General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Windrush Health Centre, Welch Way, WITNEY, Oxfordshire, OX28 6JS

Pharmacy reference: 1111414

Type of pharmacy: Community

Date of inspection: 23/04/2019

Pharmacy context

This is a community pharmacy located next door to a GP surgery just off the centre of Witney in Oxfordshire. A range of people from the local area use the pharmacy. The pharmacy dispenses NHS and private prescriptions. It offers a few services such as Medicines Use Reviews (MURs) and the New Medicines Service (NMS). It supplies some people with their medicines inside multi-compartment compliance packs, if they find it difficult to take their medicines on time. And, some people's prescriptions are assembled from another part of the company's premises before being sent back to the pharmacy for collection.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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

Members of the pharmacy team are clear about their roles and responsibilities. They identify and manage most risks effectively. The pharmacy records the mistakes it makes while dispensing medicines. But, the team have not reviewed these recently. So, they could be missing opportunities to spot patterns and trends and help prevent the same mistakes being repeated. Team members are proactive in protecting the welfare of vulnerable people. But, some of the pharmacy's records are not always kept 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

A range of documented Standard Operating Procedures (SOPs) were available to support services. Staff had read and signed SOPs. Records to demonstrate this were present. Staff explained that they tried to keep the dispensary as organised as possible. The Responsible Pharmacist (RP) explained that in order to maintain safety, a decision was taken to reduce the pharmacy's workload. This was through transferring 200 of their multi-compartment compliance packs to another branch (Kidlington). Their delivery driver collected these trays direct from this pharmacy and delivered them to local residents.

Some of the pharmacy's workload was also sent to one of the company's hubs. There was an SOP in place to cover off-site dispensing. The RP explained that they had changed the hub location three times because of issues with the amount of time it took for medicines to be returned. The inspector was told that people were verbally informed at the start of the service that their medicines were being sent elsewhere for dispensing. There had been no incidents with the off-site service although people did not like the bags that contained medicines under this service, according to staff.

Dispensary work benches were initially cluttered but somewhat cleared as the team worked. In general, the company's Safer Care processes were in place. Workbooks and checklists were complete. Near misses were recorded. However, the Safer Care champion had left the business the month before and near misses were not currently being reviewed.

Staff described removing the company's top 150 medicines from the fast moving shelf into drawers. They had seen patterns with high numbers of selection errors occurring from this location. This was described as being against head office policy, however, according to staff, the number of incidents seen here subsequently reduced. Look-alike and sound-alike (LASA's) medicines were marked and highlighted. There were also caution notes in front of medicines as an additional visual alert.

There were no details seen at the point of inspection, to inform people about the pharmacy's complaints procedure. Incidents were handled by pharmacists. The RP's process was in line with company policy. Documented details of previous incidents were present.

Staff could identify signs of concern to safeguard vulnerable people. They referred to the RP in the first instance. The RP was trained to level 2 via the Centre for Pharmacy Postgraduate Education (CPPE). Staff were trained through reading company information. Relevant local contact details and policy information was available. The latter had been read and signed by the team. The team were trained as dementia friends. Information about the company's chaperone policy was on display. There

were also documented details about previous incidents seen.

Confidential waste was segregated prior to being disposed of through the company. Sensitive information on bagged prescriptions awaiting collection was not visible from the retail area. The company's Information Governance policy was present to provide guidance to the team. Staff were aware of the EU General Data Protection Regulation (GDPR). They had completed online training.

There was no information on display about how the pharmacy maintained people's privacy. Staff were initially placing bagged prescriptions in baskets on a ledge in the dispensary that faced the retail area. Members of the public were observed to stand here and confidential information was visible. This was discussed at the time and the team's process subsequently changed in response.

The correct RP notice was on display. This provided details of the pharmacist in charge of operational activities. Records of the maximum and minimum temperature were maintained to verify appropriate cold storage of medicines. A sample of Controlled Drug (CD) registers checked and the RP record were maintained in line with statutory requirements. For CDs, balances were checked and documented every week except for in April 2019. On randomly selecting CDs held in the cabinet, quantities held matched balances within corresponding registers.

Odd records of unlicensed medicines were either missing prescriber details or details of the person to whom supply was made, prescriber information and the date of supply. Most records of emergency supplies included the nature of the emergency.

Some recent records of supplies made against private prescriptions held only one date. There were also more than 20 private prescriptions where details had not been documented or entered into the private prescription register. A private prescription (FP10PCD) from 2017 was located in amongst the pharmacy's private prescriptions. This had not been sent to the pricing bureau at the end of the month for analysis. Professional indemnity insurance arrangements were in place through the National Pharmacy Association (NPA).

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 can struggle with the workload. And, if there are no contingency arrangements in place to cope with staff absence, this could make the situation worse. The company provides the team with training material. But, team members don't have protected study time. This may mean that they do not always have opportunities to complete ongoing training and keep their skills and knowledge up to date. The pharmacy's team members do not have regular performance reviews. This could mean that gaps in their skills and knowledge are not identified and supported.

Inspector's evidence

The pharmacy dispensed around 11,000 prescription items every month with 100 people receiving their medicines inside multi-compartment compliance packs that were prepared on site and 16-18 people received medicines through instalment prescriptions. The pharmacy was dispensing 14,000 prescription items with 300 people receiving compliance packs before a decision to remove some of the latter occurred.

The team consisted of a regular part-time pharmacist, three medicine counter assistants (MCA's), two of whom were trained, the third had started employment three months ago and was due to be enrolled on accredited training, there was a newly employed pharmacy technician, two trained dispensing assistants, one of whom was undertaking accredited training for the NVQ 3 in dispensing and a dual trained dispensing and counter assistant.

In line with the volume of dispensing activity, the numbers of staff were low. Some existing members of staff had left the business. The pharmacy was not recruiting in response. The inspector was told that the pharmacy was fully staffed (with a total of 240 hours). The team had been informed of this by their company. At the inspection, the pharmacy was busy, there were long queues and staff members were noted as routinely concentrating and working hard. The team were just about managing with the workload and off-site dispensing was assisting. However, staff described the situation as stressful and they were physically exhausted at the end of the day. The inspector was also informed that there were no contingency arrangements in place for staff sickness. Name badges were worn by staff. Certificates for some of the team's qualifications obtained were seen.

In the absence of the RP, the MCA who was not yet enrolled in accredited training knew which activities were permissible and the procedure to take if the pharmacist failed to arrive. Staff asked a range of relevant questions before selling medicines over the counter (OTC) and referred to the RP when unsure or when required. Sufficient knowledge of OTC medicines was held. To assist with training needs, online modules on various topics were provided every month through the company. Staff described having to complete these at home because they were too busy at work. Formal appraisals were described as not occurring routinely or annually.

In addition to the Essential Services, the pharmacy provided Emergency Hormonal Contraception (EHC) and trimethoprim as locally commissioned services under Patient Group Directions (PGDs). The inspector was told that there were no formal targets in place to achieve services. There was an expectation to complete one supply of EHC and trimethoprim every month so that the service could

continue to be offered.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and provide a professional environment to deliver pharmacy services. But, some medicines that should only be sold under the direct supervision of the pharmacist are readily accessible from the retail area. This could affect how well the pharmacy cares for people. And, the pharmacy stores some assembled prescriptions directly on the floor. This could damage medicines and may be a trip hazard.

Inspector's evidence

The premises consisted of a medium sized retail space and dispensary. There was also another segregated space for assembly of MDS trays and staff areas were at the very rear. The pharmacy was suitably lit and well ventilated. Areas that faced the public were professional in appearance. All areas were clean.

The consultation room was signposted and of a suitable size to provide services and confidential conversations. The door was kept unlocked. There was no confidential information present or readily accessible. Pharmacy only (P) medicines were stored within enclosed Perspex units in the retail space. These were unlocked. Staff stated that people did try to help themselves and when they noticed they intervened. However, they were unable to always intervene if they were busy serving other people. In these instances, people brought the P medicine direct to the counter to purchase.

There were some baskets of assembled medicines stored on the floor in the MDS and staff areas. During the inspection, the RP noticed that a fridge item had been placed here inadvertently for some time. The RP discussed this with staff at the time.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains medicines from reputable suppliers and stores most medicines appropriately. But, it stores medicines returned by the public for disposal, in unsealed containers inside the staff toilet. This could increase the risk of theft occurring. And, it doesn't keep up-to-date records of the checks it makes in response to safety recalls. So, team members may not be able to show that they have taken the right steps in the event of a future query. In general, the pharmacy's services are provided safely and effectively. But, members of the pharmacy team don't always highlight prescriptions that require extra advice or record information when people receive some medicines. This makes it difficult for them to show that appropriate advice has been provided when these medicines are supplied. And, the pharmacy team sometimes fill compliance aids then leave them unsealed overnight while they wait for them to be checked. This means the medicines are not very well protected and could be damaged or contaminated by insects or dust. It may also increase the chance of mistakes occurring.

Inspector's evidence

Entry into the pharmacy was at street level from a wide, automatic front door. The clear open space inside the pharmacy and wide aisles facilitated easy access for people with mobility issues. There were four seats available for people waiting for prescriptions. Some car parking spaces were available outside the premises.

PGD information for EHC and trimethoprim was readily accessible and signed by authorised pharmacists. The team used baskets to hold prescriptions and medicines to prevent any inadvertent transfer. Their involvement in processes was apparent through a dispensing audit trail being used. This was through a facility on generated labels.

Staff were aware of risks associated with valproate. A separate drawer was being used to store this. There was guidance material and literature available to provide to people. Prescriptions for people in the at-risk group were flagged to the pharmacist. People prescribed high-risk medicines were not frequently identified, counselled, relevant parameters checked or details documented. This included the International Normalised Ratio (INR) levels for people prescribed warfarin.

With regard to the off-dispensing service, the team ordered prescriptions on behalf of people. After inputting prescription details into the pharmacy system, a clinical as well as an accuracy check was conducted before transmitting. Prescriptions were kept at the pharmacy. Bagged prescriptions were sent back from the hub in orange, sealed storage boxes. Staff then matched bag details to prescriptions. Records were maintained to verify the process.

The initial setup for MDS trays involved a discussion with the person's GP and pharmacists assessing suitability. Prescriptions were ordered by the pharmacy and cross-checked against records on the pharmacy system. If changes were identified, staff confirmed these with the prescriber. Details were documented on records and audit trails were maintained to verify this. These records also included details on a noticeboard and the team using a communication diary. Descriptions of medicines were provided. Patient Information Leaflets (PILs) were supplied routinely. Trays were sometimes left unsealed overnight. Warfarin and methotrexate were provided separately to people with trays. There were no details about INR levels recorded seen for the former. Around 10 people received finasteride

inside trays, female staff were aware not to handle this medicine but were unsure if these people had carers. Mid-cycle changes involved retrieving the old trays and supplying a new set.

For deliveries, audit trails were in place to verify when and where medicines were delivered. CDs and fridge items were highlighted and checked prior to delivery. Failed deliveries were brought back to the branch with notes left to inform people about the attempt. Medicines were not left unattended. Signatures from people were obtained upon receipt.

Medicines and medical devices were obtained from licensed wholesalers such as Alliance Healthcare and AAH. The latter was used to obtain unlicensed medicines. Staff were aware of the process involved with the European Falsified Medicines Directive (FMD). There was relevant equipment present although this was not functioning at the time of inspection. The team had received guidance information to ensure compliance with the process.

Medicines were stored in an organised manner. There were no date expired medicines or mixed batches seen. Short-dated medicines were identified using stickers. A date-checking schedule was in place, medicines were date checked for expiry every week. Liquid medicines were marked with the date they were opened.

Most medicines stored outside of their original packaging were marked with all relevant details. One bottle containing de-blistered lamotrigine tablets was seen in the MDS dispensary with no details about the batch number or expiry date recorded. This was discussed at the time. CDs were stored under safe custody. Keys to the cabinet were maintained during the day and overnight in a manner that prevented unauthorised access.

Prescriptions awaiting collection were stored within an alphabetical retrieval system. Fridge items and CDs (Schedules 2 and 3) were identified with stickers. Clear bags were used to hold assembled fridge and CDs to assist in identification when handing out. Uncollected items were removed every month. Not all Schedule 4 CDs were routinely identified.

The pharmacy used appropriate containers to hold medicines brought back by people for disposal. These were collected in line with contractual arrangements. However, these were being stored inside the staff WC in unsealed containers. People bringing back sharps to be disposed of, were referred to the GP surgery. Returned CDs were brought to the attention of the RP, details were entered into the CD returns register with CDs segregated and stored in the cabinet prior to destruction.

Drug alerts were received through the company and email, stock was checked, and action taken as necessary. An audit trail was available to verify this. However, safety alerts seen were dated from 2018.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has appropriate equipment and facilities to provide its services safely.

Inspector's evidence

The pharmacy held a range of current reference sources. The team had access to relevant equipment to provide pharmacy services. This included counting triangles, a separate one for cytotoxic medicines, clean, crown stamped, conical measures for liquid medicines and designated ones for measuring methadone. Staff could use a machine to help them to remove medicines from their blister packaging. This was used when assembling the multi-compartment compliance packs.

The dispensary sink used to reconstitute medicines was clean. Hot and cold running water was available with antibacterial hand wash present. The CD cabinets conformed to statutory requirements. Medicines requiring cold storage were stored at appropriate temperatures within medical fridges. Computer terminals were positioned in a manner that prevented unauthorised access. There were cordless phones to enable further privacy. Staff used individual passwords to access the pharmacy system. They used their own individual NHS smart cards to access electronic prescriptions. The smart cards were taken home overnight. There were lockers available for staff to store their personal belongings.

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.