General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 116-119 Lower Galdeford, Ludlow, Shropshire, SY8 1RU

Pharmacy reference: 9010333

Type of pharmacy: Community

Date of inspection: 06/06/2019

Pharmacy context

This is a community pharmacy located in the centre of a busy market town. The pharmacy mainly dispenses NHS prescriptions. It supplies medicines in weekly multi-compartment compliance aids for people to use in their own homes and delivers medication to people who are housebound. It also sells a range of over-the-counter medicines and other health and beauty items. The pharmacy provides a number of other NHS services including Medicines Use Reviews (MURs) and the New Medicine Service (NMS). Blood pressure, blood glucose and cholesterol testing services are available. The pharmacy also provides substance misuse treatment services and a needle exchange service.

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	Pharmacy team members complete structured ongoing training to keep their knowledge up to date and get regular feedback on their performance.
		2.4	Good practice	Pharmacy team members work in a supportive environment and are able to raise concerns and provide feedback.
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 working practices are safe and effective. It keeps people's information private and maintains the records required by law. Pharmacy team members usually follow written procedures, so they work safely. And they understand how to raise concerns to help protect vulnerable people.

Inspector's evidence

The pharmacy had some systems in place to help identify and manage risk. The details of near misses were recorded by pharmacy team members. Entries were then reviewed by the pharmacist each month to identify trends. A record of this had not been made since February 2019. The pharmacist said that reviews had taken place since this date but had not been recorded, so they could not demonstrate what they had learnt as a result. Action taken in response to near miss trends and incidents were discussed and included highlighting common 'look alike, sound alike' medicines on the shelves, as well as the segregation of olanzapine. Dispensing incidents were reported electronically and captured more detailed information on what had gone wrong. Incidents were reviewed for learning points and a record was maintained as an audit trail.

A full set of written standard operating procedures (SOPs) were in place to cover tasks within the pharmacy. The procedures were regularly updated, and a record of competence was completed for each member of staff, to confirm their acknowledgement and understanding.

Weekly audits were conducted to review the pharmacy environment and processes. The supervisor then discussed the results of the audits with the team at a monthly briefing and any remedial action was taken, as appropriate.

The roles and responsibilities of team members were defined within the pharmacy procedures. Team members wore uniforms and name badges which stated their roles. A dispenser was able to discuss the activities which could and could not take place in the absence of a responsible pharmacist (RP).

The pharmacy had a complaint procedure in place, the details of which were advertised in a leaflet. People using pharmacy services were able to raise concerns and provide feedback verbally, as well as through an annual Community Pharmacy Patient Questionnaire (CPPQ). Where a concern was raised in branch, a dispenser said that this would be referred to the pharmacist.

Professional indemnity insurance arrangements were in place. The correct RP notice was conspicuously displayed behind the medicine counter. The electronic RP log was in order.

Controlled drugs (CD) registers were maintained in a paper format and were in order. Running balances were recorded and a balance check was carried out each week. A patient returned CD register was in place and destructions were signed and witnessed.

Private prescription and emergency supply records were generally in order. Although there were some

minor issues as records of private prescriptions did not always record both the date of prescription and date of supply, so they were not technically legally compliant. Specials procurement records kept an audit trail from source to supply.

The pharmacy team completed information governance training. A dispenser discussed some of the ways in which private information would be kept safe and how confidentiality was protected within the pharmacy. Confidential waste was segregated and removed for appropriate disposal and completed prescriptions were stored out of view. A privacy notice was also displayed in the retail area. Appropriate NHS Smart card use was observed on the day.

A safeguarding procedure was in place and the pharmacy team had completed some training. The pharmacist and a dispenser had completed additional level two and level one training respectively, through the Centre for Pharmacy Postgraduate Education (CPPE). A dispenser discussed some of the types of concerns that may be identified and the way in which these would be managed. The contact details of local safeguarding agencies and a reporting flow chart were available to support the escalation of concerns. A chaperone policy was in place, the details of which were displayed near to the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members work well together in a supportive environment to effectively deliver pharmacy services. They complete structured ongoing training to keep their knowledge up to date and get regular feedback on their performance. Team members are able to raise concerns and provide feedback.

Inspector's evidence

On the day of the inspection, the pharmacy team comprised of the regular pharmacist and four trained dispensers, two of whom primarily provided cover on the medicine counter. The team worked together effectively and were able to manage the workload on the day. Leave within the pharmacy was usually planned and restrictions were in place as to the number of team members who could be absent at one time, to help ensure appropriate staffing levels were maintained. During periods of absence, cover was provided through part time team members working overtime.

Sales of medication were discussed with a dispenser who outlined the questions that she would ask to help ensure that sales were safe and appropriate. Concerns were referred to the pharmacist and the dispenser provided some examples of this, where frequent requests for some high-risk medications had been identified. The dispenser also demonstrated a knowledge of some common medication interactions, which were also referred for further advice.

Pharmacy team members were appropriately trained for the roles in which they were working. Updates were received through a daily bulletin, which was cascaded to the pharmacy from head office. Ongoing training and development opportunities were also provided through an e-Learning training platform, which included a number of mandatory training modules. In addition, regular supplementary training modules covered common over-the-counter conditions and treatments. Protected training time was provided to pharmacy team members and training was tracked to ensure it was completed. Appraisals were conducted twice a year to help identify and address development needs, and to set future development goals. Career progression was supported, and a dispenser was due to be enrolled on the NVQ level 3 pharmacy technician course, after having raised this as an aspiration.

An open dialogue was observed amongst the pharmacy team. Team members asked were comfortable in approaching the regular pharmacist with any concerns or feedback. A staff survey was also in place to enable further feedback to be provided. A whistleblowing policy was in place to enable concerns to be raised anonymously, if the need occurred.

There were targets in place for pharmacy services including MURs. The pharmacist said that the targets felt manageable and confirmed that she would only carry out a service where necessary and beneficial for a patient.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy and provides a professional environment suitable for the delivery of healthcare services.

Inspector's evidence

The pharmacy’s premises were well presented, clean and tidy. Maintenance issues were escalated to head office and daily cleaning duties were completed by the pharmacy team.

The retail area was well presented and portrayed a professional appearance. A range of appropriate healthcare-based goods were available for sale and pharmacy restricted medicines were secured from self-selection. Chairs were available for use by those less able to stand and the floor space was free from obstructions.

An enclosed consultation room was accessible from the retail area. The room was clearly signposted, well maintained and fitted with equipment to facilitate private and confidential consultations.

The dispensary had adequate space for the provision of pharmacy services. Work benches were segregated for dispensing and checking with a third area reserved for the assembly of weekly compliance aid packs. Additional storage space was provided through drawers and shelving. A small number of boxes were temporarily being stored on the floor, which may at times cause a trip hazard for staff.

The pharmacy had additional storage space, a staff tearoom area and WC facilities with appropriate handwashing materials.

There was adequate lighting throughout the premises and air conditioning maintained a temperature appropriate for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible and generally manages them safely. So that people's healthcare needs are met and they receive the information they need to take their medicines properly. The pharmacy sources and stores medicines appropriately. Team members carry out some checks to make sure that medicines are suitable for supply. But these are not always as effective as they could be, and there is a small risk that they could supply a medicine after it has expired.

Inspector's evidence

The pharmacy had a step free entrance to the front. A manual door was fitted with a functioning automatic assist button, to aid wheelchair access.

Pharmacy services were advertised throughout the retail area and in a practice leaflet, which was available for selection. Additional health promotion literature was also available, and a healthy living zone was clearly displayed. A dispenser said that a person who required another service would be referred to the appropriate provider and assistance would be sought from the pharmacist, if required.

Prescriptions in the pharmacy were dispensed using baskets to keep them separate and reduce the risk of medicines being mixed up. An audit trail for dispensing and checking was maintained on dispensing labels. Prescriptions for high-risk medicines were highlighted using stickers, records of monitoring parameters such as INR readings and lithium levels were not routinely maintained. So, they may not always be able to show that patients are receiving appropriate monitoring. The pharmacy team were aware of the risks of the use of valproate-based medicines in people who may become pregnant. An audit had been conducted to highlight affected patients and the pharmacist had provided counselling. The relevant safety literature was available for supply, but alert cards were not currently being provided in line with guidance. This was discussed with the team and the relevant MHRA guidance was reinforced. Stickers were also being used to highlight prescriptions for CDs, so that they were supplied within the valid 28-day expiry date. This was also extended to schedule 3 and 4 CDs which were not subject to safe custody requirements.

Patients identified repeat medications which were required each month to help prevent over ordering. The pharmacy team sent repeat requests to the GP surgery and kept an audit trail to help ensure that unreturned prescriptions were identified. A proportion of repeat prescriptions were sent for assembly at an off-site dispensary. Data was sent electronically and was subject to a clinical and accuracy check before sending. An audit trail was kept for this process. Patients who wished to opt out of this service could do so and record of this was made on the PMR system.

Medications for weekly multi-compartment compliance aids were managed using a four-week cycle. Repeat requests were sent by pharmacy team members, who kept a record to ensure that all prescriptions were returned. Master records of medications were kept and were updated with the details of any changes. No high-risk medications were said to be placed into weekly compliance aid packs. Completed compliance aids had patient identifying labels to the front and descriptions of individual medicines were present. PILs were supplied each month.

Signatures were obtained for deliveries, with an additional delivery sheet in place for CDs. A card was left for any person not in at the time of delivery and medications were returned to the pharmacy.

The consultation room was used for the provision of other services provided by the pharmacy. The pharmacist discussed an intervention made as part of a recent MUR. Details of general prescription interventions and advice were also recorded in a designated book as an audit trail.

Stock medications were sourced through reputable wholesalers and specials from a licensed manufacturer.

Stock medications were stored in their original packaging. Internal and external liquids were segregated from solid dosage forms and liquids had the date on which they were opened recorded. A date checking matrix was in place and some checks had recently been completed. The pharmacist said that a full check had also taken place in February 2019. During random checks, several expired medicines were identified on the shelves. So there was a small risk that these could be supplied in error. Any expired medicines which were identified, were immediately removed and placed for appropriate disposal. A number of appropriate waste disposal containers were available including a cytotoxic waste bin and a sharps bin. The pharmacy was not yet compliant with European Falsified Medicines Directive (FMD) requirements. A scanner had recently been installed to prepare the pharmacy for future compliance.

CDs were stored appropriately, and random balance checks were found to be correct. Out of date and returned CDs were clearly segregated from stock.

Needle exchange kits were pre-packed. People using the service registered through the pharmacy and were provided with a card. Returns were placed directly into a sharps bin. Some members of the team had received hepatitis b vaccinations for personal protection and a needle stick injury treatment protocol was displayed.

The pharmacy fridge was fitted with a maximum and minimum thermometer and the temperature was checked and recorded each day. The fridge was within the recommended temperature range.

Alerts for the recall of faulty medicines and medical devices were received via email. The system was checked daily. Alerts were printed and actioned and an audit trail was retained for reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The team had access to paper-based reference materials and could use the internet for additional research.

A number of ISO approved, and crown stamped glass measures were available for measuring liquids. Separate measures were marked for use with CDs. Counting triangles were available for loose tablets and a separate triangle was marked for use with cytotoxic medicines. Equipment including a blood pressure monitor and blood glucose testing machine were available. Calibration records for the blood glucose testing machine could not be located on the day. This may mean that the pharmacy is not always able to show that equipment is regularly checked to ensure it is suitable for use.

Electrical equipment appeared to be in working order. Computer systems were password protected and screens were located out of public view to help protect privacy. A cordless phone was available to enable conversations to take place in private, if necessary.

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.