General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 92a Station Road, ADDLESTONE, Surrey, KT15 2AD

Pharmacy reference: 1126165

Type of pharmacy: Community

Date of inspection: 06/02/2020

Pharmacy context

A community pharmacy set amongst some retail shops in Addlestone town centre. The pharmacy opens seven days a week. And most people who use it live, or work, close by. The pharmacy sells a range of over-the-counter medicines and health and beauty products. It dispenses NHS and private prescriptions. It delivers medicines to people who can't attend its premises in person. It supplies medicines to a few care homes. And it supplies medicines and feeds to a hospital that cares for people living with neuro-disability. The pharmacy provides multi-compartment compliance packs (compliance packs) to help people take their medicines. It offers a needle exchange service and substance misuse treatments. And it also provides seasonal influenza (flu) vaccinations and paid-for health checks.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy doesn’t have enough team members to deliver its services safely and effectively all the time it's open. And it doesn’t always have the right people working at the right time.
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 written procedures to help make sure its team works safely. It adequately monitors the safety of its services. It has appropriate insurance to protect people if things do go wrong. It mostly keeps all the records it needs to by law. And it asks people using its services for their views. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They understand their role in protecting vulnerable people. And they keep people's private information safe. They identify and manage risks appropriately. They review the mistakes they make. But they don't always record them. So, they may be missing opportunities to learn from them and stop them happening again.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) for the services it provided. And these have been reviewed since the last inspection. The pharmacy's team members were required to read, sign and follow the SOPs relevant to their roles. But they haven't all had the time to read and sign these. The pharmacy had separate areas for the assembly of medicines for care homes, people's compliance packs and medicines for the hospital that cares for people living with neuro-disability. The team members responsible for making up people's prescriptions tried to keep the workstations in each area and the main dispensary tidy. They highlighted look-alike and sound-alike drugs to help reduce the risks of them picking the wrong product. The pharmacy kept an audit trail for each stage of the dispensing process from clinical screening by a pharmacist through to the final accuracy checking of the assembled prescription. Members of the pharmacy team used baskets to separate people's prescriptions and to help them prioritise the dispensing workload. They referred to prescriptions when labelling and picking products. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by an appropriately trained checker who also initialled the dispensing label. The pharmacy had systems to record and review dispensing errors, near misses and patient safety incidents. But near misses haven't always been recorded as the team sometimes didn't get the time to do so. Members of the pharmacy team discussed its mistakes to share learning and help strengthen the pharmacy's dispensing process. For example, they separated and highlighted different strengths of Clenil Modulite inhalers following a mistake where the wrong inhaler was supplied.

The pharmacy displayed a notice that identified the responsible pharmacist (RP) on duty. But the notice couldn't be seen by people attending the pharmacy. So, it was relocated to an area it could be easily seen. Team members were required to wear name badges which identified their roles within the pharmacy. And their roles and responsibilities were described within the SOPs. Members of the pharmacy team explained what they could and couldn't do, what they were responsible for and when they might seek help. They explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products to a pharmacist. The pharmacy had a complaints procedure. And one of its leaflets told people how they could provide feedback about the pharmacy. The pharmacy participated in a patient satisfaction survey each year. And the pharmacy team asked people for their views. The results of a recent survey were available online. And people's feedback led to the pharmacy team working with the surgery to help people get an alternative product when their prescribed medicine wasn't available.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy's RP records were adequately maintained. The pharmacy used a prescription-only-medicine (POM) register to record the emergency supplies it made and the private prescriptions it supplied. But its team occasionally didn't record the details of emergency supplies in the POM register. The address from whom a controlled drug (CD) was received from wasn't always recorded in the pharmacy's CD register. But the CD register's running balance was checked regularly. The date an unlicensed medicinal product was obtained by the pharmacy wasn't routinely included in the 'specials' records.

The pharmacy had policies on information governance (IG) and safeguarding. Members of the pharmacy team were required to complete training on these policies. But they haven't all had the time to do so. The pharmacy stored prescriptions in such a way so people's names and addresses couldn't be seen by someone who shouldn't see them. And it had arrangements to make sure confidential waste was collected and destroyed securely. The pharmacy had the contacts it needed if a member of the team needed to raise a safeguarding concern. And team members could explain what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

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

Summary findings

The pharmacy doesn't have enough team members to deliver its services safely and effectively all the time it's open. And it doesn't always have the right people working at the right time. Members of the pharmacy team are under pressure. They struggle to cope with the pharmacy's workload and complete all the tasks and training they're expected to do. But they make appropriate decisions about what is right for the people they care for. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy opened for 67 hours a week. It dispensed about 9,700 NHS prescription items a month. The pharmacy team consisted of a full-time pharmacist (the RP), a full-time pharmacy manager, a part-time accuracy checking pharmacy technician, a full-time pre-registration pharmacy technician trainee, two part-time pre-registration pharmacy technician trainees, two part-time dispensing assistants and two part-time trainee dispensing assistants. The RP and the pharmacy manager have only recently joined the pharmacy team. But the pharmacy manager wasn't currently working at the pharmacy full-time as she was providing cover to other branches. There has been a turnover of pharmacists and people within leadership roles at the pharmacy since the last inspection. There was a vacancy for a part-time dispensing assistant and one of the pharmacy's dispensing assistants was currently on long term leave. The pharmacy relied upon team members from other branches and locum or relief pharmacists to cover absences.

The RP was trying to clear a dispensing backlog of repeat prescriptions that had developed over the last three days. She was also trying to check assembled prescriptions for the hospital and people's compliance packs. And she needed to supervise people taking substance misuse treatments and deal with people's urgent prescriptions and requests. The pharmacy team was under pressure throughout the inspection to do all the things it was expected to do. And team members were often interrupted during the dispensing process to help people or serve at the counter when no other team member was available. Queues of people could develop quickly at the pharmacy counter. There were inadequate contingency plans in place to make sure the right people were working at the right time despite team members raising their concerns about the level of staff cover to safely deliver the pharmacy's services. Members of the pharmacy team worked outside of their normal working hours to try and cope with the pharmacy's workload. And they rarely got time to train, keep the pharmacy clean and tidy, and complete operational tasks. But they tried to help, and support, one another when they could. They felt the targets set for the pharmacy could be challenging at times too. But they didn't feel their professional judgement or patient safety were affected by these. Medicines Use Reviews and New Medicine Service consultations were only provided by a suitably qualified pharmacist when it was clinically appropriate to do so and when the workload allowed.

The RP supervised and oversaw the supply of medicines and advice given by staff. A member of the pharmacy team described the questions she would ask when making over-the-counter recommendations and when she would refer people to a pharmacist; for example, requests for treatments for animals, infants, people who were pregnant or breastfeeding, elderly people or people with long-term health conditions. Staff performance and

development needs were discussed informally throughout the year and at colleague reviews. Members of the pharmacy team were required to undertake accredited training relevant to their roles. But the trainee pre-registration pharmacy technicians and the trainee dispensing assistants reported that they've started to fall behind with their accredited training as they didn't get time set aside for them to train while they were at work. Team meetings were held when the pharmacy wasn't busy to update staff and share learning from mistakes or concerns. Staff felt they could make suggestions about how to improve the pharmacy and its services. And they knew how to raise a concern if they had one. Their feedback led to changes in the way they processed prescriptions for CDs, which were not exempt from safe custody requirements, to maximise the amount of storage space in the CD cabinets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate and secure environment for people to receive healthcare. It has a room where people can have private conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy was air-conditioned, bright, secure and appropriately presented. It was modern and had a large retail space. It had the workbench and storage space it needed for its current workload. But several baskets, containing assembled prescriptions, cluttered up the main dispensary's worksurfaces. The pharmacy had two consultation rooms for the services it offered and if people needed to speak to a team member in private. But one of the consultation rooms was being used to store excess retail stock and point-of-sale displays. The consultation rooms couldn't be locked when not in use. So, the pharmacy team made sure their contents were appropriately secure when they weren't being used. The pharmacy team was responsible for keeping the registered pharmacy premises clean and tidy. But they didn't always get time to do so. The pharmacy had several sinks. And it had a supply of hot and cold water. It also had appropriate handwashing facilities for its staff too.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. The pharmacy provides services that people can access. It delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources and it mostly stores them appropriately and securely. Members of the pharmacy team dispose of people's waste medicines properly. They generally carry out the checks they need to. So, people get medicines or devices which are safe.

Inspector's evidence

The pharmacy was open most days of the year. It had automated doors and its entrance was level with the outside pavement. The aisles within the pharmacy were wide. And a section of the pharmacy's counter was at a lower level to the rest. So, people with mobility difficulties, such as wheelchair users, could access the pharmacy and its services. The pharmacy's services were advertised in-store and were included in its practice leaflet. Staff were helpful and knew where to signpost people to if a service wasn't provided. The pharmacy offered a delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery. And people were asked to sign an electronic delivery record to say they had received their medicines safely.

The pharmacy had appropriate anaphylaxis resources in place for its NHS and paid-for winter flu vaccination service. But the regular pharmacist wasn't trained to vaccinate people. And people needed to make an appointment for a flu vaccination. So, the pharmacy team could make sure an appropriately trained member of staff was available to provide the service. The pharmacy had valid, and up-to-date, patient group directions for its flu vaccination service. It kept a record for each vaccination. This included the details of the person vaccinated and their written consent. But an audit trail of who vaccinated them and the details of the vaccine used weren't always kept. The pharmacy team made sure the sharps bin was kept securely when not in use. Some people chose to be vaccinated at the pharmacy rather than their doctor's surgery for convenience or because they weren't eligible for the NHS service. The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. The pharmacy team checked whether a medicine was suitable to be re-packaged. It provided a brief description of each medicine contained within the compliance packs. It kept an audit trail of the person who had assembled and checked each prescription. And patient information leaflets were routinely supplied. So, people had the information they needed to make sure they took their medicines safely. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. Prescriptions were highlighted to alert staff when these items needed to be added or if extra counselling was required. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. Valproate educational materials were available at the pharmacy.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It stored its stock, which

needed to be refrigerated, appropriately between two and eight degrees Celsius. The pharmacy team removed some pet medicines from sale during the inspection to prevent people being able to self-select them. The pharmacy kept most of its medicines and medical devices in an organised fashion within their original manufacturer's packaging. But some medicines had fallen onto the floor underneath the dispensary drawer system making it difficult to close the bottom drawers. The pharmacy's stock was subject to date checks. But these weren't always documented. The pharmacy team marked products nearing their expiry. It also marked containers of liquid medicines with the date they were opened. The pharmacy stored its CDs, which were not exempt from safe custody requirements, securely. A record of the destruction of patient-returned CDs was maintained. The pharmacy team was required to keep patient-returned and out-of-date CDs separate from in-date stock. But out-of-date CDs have been allowed to build up. So, the amount of space available in the CD cabinets was restricted. And the pharmacy needed to have its out-of-date CDs promptly destroyed in the presence of an authorised witness. Members of the pharmacy team were aware of the Falsified Medicines Directive (FMD). And they could check the anti-tampering device on each medicine was intact during the dispensing process. But they weren't decommissioning stock despite the pharmacy having the appropriate equipment to do so. They didn't know when the pharmacy would become FMD compliant. The pharmacy had procedures for the handling of patient-returned medicines and medical devices. Patient-returned waste was checked for CDs or prohibited items. And needle exchange clients were asked to return their spent syringes and needles in an appropriate sharps bin and deposit these within a designated waste receptacle when attending the pharmacy. The pharmacy had suitable waste receptacles for the disposal of hazardous and non-hazardous waste. People attempting to return prohibited items, such as household chemicals, were appropriately signposted. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they would take and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. Its team makes sure the equipment it uses is clean and is stored securely.

Inspector's evidence

The pharmacy had a range of glass measures. It had equipment for counting loose tablets and capsules too. And staff made sure the equipment they used to measure or count medicines was clean before using it. The pharmacy team had access to up-to-date reference sources. And it could contact the superintendent pharmacist's office to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the refrigerators' maximum and minimum temperatures. The pharmacy provided blood pressure (BP) checks on request. And its BP monitor was replaced last year. But the pharmacy team had recently suspended providing health checks as the diagnostic equipment it used hadn't been checked for some time. The pharmacy team made sure that any pharmacy equipment stored in the consultation rooms was kept secure. Access to the pharmacy's computers and the patient medication record system was restricted to authorised team members and password protected. The computer screens were positioned so only staff could see them. A cordless telephone system was installed at the pharmacy to allow staff to have confidential conversations when necessary. The team members responsible for the dispensing process each had their own NHS smartcard. And they made sure it was stored securely when they weren't working.

What do the summary findings for each principle mean?

✔ **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.