General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Park Medical Centre, Ball Haye Road, Leek, Staffordshire, ST13 6QR

Pharmacy reference: 9010091

Type of pharmacy: Community

Date of inspection: 09/04/2019

Pharmacy context

This is a busy pharmacy in a medical centre close to the town centre. Most people who use the pharmacy are from the local area. The pharmacy dispenses NHS prescriptions and a small number of private prescriptions, some of which are from the company's online prescribing service. Some medicines are supplied in multi-compartment compliance aid devices to help people take their medicines at the right time. The pharmacy sells a range of over-the-counter medicines and provides a range of health checks. It also sells independent living aids and equipment to help people with mobility issues. Some prescriptions are prepared in another Lloyds pharmacy in Warrington known as the offsite dispensary.

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	2.2	Good practice	The pharmacy team members have the appropriate skills, qualifications and competence for their role. And there is a structured approach to training and development
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 to make sure its services are safe. It takes some action to improve patient safety. But team members do not make full records or review all their mistakes, so they may be missing out on some learning opportunities. The pharmacy keeps its records up to date, so it can show it is providing services safely. It has written procedures to keep people's private information safe. But team members do not always follow these procedures, which increases the chance of people's confidential information being seen. The pharmacy asks its customers for their views and understands how it can help to protect the welfare of vulnerable people.

Inspector's evidence

There were up-to-date standard operating procedures (SOPs) for the services provided, with signatures showing that most members of the pharmacy team had read and accepted them. There was no record available that the pre-registration pharmacist (pre-reg) had read the SOPs but she said she had read them during her first week in the pharmacy. The locum pharmacy said he had been required to read the SOPs in electronic version and confirm he had done this when he accepted the booking. Roles and responsibilities of the pharmacy team were set out in SOPs and the team members were performing duties which were in line with their role. The team members were wearing uniforms and name badges showing their role. The name of the responsible pharmacist (RP) was displayed as per the RP regulations.

Dispensing incidents were reported to the superintendent via 'PIMS' – Lloyds incident reporting system on the intranet, and a copy of the patient safety incident form was retained in the pharmacy. Action points were included, e.g. 'discuss with colleagues at safer care monthly briefing'. A root cause analysis and reflective statement had been completed for an incident which recently occurred to ensure that it was fully investigated, and the people involved had reflected on their practice

Around one or two near misses had been recorded each month over the last year, but none had been recorded in March or April 2019. There had been no documented review of near misses since August 2018 or safer care monthly briefings. Members of the pharmacy team said that they discussed dispensing incidents and acted to reduce errors but they were not getting time to document this. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out.

A customer complaint SOP was in place and customer complaints were reported on 'PIMS'. 'Customer Charter Standards of service' leaflets were available with the details of the complaint policy, and who to complain to.

A customer satisfaction survey was carried out annually. The results of the previous survey were on display and available on the NHS choices website. Areas of strength (100%) were providing an efficient service, staff overall, service received from other staff, being polite and taking time to listen and offering a clear and well organised layout. An area identified which required improvement was comfort and convenience of the waiting area (1.8% dissatisfied). The pharmacy's published response was that the 'Pharmacy will review waiting areas within 28 days of the report'. There had been no significant change to the waiting area since the survey, it contained two chairs.

A current certificate of professional indemnity insurance was on display in the pharmacy. Private prescription and emergency supply records, the RP record, and the CD register were appropriately maintained. Records of CD running balances were kept and these were regularly audited. 2 CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately.

Most of the staff had read and signed documents in the information governance (IG) file which included confirmation that they had been trained on confidentiality. A dispenser correctly described the difference between confidential and general waste. A privacy statement was on display in line with General Data Protection Regulations (GDPR). Around 20% to 25% of prescriptions were sent to the off-site dispensary (OSD) in Warrington but the pharmacy was not obtaining consent from the patients to do this. The accuracy checking technician (ACT) said everyone was assumed to have 'opted in' to OSD unless they objected to it. If this happened, which was usually when the patient received their medication back from the OSD, a box on the patient's medication record (PMR) was unchecked and they were 'deselected' for OSD. The OSD SOP stated that the pharmacy should be obtaining explicit written consent prior to sending prescriptions to the OSD. Pharmacy team members said they did not recall anything about consent when they were training in preparation for OSD.

The ACT had completed level 2 training on safeguarding. Other staff had read the safeguarding policy. The pharmacy had a chaperone policy and this was highlighted to patients.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members complete training for the jobs they do. And they do some ongoing learning to help them keep their skills and knowledge up to date. They are comfortable about providing feedback to their manager and receive feedback about their own performance. Team members have opportunities to discuss issues informally together. These communications are not usually recorded, so issues raised might not always be acted on.

The pharmacy enables the team members to act on their own initiative and use their professional judgement to help people who use the pharmacy's services.

Inspector's evidence

There was a locum pharmacist (RP), an ACT, a pre-reg and three NVQ2 qualified dispensers (or equivalent) on duty at the time of the inspection. Planned absences were organised so that not more than one person was away at a time. Staff absences were covered by re-arranging the staff rota. Authorisation was required if extra staff hours were needed. Members of the pharmacy team commented that they as they had to work at a running pace to get the essential tasks completed, so less important tasks were sometimes missed. The staff level appeared adequate for the volume of work seen during the inspection, although there was a large stack of baskets waiting to be assembled for patients who were collecting later. The ACT was the pharmacy's supervisor and said that staff levels had been discussed with management but felt to be adequate by head office. Requests could be made to transfer staff from a neighbouring branch to cover absences, but they also had limited staff levels, so were usually unable to help. The pharmacy manager was also a 'cluster manager' so was only in the pharmacy one or two days each week. This increased pressure on the pharmacy team as locum pharmacists were often used, who were not familiar with the pharmacy, and could not provide all the services offered.

An appraisal system 'My Pad' was used to formally manage staff performance, training and development. The pharmacy manager had recently carried out team members reviews. The team was also given positive and negative feedback by the manager and supervisor. All members of the team completed a monthly knowledge assessment which they were required to pass. Packages on child oral health, Syndol and Grahams Natural skincare had been completed recently. Team members carrying out services had completed the appropriate training. They had regular protected training time, but because the internet was very slow, training was often carried out at home.

Daily dose and weekly bulletins were sent from head office to keep the team up to date and these were discussed at daily catch ups and informal weekly meetings. There was an operations diary which was used to pass on messages throughout the team. It was not used very often and issues discussed at meetings were not usually documented. Members of the pharmacy team said they felt there was an open and honest culture in the pharmacy and said they would feel comfortable talking to the supervisor or pharmacy manager about any concerns they might have. They said they could give suggestions or criticisms informally. There was a whistleblowing policy.

Pharmacists were empowered to exercise their professional judgement and could comply with their own professional and legal obligations, e.g. refusing to sell a pharmacy medicine because they felt it was inappropriate. A dispenser said a member of the pharmacy team would contact the patient's GP and make a record on their PMR if abuse was suspected and the sale was refused. She said the team would be supported from head office if this was the case. She said targets were set for services such as MURs but she didn't feel targets ever compromised patient safety and MURs were very helpful for the patient. If the pharmacist was carrying out an MUR she said the team would let patients know that their prescription might take a little longer than usual, to ease any pressure on the team.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The pharmacy premises including the shop front and facia were clean, well maintained and in a good state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with two chairs. The temperature and lighting was adequately controlled. The pharmacy had been fitted out to a good standard when it opened, and the fixtures and fittings were in good order. Maintenance problems were reported to the maintenance department via a 'one call' number and the response time was appropriate to the nature of the issue.

There was a room which was used as an office, staff room and stock room for retail stock. It included a small kitchen area, and a WC with a wash hand basin and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand sanitizer gel was available.

There was a consultation room equipped with a sink, which was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. Staff explained they would use this room when carrying out the services and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which it makes available to people with different needs. The services are generally well managed. People receive their medicines safely and the pharmacy gives people taking high-risk medicines extra advice. The pharmacy sources and supplies medicines safely. And carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchair users. There was an automatic door at the external entrance, and a wide entrance from the medical centre into the pharmacy. There was a hearing loop in the pharmacy. Easy grip pens were available, magnifiers and a low-level shelf for wheelchair users to sign prescriptions on. The pharmacy stocked a range of mobility and independent living aids including walking sticks for purchase by customers.

A list of the services provided by the pharmacy was displayed with the opening hours. Services were advertised inside the pharmacy and listed in the practice leaflet. Staff were clear what services were offered and where to signpost to a service not offered, e.g. needle exchange. The pharmacy team explained that when the pharmacy manager was not present, some of the services advertised could not be provided so patients would be signposted to other local pharmacies. Signposting was not usually recorded so it was difficult for staff to remember examples of improved patient outcomes. There was a small range of healthcare leaflets providing information on diabetes, asthma and the travel service.

Around 20% to 25% of patients were on the express repeat prescription service and these prescriptions were usually sent to the OSD for dispensing. Patients indicated their requirements a month in advance when they collected their medication. Requirements were checked again at handout and any unrequired medicines were retained in the pharmacy and the prescription endorsed as not dispensed. This was to reduce stockpiling and medicine wastage.

There was a delivery service and a robust audit trail was in place. Each delivery was recorded and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was quite limited in the dispensary but the work flow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. The ACT explained that a stamp was used to record the clinical check by the pharmacist when she carried out the accuracy check on prescriptions. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed.

‘Pharmacist’ stickers were used to highlight counselling was required and high-risk medicines such as warfarin, lithium and methotrexate were targeted for extra checks and counselling. INR levels were requested and recorded when dispensing warfarin prescriptions. A valproate audit had been carried out and identified one person who may become pregnant. A note had been made on her records to discuss pregnancy prevention. The valproate information pack and care cards were available to ensure female patients were given the appropriate information and counselling.

The multi-compartment compliance aids service was well organised and dispensing audit trails were completed. There was a partial audit trail for changes to medication in devices but it was not always clear who had confirmed the changes and the date the changes had been made. Packaging leaflets were included but medicine identification was not completed so identification of the individual medicines by the patient or carer, might not always be possible. Disposable equipment was used.

A dispenser knew what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

Date expired and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Recognised licensed wholesalers were used for the supply of medicines and appropriate records were maintained for medicines ordered from ‘Specials’. No extemporaneous dispensing was carried out.

Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired medicines were segregated.

The pharmacy was not compliant with the Falsified Medicines Directive (FMD). The team thought that the hardware had been received in branch, but they had not had any training on it, and had not begun to scan medicines to verify or decommission them.

Alerts and recalls etc. were received via e-mail messages from head office and the NHS area team. These were read and acted on by the ACT or member of the pharmacy team and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely.

Inspector's evidence

Current BNF and BNF for children etc. were available and the pharmacist also used the 'One Portal' system to access approved professional websites for the most up to date information, e.g. electronic medicines compendium (eMC) X-PIL to obtain packaging leaflets for patients.

There was a clean medical fridge. The minimum and maximum temperatures were being recorded daily and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested. There were some records to show that the blood glucose testing equipment was being checked regularly and the blood pressure machine was replaced regularly, to ensure it was accurate.

There was a selection of clean liquid measures with British Standard and crown marks. Separate measures were marked and used for CDs. The pharmacy also had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. Individual electronic prescriptions service (EPS) smart cards were used appropriately. Cordless phones were available in the pharmacy so staff could move to a private area if the phone call warranted privacy.

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.