the errors regularly and discuss their learning together. And they use this information to make changes to their working environment to help prevent similar mistakes happening again. And they complete regular weekly checks to confirm they are following pharmacy procedures. And they discuss this monthly in a team meeting.
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 processes and procedures to help the team manage the risks to services. The pharmacy keeps the records it must by law. It advertises how people can provide feedback and raise concerns. The pharmacy keeps people's private information safe. It has processes available to its team members, to help protect the welfare of vulnerable people. The pharmacy is good at recording and analysing any near miss errors made when dispensing. And its team members can demonstrate how they have made changes to their working environment to help them reduce near miss errors.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. They were stored in a folder with an index at the front. Which made it easy to find a specific SOP. The SOPs were due for their next review in August 2019. All the team members had a list of the SOPs relevant to their role and they had read these SOPs. The team members said they would ask the pharmacist if there was a task they were unsure about or felt unable to deal with.

The pharmacy had implemented the company's Safer Care requirements to help improve patient safety. This involved the team completing rotating weekly checks over three weeks and it included checks on the pharmacy environment and staffing. A Safer Care briefing was completed on the fourth week. The briefing focused on any issues found. The Safer Care checks were seen to be completed weekly.

A process was in place to report and record near miss errors that were made while dispensing. The pharmacist typically spotted the error and then made the team member aware of it. And then asked them to rectify it. The team member who made the error then recorded the details of the error on a log. The details recorded included the time, date and cause of the error. The regular pharmacist analysed the near misses each month. And the findings were documented and discussed with the team during a monthly team meeting. The team demonstrated various actions taken to help reduce errors. These included the separation of medicines that looked and sounded similar and creating a new 'fast line' area in the dispensary. This area held the top 150 medicines that the pharmacy dispensed. The team said that they were able to find these medicines more easily and this reduced the number of errors made. The pharmacy had a process in place to record, report and analyse dispensing errors that had been given out to people. It recorded the details of the errors on to an electronic reporting form called PIMS and the form was sent to the superintendent pharmacist's team to be analysed. The form was printed and filed for future reference. The details recorded included the reason why the error had happened and what the team had done to prevent similar errors happening in the future.

The pharmacy outlined the details of how people who used the pharmacy could make a complaint. The details were outlined in a leaflet that people could self-select. But the leaflet was stored in the consultation room. And so, was not easily accessible. The pharmacy obtained feedback from people who used the pharmacy, through a community pharmacy questionnaire. The team said the feedback they received was generally positive. The pharmacy displayed the results of the latest survey on a wall in the retail area. So, they were easy for people to see. The team were unable to give any examples of how they had used feedback to make improvements to services.

The pharmacy had up to date professional indemnity insurance.

The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. The responsible pharmacist register was correctly completed each day. A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries were being made in chronological order. Running balances were maintained and audited every month. A random CD item was balance checked and verified with the running balance in the register (morphine ampoules 10mg/ml x 20). The pharmacy recorded the destruction of patient returned CDs. The pharmacy kept complete records of private prescription supplies and supplies of unlicensed medicines. The pharmacy kept complete records of medicines that were supplied to people in an emergency.

A privacy policy was on display in the retail area. It outlined how the pharmacy protected people's private information. The pharmacy had an information governance (IG) policy in place. It contained information on how the team should protect people’s information and data. The team were clear of the importance of protecting the confidentiality of the people they provided services to. The pharmacy stored confidential waste in separate containers. The waste was collected by a third-party contractor who arranged its destruction.

The pharmacist on duty and two pharmacy assistants had completed training on safeguarding the welfare of vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). Other team members had completed a company training course. The team members gave several examples of symptoms that would raise their concerns. The team had access to safeguarding incident guidance documents to help them report a concern. The team explained that they would always bring any potential concerns to the attention of the on-duty pharmacist. The team said that they had not had any concerns to deal with to date.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the right skills and qualifications to undertake the tasks within their roles. The pharmacy supports its team members to complete training. And this helps them improve their knowledge and skills. They tailor their training to their own needs. And they get time in the working day to complete their training each month. The team members work openly and honestly, and regularly discuss how to improve patient safety. The pharmacy encourages the team members to feedback their ideas to improve services.

Inspector's evidence

At the time of the inspection, the team members present were a relief pharmacist who worked at the pharmacy every Wednesday, two NVQ2 qualified pharmacy assistants and a trainee pharmacy assistant. Other team members who were not present included the resident pharmacist and a trainee counter assistant. The team members often worked overtime to cover both planned and unplanned absences. They were not permitted to take time off in December, as this was the pharmacy's busiest period. The pharmacy had three live vacancies for dispensary team members. This was in response to several more experienced team members, leaving the pharmacy in the last two to three weeks. The team members said that they were looking forward to the vacancies being filled as has felt under some pressure to cope with the workload.

The pharmacist supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team was aware of what could and could not happen in the pharmacists' absence.

The pharmacy had a structured process to help its team members to engage in ongoing learning. The team had access to an online learning platform that consisted of modules the team worked through. The modules were often mandatory and were based on various topics or new SOPs. Other modules could be completed voluntarily and were could be done when team members wanted to learn about a certain healthcare topic. The team members were normally given protected time to complete their training. The team members could tailor their learning to their own needs. A pharmacy assistant said that had recently asked for more managerial responsibility. And had successfully trained to become a supervisor.

The team members were scheduled to have a team meeting every month. The meetings were for the team to discuss, errors, company news, concerns and to give feedback on how they can improve the services. The team said that they had recently discussed a company newsletter which focused on the medicine, enoxaparin.

The pharmacy had a structured performance appraisal process in place. The appraisals were a one-to-one conversation between a team member and the pharmacist. The appraisals were an opportunity for the team member to discuss what they enjoyed about their job and what they wanted to achieve in the future. They were set goals to achieve by the time the next appraisal took place.

The team members confirmed that they were able to discuss any professional concerns with the pharmacist. And they were aware of how they could raise concerns externally if they required. A whistleblowing policy was in place. So, team members could raise a concern anonymously. The pharmacy set the team some targets to achieve. These included NHS prescription items and MUR consultations. The team said that the targets were achievable and they were not under pressure to meet them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy dispensary and retail area appeared clean, hygienic and well maintained. The floor spaces were clear and there were no obvious trip hazards. There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a WC and a sink with hot and cold running water and other facilities for hand washing. The pharmacy had a sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. The lighting was bright, and the temperature was comfortable throughout inspection. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people and it provides services to support people's health needs. The pharmacy has robust procedures that the team members follow when they dispense medicines into multi-compartmental compliance packs. They provide information with these packs to help people know when to take their medicines and to identify what they look like. The pharmacy sources its medicines from licenced suppliers. And it generally stores and manages it medicines appropriately.

Inspector's evidence

The pharmacy had level access from the street. The pharmacy advertised the services it offered via displays in the main window. It provided seating for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer.

The team members attached stickers to the prescriptions during the dispensing process to alert the pharmacist during checking of any issues, interactions or new medicines. And this also alerted team members during the hand out process, for example to the presence of a controlled drug or fridge line. The pharmacy had an audit trail for dispensed medication. The team achieved this by using dispensed by and checked by signatures on dispensing labels. The team members used separate areas to undertake the dispensing and checking parts of the dispensing process. They used baskets to keep prescriptions and medicines together. This helped prevent people’s prescriptions from getting mixed up.

The pharmacy supplied some people with medicines that had been dispensed at another pharmacy, an offsite location called a hub. These people were told their prescriptions were being dispensed elsewhere. The team members were responsible for ordering the person's prescription. And the pharmacist checked the prescription was clinically suitable. The team entered the details of the prescription on to the computer system and the accuracy was checked by the pharmacist. The details were then sent electronically to the hub. The dispensed and checked medicines were then delivered to the pharmacy in clear, sealed plastic bags. The team members said that they always visually checked that the medicines in the bag were correct before they supplied the medicines to people.

The team identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling by the pharmacist, if the pharmacist felt there was a need to do so. But details of these conversations were not recorded on people’s medication records. So, the pharmacy could not demonstrate how often these checks took place. The pharmacy did not always assess the INR level. The team knew about the pregnancy prevention programme for people who were prescribed valproate. The team said that they knew about the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had access to information cards about the programme that they could provide to people. The team had completed an audit to identify people they regularly supplied valproate to. But they were not sure of the findings.

People could request for their medicines to be dispensed in multi-compartmental compliance packs. The team dispensed the packs in a separate area at the back of the dispensary. They said that this was

to prevent them from having to break off from dispensing to serve people who were waiting in the retail area. The team were responsible for ordering the person's prescription. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team queried any discrepancies with the person's prescriber. The team recorded details of any changes, such as dosage increases and decreases. The team supplied the packs with backing sheets which contained dispensing labels and information which would help people visually identify the medicines. But they were not always clear. For example, a backing sheet was seen that described three separate medicines as 'white round tablet'. And so, people would struggle to differentiate between them. The team supplied patient information leaflets to people each month as required by law.

The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. The pharmacy supplied people with a note when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy gave people owing slips when it could not supply the full quantity prescribed. One slip was given to the person and one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day.

The pharmacy stored pharmacy (P) medicines in glass cabinets next to the retail counter. These medicines were not for self-selection and could only be sold in a pharmacy, and under the supervision of a pharmacist. The cabinets were not locked. There was a notice on the front of the cabinet which read 'please ask for assistance'.

The team checked the expiry dates of stock every three months and the team kept a record of the activity. But records were not complete. Some medicines had not been date checked since January 2019. No out of date medicines were found after a random check. The team used alert stickers to highlight any stock that was expiring in the next 6 months. The date of opening was not always recorded on liquid medication that had a short-shelf life once opened. And so, the pharmacy could not be certain that these medicines were fit for purpose. The team were not currently scanning products as required under the Falsified Medicines Directive (FMD). The pharmacy did not have any software installed to assist the team to comply with the directive. The team members had received training on how to follow the directive.

The team had not been recording the fridge temperatures during June 2019. This was because the fridge had developed a fault. A new fridge had been installed the day before the inspection. There was no evidence that the team had taken any steps to make sure that the medicines stored in the fridge were fit for purpose, while the fault was present. This was discussed during the inspection.

The pharmacy obtained medicines from several reputable sources. It received drug alerts via email and the team actioned them. The pharmacy kept records of the action taken after the alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The equipment and facilities the pharmacy uses in the delivery of services are clean, safe and protect people’s confidentiality.

Inspector's evidence

The pharmacy had several reference sources available. And the team had access to the internet as an additional resource. The resources included a hard copy of the British National Formulary (BNF) and the children’s BNF. The pharmacy used a range of CE quality marked measuring cylinders. And ones that were only used for dispensing methadone. The medical fridges were of an appropriate size. The medicines inside were well organised.

The equipment used to check people’s blood sugar and cholesterol was calibrated at least every four weeks.

The computers were password protected and access to people's records were restricted by the NHS smart card system. And computer screens were adequately positioned to ensure confidential information wasn’t on view to the public. The pharmacy stored prescriptions awaiting collection out of the view of people in the shop.

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.