General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 31 High Street, Soham, ELY, Cambridgeshire, CB7 5HA

Pharmacy reference: 1095182

Type of pharmacy: Community

Date of inspection: 13/06/2019

Pharmacy context

This community pharmacy is on the main street in Soham alongside various retail and food outlets. The pharmacy's main activities are dispensing NHS prescriptions and dispensing prescriptions for a prison. It also offers a prescription delivery service, Medicines Use Reviews (MURs), New Medicine Service (NMS) checks, seasonal flu vaccinations, travel vaccinations and malaria prophylaxis, emergency hormonal contraception, and health checks including blood pressure and blood glucose checks. It supplies some medicines in multi-compartment compliance packs to people who need this help taking their medicines. There is a needle exchange service and the pharmacy provides supervised consumption for substance misuse treatment.

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 generally manages risks well. It makes changes when things go wrong, to improve its services. It 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.

Inspector's evidence

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 SOPs also included details about the roles and responsibilities of staff. This meant the pharmacy could clearly identify who had completed these tasks. There were in-house checks to make sure the pharmacy was following procedures correctly. In accordance with the SOPs, prescription labels, including those on compliance packs, were initialled at the dispensing and checking stages.

The pharmacy team used other ways to reduce risks in the dispensing process. Separate areas of the dispensary were used for specific tasks. There were alert stickers for higher-risk medicines, fridge lines, and controlled drugs (CDs). These were supposed to be applied to prescription medicines waiting to be collected so the staff knew that additional care and advice was needed when handing these medicines to people. Prescriptions in the retrieval system were checked and the alert stickers were generally used correctly. However, one prescription for diazepam was found which did not carry an alert sticker. The medicine counter assistant did not know that this prescription was only valid for 28 days.

The team members said that the pharmacist pointed out any dispensing mistakes they had made, and which were picked up during the final check of prescriptions. Near misses were recorded and the records seen included a good level of detail about why or how the mistakes had been made. Errors which reached patients were also recorded and these were reported to head office. Evidence of previous reports was seen. The pharmacist explained how errors had to be reviewed and that any action points were recorded as part of that review. Learning points from all dispensing incidents were included in the regular safety reviews (known as Safer Care) and were shared with the team. These briefings also included learning points from incidents that had occurred elsewhere in the company. Some medicines with similar sounding names or in similar packaging had been more clearly separated on shelves to prevent selection errors. There was information provided to the team about these medicines. Cholecalciferol products of different strengths had also been more clearly separated because of previous mistakes.

The roles and responsibilities of the team members were clear. Staff wore uniforms and name badges and so could be readily identified by people visiting the pharmacy. When asked, the staff could explain what they could and couldn't do in the absence of a responsible pharmacist (RP). 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 on display. 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. The pharmacy had responded to previous feedback about stock availability by carrying out daily stock checks to improve its stock holding. The RP could explain how he would deal with a complaint, including how formal complaints were reported to head office. Following previous complaints, the pharmacy team tried to use the consultation room more to have private conversations with people, particularly about more sensitive matters.

There were appropriate insurance arrangements in place for the services provided. The RP notice correctly showed who the pharmacist in charge was and it was displayed clearly. The RP record and records about CDs were complete and running balances were checked regularly. CDs returned by people for safe destruction were recorded in a designated register. Private prescription records were made in a book and 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 about protecting people's information and there were written procedures about information governance. There was no confidential material left on display. And there was information for the public about how their data was processed by the pharmacy. Patient medication records were password protected and staff used their own NHS smartcards to access electronic prescriptions.

There were procedures in place to help make sure the pharmacy took appropriate action to protect vulnerable people. The pharmacy had a chaperone policy for use of the consultation room. Staff had read procedures about safeguarding. The pharmacist 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 ✔ Standards met

Summary findings

The pharmacy's team members are suitably trained or undertaking the right training for the roles they undertake. They are supported in ongoing learning and development and they have some set-aside time at work to training. The team can share ideas to improve how the pharmacy works. The pharmacist can take decisions and make suitable changes so that services are provided safely.

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 trained full-time dispenser and a full-time trainee counter assistant who was the pharmacy's supervisor. A further trained dispenser was due back at work the following week. And there was a trainee medicine counter assistant who worked at weekends. The team was coping with the workload but there was little capacity to manage any additional leave or increase in workload. Team members generally tried to cover for each other's holidays. There was said to be some support possible from other branches if the team couldn't cope. The pharmacy was also going through a validation process to enable some of the dispensing work to be transferred off-site, reducing some of the pressure on the local team. The team members were observed working closely together, referring queries to the pharmacist where needed.

The staff had records of training they had completed. And certificates for the required accredited training they had completed were displayed. They were provided with a variety of eLearning 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 some time at work to do training modules, especially for mandatory training. Recent training topics had included valproate.

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. 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 members 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 RP said that he felt able to exercise his professional judgement when delivering services, putting the needs of the patients first. He explained how he had requested a change to the delivery driver's schedule to reduce pressure on the pharmacy team and give more time to safely dispense prescriptions for delivery. There were targets set for services, but these did not adversely affect the safe running of the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are generally suitable for the services the pharmacy provides. Some dispensing areas are quite cramped, so additional care is needed to minimise the chance of mistakes happening.

Inspector's evidence

The retail area of the pharmacy was spacious and reasonably well-maintained. The aisles and floors were kept clear of slip and trip hazards. Entry to the pharmacy was at street level. The entry door had an automatic opening function, but this was not working at the time of the inspection. The fault had been reported to head office.

The main dispensary was very open though unauthorised access could be restricted. There was very limited dispensing bench space, particularly in the area reserved for assembling medicines for the prison and compliance packs. The team members were trying to keep benches as clear as possible but there were several stacks of baskets containing dispensed prescriptions waiting to be checked. Archived paperwork was also putting pressure on storage space.

A consultation room was located off the shop floor and this was used for services and private conversations. It was well-screened and was big enough to accommodate a wheelchair. The room had a computer terminal to enable access to patient medication records and other information sources. And it had lockable storage.

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. Room temperatures were suitable for working and storing medicines and there was air conditioning if needed. Ventilation was good during the inspection.

The premises had experienced episodes of flooding in the past though this had generally not affected the retail area, dispensary, or stock. There were some signs of damp at floor level and staining on ceiling tiles from previous water leaks, though these were generally away from the patient-facing areas. There were ongoing discussions with the landlord to remedy this.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are largely 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 considers the needs of people affected by product recalls so their care is not affected.

Inspector's evidence

Information about the services the pharmacy offered and sources of support available elsewhere were advertised by way of leaflets and posters displayed in the pharmacy. The team members also used local knowledge to direct people to other care providers for services that the pharmacy did not offer. The opening hours were displayed for the public. 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. The pharmacy had an induction hearing loop.

For those services offered under Patient Group Directions (PGDs), for example emergency hormonal contraception, 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 and were in-date.

Instalment supplies were made up in advance to reduce pressure on other dispensing activities. The records for these were complete and there was a process to notify the substance misuse team if repeated doses were missed.

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 pharmacy had carried out an audit to identify any regular patients who might be affected by the updated guidance; none were found at the time of the audit. 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.

There was a lead dispenser for the supply of medicines to a prison. She explained how she tried to forward plan for any holidays to reduce the possible impact on the service. Prescriptions would be requested further in advance where needed to help with this planning. Prescriptions would usually received by fax in the first instance and then the original copy collected by the delivery driver. There was a process to match up the faxes and originals before medicines were sent to the prison. Where changes to people's medicines were made, notes were added to the prescriptions. Scanned copies of all prescriptions were kept for future reference. The dispenser explained how she had improved the filing system for this service, so paperwork was much easier to find in the event of a query. Deliveries of medicines to the prison were recorded. Some of the medicines were supplied in multi-compartment

compliance packs. These packs were labelled with dose, descriptions, and cautions. There was an audit trail to show who had prepared each tray.

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 was required by the company to check the expiry dates of its stock every quarter. The records viewed were last updated in November 2018. This was said to be because of staffing issues. The RP said he was aware the pharmacy was behind on this routine and said he was taking extra care to check the dates of any medicines as part of the final accuracy check to prevent date-expired medicines being supplied.

When stock was checked at random, there was evidence found of short-dated items being highlighted using an alert sticker. There were no date-expired medicines found. Medicines were generally kept in appropriately labelled containers. One unmarked container which held some loose tablets was removed from the shelves and destroyed. 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.

Appropriate arrangements were in place for storing CDs and access to this storage was well-controlled. CDs returned by people were clearly segregated from dispensing stock. There was enough storage capacity for medicines requiring cold storage. 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 RP was observed giving advice to someone about medicines shortages resulting from a product recall. The pharmacy offered to contact GPs to discuss alternatives where this assistance was needed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services effectively. It checks its equipment to make sure it is safe to use.

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, and some were reserved for measuring methadone to prevent cross-contamination. There was ample refrigerated storage space for medicines. Fridge maximum and minimum temperatures were checked daily and recorded. These were largely within the required range.

The pharmacy had 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.