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: 22/06/2022

Pharmacy context

This is an NHS community pharmacy set amongst some retail shops in Addlestone town centre. The pharmacy is part of a large chain of pharmacies. It opens six days a week. It sells a range of health and beauty products, including some over-the-counter medicines. It dispenses people's prescriptions. And it delivers medicines to people who can't attend its premises in person. The pharmacy offers a needle exchange service and substance misuse treatments. It provides multi-compartment compliance packs (compliance packs) to help people take their medicines. It dispenses medicines to people who live in care homes. And it supplies medicines to a hospital that cares for people living with a neuro-disability. People can get a flu jab (vaccination) from the pharmacy. They can receive a test to see whether they have coronavirus (COVID-19) or if they're 'fit to fly'. And they can book an appointment for a travel clinic which is run from a room in the pharmacy by a third-party company.

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 generally manages its risks appropriately. It has written instructions to help its team works safely. It mostly keeps the records it needs to by law. And it has appropriate insurance to protect people if things do go wrong. People who use the pharmacy can provide feedback to help improve the services they receive. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They mostly keep people's private information safe. They understand their role in protecting vulnerable people. And they talk to each other about the mistakes they make. So, they can learn from them.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. And a team at its head office regularly reviewed them. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. They stopped providing some diagnostic tests as they were no longer adequately protected from the risks of handling people's blood. And they couldn't routinely offer to check a person's blood pressure due to their current workload. The pharmacy had considered the risks of COVID-19. And, as a result, it completed an occupational risk assessment for its team members and put two plastic screens on its counter to try and stop the spread of the virus. Members of the pharmacy team were encouraged to self-test for COVID-19. They knew that any work-related infections needed to be reported to the appropriate authority. They had the personal protective equipment they needed. And hand sanitising gel was freely available.

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 a neuro-disability. The team members responsible for making up people's prescriptions kept 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 processes to review the dispensing mistakes that were found before reaching a person (near misses) and dispensing mistakes where they had reached the person (dispensing errors). Members of the pharmacy team discussed and documented the mistakes they made to learn from them and reduce the chances of them happening again. But they didn't routinely review them as they were expected to do. So, they could be missing opportunities to spot patterns or trends with the mistakes they made. The pharmacy team reviewed and strengthened its processes and separated different gabapentinoids from each other in the dispensary after the wrong one was dispensed.

The pharmacy displayed a notice that told people who the responsible pharmacist (RP) was. But this wasn't for the RP on duty at the time of the inspection. The RP changed the notice once they were notified of the matter. Members of the pharmacy team wore name badges which identified their roles

within the pharmacy. They knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. A team member 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, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints procedure. And it had a leaflet that told people how they could provide feedback about it and its services. The pharmacy had received feedback from people online. It asked people for their views and suggestions on how it could do things better. And, for example, it tried to keep a person's preferred make of a prescription medicine in stock when its team was asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and when. The pharmacy kept a controlled drug (CD) register. But the details of where a CD came from weren't always completed in full. The pharmacy team checked the stock levels recorded in the CD register regularly. The pharmacy kept appropriate records for the supplies of the unlicensed medicinal products it made. The pharmacy used a private prescription register to record the emergency supplies it made and the private prescriptions it supplied. And the entries seen in the private prescription register were generally in order. But some private prescription supplies hadn't been recorded. The pharmacy team had a plan to make sure these were entered as quickly as possible. And assurances were given that the private prescription register would be kept up to date.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy displayed a notice in-store that told people how their personal information was gathered, used and shared by the pharmacy and its team. It had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always obliterated or removed from the unwanted medicines they returned to it before being disposed of. The pharmacy had policies on information governance and safeguarding. Members of the pharmacy team were required to complete safeguarding training relevant to their roles and training on information governance. The pharmacy had the contacts it needed if a member of the team needed to raise a safeguarding concern. And its team members knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. Team members were aware of the 'Ask for Ani' campaign. And they could help people get the support they needed if they were asked.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough people in its team to deliver safe and effective care. But sometimes team members feel they don't have time to do all the things they're expected to do. Members of the pharmacy team do the right training for their roles. They work well together and make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy and its 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. And this meant the pharmacy team needed to do all the things they were expected to do in less time. The pharmacy team consisted of a pharmacist, a pharmacy manager, an accuracy checking pharmacy technician (ACPT), a trainee pharmacy technician, a dispensing assistant and two trainee dispensing assistants. And a dispensing assistant from a neighbouring branch was due to join the pharmacy team shortly to help it manage an expected increase in workload when a neighbouring pharmacy closed. The pharmacy had taken on some of the neighbouring pharmacy's workload already. And its team recently accommodated some additional care home dispensing workload too. Members of the pharmacy team were a few days behind with their workload. They occasionally stayed behind after the pharmacy closed when there wasn't a RP to try and catch up with the workload. And they sometimes struggled to do all the things they were expected to do. But they supported each other so prescriptions were processed safely. And they tried to serve people at the pharmacy counter when they could. A senior representative of the company provided assurances that the pharmacy team would be supported, and the pharmacy would have enough of the right people working at the right time to make sure it could continue to deliver its services safely.

The pharmacy manager, a locum pharmacist (the RP), the ACPT, the trainee pharmacy technician, the dispensing assistant and a trainee dispensing assistant were working at the time of the inspection. 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 recommending over-the-counter medication. 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 the pharmacist on duty.

Members of the pharmacy team needed to complete mandatory training during their employment. They, including the pharmacy manager, were required to undertake accredited training relevant to their roles too. They discussed their performance and development needs with their line manager when they could. They encouraged each other to ask questions and share learning from the mistakes they made. And they were also asked to complete online training to make sure their knowledge was up to date. But the pharmacy was often too busy for them to complete the training they were expected to do while they were at work. So, they trained in their own time. The pharmacy team sometimes felt under pressure to complete all the things it was expected to do. But members of the pharmacy team didn't feel that the targets they were set stopped them from making decisions that kept people safe. They were comfortable about making suggestions on how to improve the pharmacy and its services. They

knew who they should raise a concern with if they had one. And their feedback led to them using the pharmacy's texting service more than they were. This was to try and reduce the number of telephone calls the pharmacy received from people asking if their prescriptions were ready.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare in. And its premises are bright 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 professionally 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. But its workspace and corridors could become cluttered quickly with totes when the pharmacy was busy. 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 some sundries. 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. Members of the pharmacy team were responsible for keeping the premises clean and tidy. But they didn’t always get time to clean the pharmacy as often as they would like.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access. Its working practices are generally safe and effective. And its team members are helpful. Members of the pharmacy team mainly dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy 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 stores most of them appropriately and securely.

Inspector's evidence

The pharmacy had an automated entrance that was level with the outside pavement. It had wide aisles. And a section of its counter was at a lower level to the rest. This meant that people who may have difficulty climbing stairs could access its premises and its services more easily. And the pharmacy had a small seating area for people to use when they wanted to wait. Members of the pharmacy team were helpful and knowledgeable. They knew where to signpost people to if a service wasn't provided. But they were often too busy dealing with the dispensing workload or people's queries to serve people quickly. This meant that queues of people could develop rapidly at the pharmacy counter if a team member wasn't available to serve. And, at the time of the inspection, a notice at the counter told people that there was up to a 45-minute wait for prescriptions to be processed.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. It used a third-party company to make its deliveries. And it kept an audit trail for each delivery to show that the right medicine was delivered to the right person. 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. And it generally assessed each request for the service to make sure compliance packs were appropriate for the patient. The pharmacy 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 the team member when these items needed to be added or if extra counselling was required. Team members knew that women or girls able to have children mustn't take valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed valproate needed to be counselled on its contraindications. And they had access to the valproate educational materials they needed.

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 the pharmacy team removed and disposed of some loose and unlabelled medicines that were found during the inspection. Team members marked containers of liquid medicines with the date they were opened. They were required to check the expiry dates of medicines regularly or before they dispensed them. And they marked products which were soon to expire. But they hadn't done a date-check for some weeks due to the pharmacy's current workload. 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 team recorded the destruction of the CDs that people returned to it. And out-of-date and patient-returned CDs were kept separate from in-date stock. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in a pharmaceutical waste bin. But the pharmacy didn't have an appropriate bin for the disposal of hazardous waste medicines. And some intact patient-returned CDs and cytotoxic medication were found in a waste bin intended for non-hazardous pharmaceutical waste. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And one of its team members described the actions they took and demonstrated what records they made when they received a drug alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure out, or count, medicines 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 travel clinic, which was operated by a third-party company, kept its vaccines in its own medical refrigerator within one of the consultation rooms. This refrigerator was locked when not in use and its temperature was seen to be within range. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. It restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password.

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.