General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 42 Elm Grove, HAYLING ISLAND, Hampshire, PO11 9EF

Pharmacy reference: 1031755

Type of pharmacy: Community

Date of inspection: 22/09/2020

Pharmacy context

A community pharmacy set near a health centre and next to an optician. The pharmacy opens six days a week. And most people who use it live nearby. The pharmacy sells a range of over-the-counter (OTC) medicines. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy provides Medicines Use Reviews (MURs) and the NHS New Medicine Service (NMS). And it also offers winter influenza (flu) vaccinations and blood pressure checks. The pharmacy supplies medicines to people who live in a nearby care home. And it provides multi-compartment compliance packs (compliance packs) to help people take their medicines. 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 generally manages its risks appropriately. And it has written procedures to help make sure its team works safely. The pharmacy asks people using its services for their views. It keeps most of the records it needs to. And it has adequate insurance to help protect people if things do go wrong. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They review the mistakes they make. So, they can try to stop them happening again. They understand their role in protecting vulnerable people. And they keep people's private information safe.

Inspector's evidence

The pharmacy team had risk assessed the impact of COVID-19 on the pharmacy and its services. And, as a result, some of the pharmacy's services, such as paid-for health checks, were suspended. 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 pharmacy manager was aware of the need for community pharmacy employers to report instances of exposure to COVID-19 in the workplace. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed and updated centrally by the pharmacy's head office. Members of the pharmacy team were required to read, sign and follow the SOPs relevant to their roles. The pharmacy had received some supplemental guidance from its head office to help its team manage its services safely during the pandemic.

The team members responsible for making up people's prescriptions used baskets to separate each person's medication and to help them prioritise their 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 the responsible pharmacist (RP) 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 any 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 formulations of ramipril in the dispensary after the wrong one was selected a few times during the dispensing process.

The pharmacy displayed a notice that identified the RP on duty. The roles and responsibilities of the pharmacy team were described within the SOPs. Members of the pharmacy team 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 the RP. 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. People's feedback led to the pharmacy team trying to make sure a team member was free to serve at the pharmacy's counter more often.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for

the services it provided. The pharmacy team generally kept the controlled drug (CD) register in order. And the CD running balance was checked at regular intervals. But the pharmacy team occasionally forgot to record the address from whom a CD was received from. The pharmacy kept a record to show which pharmacist was the RP and when. It also kept records for the supplies of unlicensed medicinal products it made. But it didn't always record when it had received each product. The pharmacy recorded the emergency supplies it made and the private prescriptions it supplied in a paper register. And while these records were mostly in order, the team sometimes forgot to record the date of prescribing.

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 undergo training for the jobs they do. So, they can deliver safe and effective care. 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 or incentives.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacy manager, a full-time pharmacy technician, a full-time trainee dispensing assistant, a part-time trainee dispensing assistant and a part-time delivery driver. The pharmacy had a vacancy for a part-time team member. And the pharmacy didn't have a permanent resident pharmacist. So, it relied upon locum and relief pharmacists. It also relied upon its team and team members from a nearby branch to cover absences. The pharmacy manager, a locum pharmacist (the RP), the pharmacy technician and a trainee dispensing assistant were working at the time of the inspection. The pharmacy saw a large increase in its workload following the closure of a neighbouring pharmacy a few weeks ago. This meant the pharmacy team had several more prescriptions and compliance packs to make up for people. The pharmacy team was a day or so behind when the inspection took place. And members of the pharmacy team occasionally struggled to do all the things they were expected to do. But they supported each other so prescriptions were processed quickly, but safely, and people were served promptly. The pharmacy's regional manager promised that 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 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 and people with long-term health conditions to the RP. 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 occasionally felt under pressure to complete some tasks. But they were coping with 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 MURs and NMS 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 change in the way people's prescriptions were stored.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate and secure environment for people to receive healthcare. But its team don’t always have the space they need to work in when it’s busy. The pharmacy has a room where people can have private conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy had a retail area, a counter, a dispensary, a small consulting room, a stockroom, a kitchenette and a toilet. The pharmacy’s premises were bright, clean, secure and adequately presented. The retail area was narrow. The dispensary had limited workspace and storage available. The flooring was worn in places too. And some fixtures were dated. The dispensing worksurfaces could become cluttered when the pharmacy was busy. But the pharmacy team kept the pharmacist’s checking workstation clear of clutter. People tried to socially distance themselves from one another when inside the pharmacy. And they wore face coverings too. Members of the pharmacy team used the consulting room if people needed to speak to them in private. The consulting room couldn’t be locked when not in use. So, team members made sure its contents were appropriately secure when it wasn’t being used. The pharmacy had some 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 handwash and alcoholic hand sanitiser for people to use. And 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. Its team members are helpful. And they make sure that people have all the information they need. So, they can use their medicines safely. The pharmacy offers flu vaccinations and keeps records to show that it has given the right vaccine to the right person. It gets its medicines from reputable sources. And it stores most of them appropriately and securely. Members of the pharmacy team generally carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose. The pharmacy team disposes of most people's waste medicines properly too.

Inspector's evidence

The pharmacy had a small ramp leading up to its entrance. But it didn't have an automated door. So, the pharmacy team generally left the door open throughout the day. This meant that people with mobility difficulties, such as wheelchair users, could enter the building easily. The pharmacy listed the services it could provide in-store, online and in its practice leaflet. Members of the pharmacy team were helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy. 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 had appropriate resources in place for its flu vaccination service. The pharmacy had up-to-date patient group directions for this service. And people could book a flu vaccination appointment online. The pharmacy kept a record of the vaccinations it made. And this included the details of the person vaccinated and their consent, an audit trail of who vaccinated them and the details of the vaccine used. The pharmacy team made sure the sharps bin was kept securely when not in use. But the pharmacy team had to cancel some people's appointments over the past few days as a suitably trained pharmacist wasn't available to vaccinate them. 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, for example with high-risk medicines. 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 tidily within their original manufacturer's packaging. But some medicines had fallen onto the floor underneath the dispensary drawer system. The pharmacy team checked the expiry dates of medicines when it dispensed them and at regular intervals. It recorded 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, 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 needed to keep patient-returned and out-of-date CDs separate from in-date stock. But these had been allowed to build up and needed to be destroyed. Members of the pharmacy team were aware of the Falsified Medicines Directive (FMD). And they had completed some training on FMD. They could check the anti-tampering device on each medicine was intact during the dispensing process. They weren't decommissioning stock at the time of the inspection despite the pharmacy having the equipment to do so. But the pharmacy was shortly to become FMD compliant once its computer software was updated. 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. But its team sometimes put hazardous waste into the wrong bin. 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 clean.

Inspector's evidence

The pharmacy had reviewed the equipment its team needed as a result of the pandemic. It had put up a plastic screen on its counter. And markings on its floor were there to help people keep two metres apart and restrict the number of people in the pharmacy at any one time. 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 replaced the monitor its team used to take people's blood pressure once a year. And its team members cleaned and sanitised the monitor's cuff before and after 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 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.