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: 19/08/2020

Pharmacy context

A community pharmacy set amongst some retail shops in Addlestone town centre. The pharmacy opens six days a week. And most people who use it live, or work, close by. The pharmacy sells a range of over-the-counter (OTC) medicines and some health and beauty products. It dispenses prescriptions. And it delivers medicines to people who can't attend its premises in person. The pharmacy dispenses medicines to people who live in a few nearby 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. This inspection took place during the coronavirus (COVID-19) pandemic.

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

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 identify and manage risks appropriately. They review the mistakes they make and learn from them to try and stop them happening again. They understand their role in protecting vulnerable people. And they keep people's private information safe.

Inspector's evidence

A member of the pharmacy's management team had completed a risk assessment of the impact of COVID-19 on the pharmacy and its services. And, as a result, the pharmacy suspended some of its face-to-face services during the peak of the pandemic. The pharmacy offered to undertake an occupational risk assessment for each team member to help identify and protect those at increased risk in relation to COVID-19. The inspector reminded the pharmacy manager of the need for community pharmacy employers to report instances of exposure to COVID-19 in the workplace. The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. Members of the pharmacy team were required to read, sign and follow the SOPs relevant to their roles. The pharmacy's head office team regularly reviewed the SOPs. The pharmacy team had received some supplemental guidance to help it manage its services safely during the pandemic.

The pharmacy had two separate areas to its main dispensary 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 and near misses. Members of the pharmacy team discussed and documented individual learning points when they identified a mistake. They reviewed their mistakes periodically to help spot the cause of them. And they shared learning from these reviews with each other. So, they could try to stop the same types of mistakes happening again. The pharmacy team separated the different strengths of asthma inhalers after the wrong one was selected during the dispensing process.

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. Members of the pharmacy team wore name badges which identified their roles within the pharmacy. And their responsibilities were described within the SOPs. They knew 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 team asked people for their views. People were also asked to complete a satisfaction survey once a year. And the results of a few of these surveys were available online. The pharmacy team tried to keep people's preferred makes of prescription-medicines in stock when asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy's RP records and its records for the supply of unlicensed medicinal products were adequately maintained. The pharmacy's controlled drug (CD) register was generally kept in order. And the CD running balance was checked regularly. But the pharmacy team occasionally forgot to record the address from whom a CD was received from in the register. The pharmacy used a prescription-only-medicine (POM) register to record the emergency supplies it made and the private prescriptions it supplied. The pharmacy's records for emergency supplies were mostly in order. But some recent private prescription supplies hadn't been recorded. The pharmacy team gave an assurance that the POM register would be kept up to date.

The pharmacy had policies on information governance and safeguarding. Members of the pharmacy team were required to complete training on these policies. 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 met

Summary findings

The pharmacy has enough people in its team. Members of the pharmacy team keep their skills and knowledge up to date. So, they can deliver safe and effective care. They use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy had reduced its opening hours since the last inspection. The pharmacy team consisted of a full-time pharmacy manager, a full-time accuracy checking pharmacy technician (ACPT), a full-time trainee pharmacy technician, two part-time trainee pharmacy technicians, a full-time dispensing assistant and two part-time trainee dispensing assistants. One of the trainee pharmacy technicians was leaving the pharmacy soon. And the pharmacy didn't have a permanent resident pharmacist. So, two experienced part-time relief pharmacists covered the pharmacy for the hours it opened. A full-time pharmacist and a full-time trainee pharmacy technician from a nearby branch were due to start at the pharmacy over the coming weeks. And they were scheduled to work alongside the pharmacy team for a few days before they started at the pharmacy full-time to help them better understand the pharmacy and its services. The pharmacy manager, a relief pharmacist (the RP), the ACPT, three trainee pharmacy technicians, a dispensing assistant and a trainee dispensing assistant were working at the time of the inspection. The pharmacy relied upon its team and team members from nearby branches to cover absences. The pharmacy's team members occasionally struggled to do all the things they were expected to do. But they supported each other so prescriptions were processed in a timely manner and people were served promptly. The pharmacy's regional manager promised that the pharmacy will have enough of the right people working at the right time to make sure the pharmacy could continue to deliver its services safely.

The RP supervised and oversaw the supply of medicines and advice given by staff. The pharmacy had a sales of medicines protocol which its team needed to follow. A team member described the questions they would ask when making OTC recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding, people who were old and people with long-term health conditions to a pharmacist. Team members needed to complete mandatory training during their employment. And they, including the pharmacy manager, were required to undertake accredited training relevant to their roles. They discussed their performance and development needs with their line manager when they could. They were encouraged to ask questions and familiarise themselves with new products. They were also asked to complete online training to make sure their knowledge was up to date. And they could train while they were at work when the pharmacy wasn't busy. But they could choose to train in their own time. The pharmacy held meetings and one-to-one discussions to update its team and share learning from mistakes or concerns.

The pharmacy's team members sometimes felt under pressure to complete some tasks. But they were adequately managing the pharmacy's workload at the time of the inspection. They didn't feel their professional judgement or patient safety were affected by targets. The pharmacy only provided Medicines Use Reviews and NHS New Medicine Service consultations when a suitably qualified

pharmacist decided it was clinically appropriate to do so and when the workload allowed. Members of the pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. The pharmacy had a whistleblowing policy in place. And its team members knew who they should raise a concern with if they had one. The team's feedback led to a switch in the areas in which medicines were made up for care homes and the hospital.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable and secure environment for people to receive healthcare. And its premises are clean and tidy. The pharmacy 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 area. It had the workbench and storage space it needed for its current workload. It also had an adequately sized dispensary. This meant that team members could generally socially distance themselves from each other. But there were times when they couldn't. 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 needed to make sure their contents were appropriately secure when they weren't being used.

The pharmacy had several sinks. And it had a supply of hot and cold water. The pharmacy's team members were responsible for keeping the pharmacy's premises clean and tidy. They wiped and disinfected the surfaces they and other people touched. The pharmacy had plenty of handwash and alcoholic hand sanitiser for people to use. So, its team members could wash or sanitise their hands regularly.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access. Its working practices are safe and effective. 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 generally stores them appropriately and securely. Members of the pharmacy team mostly carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose. And they dispose of waste medicines properly too.

Inspector's evidence

The pharmacy had an entrance that was level with the outside pavement. But its automated doors weren't working properly at the time of the inspection. So, the pharmacy team opened one of the doors when necessary to help people into the pharmacy. The pharmacy had aisles that were wide. And a section of its counter was at a lower level to the rest. This made it easier for people with mobility difficulties, such as wheelchair users, to access the pharmacy and its services. The pharmacy advertised its services in-store and included them in its practice leaflet. Members of the pharmacy team were helpful. They knew where to signpost people to if a service wasn't provided. The pharmacy offered a 'contactless' delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery to show that the right medicine was delivered to the right person. The pharmacy team was getting ready to deliver a winter flu vaccination service. And it had thought about how it could reduce the time people spent in the consultation room. People were already able to book appointments in-store or online for their flu jabs. So, the pharmacy could make sure it had enough vaccines and the right people working at the right time to deliver the 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 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 the team member 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. The pharmacy had some valproate educational materials available.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices in an organised fashion within their original manufacturer's packaging. But a few loose blisters strips of prescription-medicines were found. The pharmacy team regularly checked the expiry dates of medicines. But it didn't always document when it had done these checks. It marked products which were soon to expire. And it marked containers of liquid medicines with the date they were opened. This helped the team reduce the chances of it giving people out-of-date medicines by mistake. The pharmacy stored its stock, which needed to be refrigerated, appropriately between two and eight degrees Celsius. And it also stored its CDs, which weren't exempt from safe custody

requirements, securely. The pharmacy kept a record of the destruction of patient-returned CDs. The pharmacy team was required to keep patient-returned and out-of-date CDs separate from in-date stock. Members of the pharmacy team were aware of the Falsified Medicines Directive (FMD). And they had completed some FMD training. They could check the anti-tampering device on each medicine was intact during the dispensing process. But they weren't decommissioning stock. And they didn't know when the pharmacy would become FMD compliant. The pharmacy had procedures for handling unwanted medicines people returned to it. And its team checked if these included any CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. The pharmacy had suitable pharmaceutical waste bins for the disposal of hazardous and non-hazardous waste. 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. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is kept clean.

Inspector's evidence

The pharmacy had reviewed the equipment its team needed as a result of the pandemic. It had put up two plastic screens on its counter. And markings on its floor were there to help people keep two metres apart and encourage them to follow a one-way system. The pharmacy had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment, including face masks, its team members needed when they couldn't socially distance from people or each other. The pharmacy had a range of clean glass measures. It had equipment for counting loose tablets and capsules too. And its team members made sure the equipment they used to measure, or count, medicines was clean before they used 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. The pharmacy team was getting ready to start providing health checks again. And it had started to check the diagnostic equipment it used was fit for purpose. The pharmacy team made sure any pharmacy equipment kept in the consultation rooms was stored securely when not being used. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. The pharmacy had a cordless telephone system. So, its team could have confidential conversations with people 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?

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.