General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Lloydspharmacy, St. Georges Medical Centre, Parsons Lane, Littleport, Ely, Cambridgeshire, CB6 1JU

**Pharmacy reference:** 9010154

**Type of pharmacy:** Community

**Date of inspection:** 12/08/2019

## Pharmacy context

This pharmacy is adjacent to a GP surgery and there is a shared entrance to the pharmacy and the surgery. Most of the NHS prescriptions it dispenses come from this surgery. It offers a prescription delivery service and supplies some medicines in multi-compartment compliance packs to people who need this help to take their medicines. It also offers Medicines Use Reviews (MURs), New Medicine Service (NMS) checks, instalment supplies and supervised administration for substance misuse treatment, and needle exchange. The pharmacy is currently recruiting for a pharmacy manager. Some services provided by the previous manager, including emergency hormonal contraception under a patient group direction (PGD), were not available at the time of the inspection.

## 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's team members generally follow written procedures to provide services safely. The new team is using audits and feedback to check if it is working effectively and to identify areas where it can improve. The team members largely keep people's private information safe. They understand their role in protecting vulnerable people. And they keep the records they need to by law. They record their mistakes and review them, so they can learn and reduce risks in the future.

### Inspector's evidence

Pharmacy services were supported by written standard operating procedures (SOPs) and these were reviewed regularly. The head office had issued some new and updated SOPs to staff in July 2019 and the team members were still to read these. These included the supply of valproate medicines, and supply of transdermal fentanyl. There was evidence that team members had read all existing SOPs relevant to their roles though the management sign-off for some of these had not been completed. The responsible pharmacist (RP) on duty during the inspection was a locum pharmacist and this was his first day in this pharmacy. He said that he had already read the company's SOPs and had confirmed this as part of the locum booking process. He also received any updates about SOPs through the same booking process.

The pharmacy had recently completed a Professional Standards audit and this had identified actions the pharmacy could take to further improve its processes to reduce risks. The member of staff in charge (the supervisor) explained that the team had been through a significant period of change which had meant that some of the pharmacy's routines and tasks had not been kept up to date. New members of staff were now more settled, and service to people using the pharmacy had improved. The team was focussing on making sure tasks such as stock counts, date checking, and clinical governance activities were prioritised.

Staff tried to record their own dispensing mistakes regularly. Follow-up actions often included instructions to 'double-check' or 'read carefully' though some related more closely to why a mistake had been made. There was a notice for staff, highlighting medicines with similar sounding names or with similar packaging. Some of these items had been more clearly separated on shelves to prevent selection errors and some had alert stickers applied to the storage location. A common mistake identified was that trainee dispensers were labelling medicines with the shorthand dosage instructions written on electronic prescriptions. These could be ambiguous for people. So, the team had been briefed to review how they labelled medicines and make sure that any instructions for people were clear.

There was a process to report any errors which had reached people and the pharmacy could show this process had been followed. The supervisor explained how errors were reviewed and that any action points were recorded as part of that review. Error reports viewed contained reflective statements by staff and follow-up actions to prevent similar events in the future. Learning points from all dispensing incidents were included in a monthly patient safety review, referred to as 'Safer Care', and were shared with the team. With recent staff changes, the Safer Care process had not been followed as well as it had been, but the supervisor was keen to get the process back on track. A Safer Care noticeboard was also

used to share information about incidents and action points with the team. Following an error where confidential information had been disclosed by mistake, the way that prescription repeat slips were stored had been changed to prevent a similar event. The new process was followed routinely.

Prescription labels, including those on compliance packs, were initialled at the dispensing and checking stages. This meant the pharmacy could be sure who had completed each of these tasks. Roles and responsibilities were identified in the SOPs. Team members could explain what they could and couldn't do in the absence of the RP. They were observed asking people questions before selling medicines to establish if it was safe to sell the medicines. And they knew medicines were more closely controlled to minimise the risk of misuse, for example, pseudoephedrine-containing medicines and codeine-containing painkillers. Staff in training referred queries to more experienced members of staff throughout the inspection. The staff wore name badges and uniforms so could be easily identified by people visiting the pharmacy.

The pharmacy sought feedback from people about its services and results of the most recent feedback survey were displayed in the shop. Results overall were positive. The supervisor explained that the pharmacy had been trying hard to improve its customer service in recent months. There was a company complaints procedure which enabled people to raise concerns about the pharmacy. Information about this was included in a Customer Charter leaflet.

There were appropriate insurance arrangements in place for the services provided. The RP notice showed who the pharmacist in charge was and it was displayed where the public could see it. The RP record was complete. Schedule 2 controlled drugs (CDs) were recorded in paper registers. The records were largely complete and running balances were checked regularly. CDs returned by people for destruction, including Schedule 3 CDs, were recorded when received. And denaturing kits were available for their destruction. An error involving a CD had been correctly reported to the CD Accountable Officer. Private prescriptions and emergency supplies were recorded in a book and the entries were largely complete.

The pharmacy protected sensitive information in several ways. There was a notice informing the public that the premises had CCTV. Confidential waste was segregated and disposed of securely. Staff had completed training packages on protecting people's information and there were written procedures about information governance. Patient medication records were password protected. Not all staff had their own NHS smartcards to access electronic prescriptions. One member of staff needed to have their card unlocked and the supervisor said this would be done promptly. Another trainee dispenser was in the process of applying for their own card so they didn't need to share cards.

There were procedures in place to help make sure the pharmacy took appropriate action to protect vulnerable people. Staff had read these procedures. Information about the pharmacy's chaperone policy was displayed in the shop area. The pharmacist had completed level 2 training about safeguarding. Staff said they would report any safeguarding concerns to the pharmacist.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy's team members are suitably trained or are completing the required training for the roles they undertake. The team is very new but there are enough staff to cope with the workload. They can share ideas or raise concerns about how the pharmacy is working. And the team works well together. They are provided with training materials to help keep their skills and knowledge up to date. But they sometimes struggle to find time to complete this training at work.

### Inspector's evidence

The pharmacy team consisted of; a supervisor (a trainee pharmacy technician), one trained dispenser, one full-time and a part-time trainee dispenser, a part-time healthcare assistant, and delivery drivers. The pharmacy occasionally received support from an accuracy checking technician (ACT) who was based at another branch. The team coped with their workload during the visit and were seen working closely together. The pharmacy did not currently have a regular pharmacist and were using various locum pharmacists to provide cover. Recruitment for a pharmacist was underway.

The team members had records of the training they had completed. They had to complete refresher training regularly on mandatory topics including data protection. Staff said that it was sometimes difficult to find time to do training when at work because of the recent staff changes and workload volume. But the supervisor said she had spoken to the cluster manager about not being able to complete her technician training and had been allocated two hours a week as study time to help with this.

There was evidence available that the previous pharmacist who had been providing some services under PGDs had completed the appropriate training for these services, including seasonal flu vaccinations and emergency hormonal contraception.

The team members said they were happy to share ideas with each other about how to improve the pharmacy's services. They had team briefings to discuss safety incidents and case studies that were provided by head office to help the team learn. A container with mixed Madopar capsules had been found and the supervisor explained how she had shown this to the rest of the team to raise awareness when dispensing. She had also briefed the team about marking split boxes to reduce the possibility of supplying the wrong quantity of medicines to people.

All staff members had had appraisals with their manager in the last year. Completion of these was tracked by head office. The team members said they would feel comfortable raising any concerns with their manager or cluster manager if needed. There was a confidential helpline for staff who wanted to raise concerns.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises are safe, secure, and suitable for the pharmacy services provided.

### Inspector's evidence

The premises had enough space to carry out all dispensing tasks safely. Quieter parts of the dispensary were used for specific tasks such as preparing compliance packs, so distractions were fewer. The pharmacy could be secured against unauthorised access. The dispensary was separated from the rest of the shop and was not easily accessible by members of the public. Dispensed medicines were held out of reach and sight of the public.

The pharmacy was generally clean and maintained to a suitable standard. Patient facing areas were professional in appearance. There was seating available for people waiting for services though access to one of these was blocked by stock waiting to be put out. Room temperatures were comfortable and could be controlled by the staff. There was good lighting throughout the premises.

A private consultation room was available and signposted. There was no patient identifiable information on display. Electronic patient medication records could be accessed by the pharmacist if needed. This room was used for Medicines Use Reviews, flu vaccinations and private conversations with people. The room was generally tidy and accessible but was used to store a mobility scooter which detracted a little from its appearance.

There were sinks equipped with hot and cold running water in the dispensary, colleague area, and consultation room. These were badly stained. The supervisor said it was hard to clean them properly but would investigate other options to improve their appearance. There were separate handwashing facilities for staff. Designated bins filled with waste medicines were stored in the WC along with some containers holding shop stock. The supervisor said they would find an alternative storage location for these.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy's services are generally undertaken safely and effectively. It gets its medicines from reputable sources and generally stores its medicines and other stock safely. It takes the right action in response to medicine recalls and safety alerts to protect people's health and well-being. And it takes care when it supplies medicines which may be higher-risk. But prescriptions for these medicines are not always highlighted to staff and so they may miss opportunities to provide advice to people. And its team members don't always record the interventions that they make so this information may not be available if there is a query in future.

### Inspector's evidence

The entrance to the pharmacy was at street level and there were automatic-opening doors. The shop area was clear of slip or trip hazards and could accommodate wheelchairs and prams. Services were advertised to people by posters and leaflets on display. But some of these were only available in the consultation room, out of sight of the public. And one of the posters in the entrance gave details about an emergency hormonal contraception service that the pharmacy could not provide currently as the accredited pharmacist was no longer working at this pharmacy. This could cause some confusion or inconvenience for people.

There were SOPs for local services including needle exchange and evidence that staff had read these. Staff were aware of safe handling techniques for sharps waste. There were alerts stickers which were sometimes applied to prescriptions for higher-risk medicines and controlled drugs (CD). These were intended to signal that additional care was needed when prescriptions for these items were handed out. When checked, these were not always used. For example, there were prescriptions for methotrexate and warfarin found in the retrieval system which had no alert sticker applied. And there were prescriptions for Schedule 3 CDs which did not have stickers to highlight the expiry date of the prescription. These prescriptions were beyond their valid date and the supervisor removed these straightaway. The team was aware of the need to provide counselling about pregnancy prevention to some people who received valproate. Leaflets and cards were available, and an audit had been undertaken to identify people who might need this information.

Some checks were made with people by the pharmacy about therapeutic monitoring of higher-risk medicines. But records of these checks were not always added to the patient's medication record. On one record checked at random, only one entry had been made to show that the pharmacy had checked the person was having regular blood tests despite the person receiving monthly supplies of warfarin from the pharmacy.

Medicines were supplied in multi-compartment compliance packs for some people living at home who needed this level of support. The pharmacy also supplied medicines in multi-compartment packs to a care home. The packs were prepared in accordance with a planned rota over four weeks and in a separate area of the dispensary to reduce distractions. Prescriptions for people living at home were generally ordered on behalf of the patient by the pharmacy. Care home staff ordered prescriptions for their residents. The pharmacy queried missing items or unexpected changes with the person, their

carer or their GP. Records were generally added to people's records of any interventions or changes. Package information leaflets were provided regularly, and the packs were fully labelled and included tablet descriptions. Staff could explain the types of medicines they wouldn't put in the compliance packs, for example, medicines with varying doses or medicines which were hygroscopic. Where there were mid-cycle changes, the pharmacy retrieved existing packs from the person, made the necessary changes, and resupplied the packs to prevent any medication errors.

The pharmacy got its medicines from licensed wholesalers and specials were obtained from specials manufacturers. No extemporaneous dispensing was carried out. Medicine stock for dispensing was stored in an orderly fashion, out of reach of the public. There was a process to date-check stock and to highlight short-dated medicines. When medicines were checked at random, there were no out-of-date items found. And all medicines were stored in appropriate containers. However, there were some short-dated medicines found without alert stickers applied. The records for date checking were not up to date. The last entry was in April 2019, but the supervisor said checks had been made since then. The supervisor said this was one of the routine tasks that the team was trying to improve on now that the staff was more settled. The team had recently managed to get back on track with stock counts in the dispensary. Out-of-date medicines and patient-returned medicines were transferred to designated bins and waste sacks and collected by licensed waste contractors for safe disposal.

Appropriate arrangements were in place for storing CDs. The pharmacy had scanning equipment to comply with the Falsified Medicines Directive. Staff were still to complete training in its use. There was enough storage capacity for medicines requiring refrigeration. The medicines fridge was equipped with a maximum and minimum thermometer and temperatures were checked daily and recorded. The records seen were within the appropriate range. The pharmacy had a process to receive drug recalls and safety alerts. The supervisor kept records of how recent alerts had been received and acted upon.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It generally maintains its equipment appropriately, so it is safe to use.

### Inspector's evidence

The pharmacy had up-to-date reference sources available to support its services. Patient records were stored electronically and there were enough terminals for the workload undertaken. Access to these was password protected. Computer screens were not visible to the public. The availability of cordless phones meant staff could move to quiet areas of the dispensary to make phone calls out of earshot of waiting customers.

There were suitable measures available to measure liquids accurately. Some of these needed descaling. Other counting equipment, which included tablet triangles, was clean.

Electrical equipment appeared to be in good working order and most portable appliances were tested regularly. But it wasn't clear how old the blood pressure meter was or if it had been tested in any way. The supervisor said she would replace this.

## 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. |