General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Lloydspharmacy, Outpatients Pharmacy, Unit 1a, The Atrium, Thomas Guy House, Guy's Hospital,, Maze Pond Road, London, SE1 9RT

**Pharmacy reference:** 9011051

**Type of pharmacy:** Hospital

**Date of inspection:** 29/03/2022

## Pharmacy context

This pharmacy is located within a hospital in South East London and serves people from a wide geographical area. It is a busy pharmacy and it dispenses medication for outpatients and sells medicines over the counter. The inspection took place during the Covid-19 pandemic.

## Overall inspection outcome

**Standards not all met**

**Required Action:** Improvement Action Plan

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 not all met | 2.1 | Standard not met | The pharmacy does not have enough staff to operate effectively. It has a backlog of work and people using the pharmacy have very long waiting times. There is insufficient contingency planning for when team members are off work. |
| **3. Premises** | Standards not all met | 3.1 | Standard not met | The premises are cluttered and there are tripping hazards which represent a risk to staff. Workspaces are congested and trays of dispensed medicines are stored on top of each other. This could increase the risk of dispensing mistakes. |
| **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

There are issues around staffing and the tidiness of the premises, but otherwise the pharmacy generally manages its risks appropriately to make sure people are kept safe. It keeps the records it needs to by law, so it can show that supplies are made safely and legally. Team members get training, so they know how to protect vulnerable people and the pharmacy largely manages and protects people's confidential information appropriately. People who use the pharmacy can provide feedback about the pharmacy's services. But there remain ongoing staffing issues.

### Inspector's evidence

There were designated areas for tasks. The prescription hand-in and hand-out areas were clearly signposted in the retail area so that people queued in the correct section. Colour-coded trays were used to prevent transfer between people's prescriptions and allow the team to prioritise their workload. But there were large quantities of trays piled on top of each other. A 'LASA' stamp was used to highlight look-alike or sound-alike medicines. A list of these medicines was also displayed in the dispensary for team members to refer to.

Near misses, where a dispensing mistake was identified before the medicine was handed to a person, were documented and discussed with the team. One regular locum pharmacist said he tried to educate the pharmacy team whenever there was a dispensing mistake, for example, he had informed the dispensers about the difference between phosphate and calcium and how each of their channels worked. As the pharmacy had a large team it was at times difficult to arrange face-to-face meetings to discuss near misses, so team members communicated via a telephone messaging application. The near miss log was reviewed by one of the regular pharmacists who would flag up any common errors. A procedure was in place for dealing with dispensing mistakes which had reached a person (dispensing errors), which included reporting the mistake to the pharmacy's head office and to the hospital Trust. The responsible pharmacist (RP) discussed a recent dispensing mistake where a prescription for a multi-compartment compliance pack was dispensed in original packs as it had not been made clear on the prescription. The RP had spoken to the ward to make the prescriptions clearer. Healthcare assistants (HCAs) were also briefed to highlight prescriptions for compliance packs.

Standard operating procedures (SOPs) and Trust policies were in place. These had been reviewed in 2021 and due another review in 2023. Members of the team had signed individual record sheets to confirm they had been read and understood the SOPs.

The pharmacy had current indemnity insurance cover. The correct responsible pharmacist (RP) notice was displayed. Samples of the RP record were seen to be well maintained. The pharmacy did not dispense private prescriptions or provide emergency supplies. Records for unlicensed medicines could not be found. One of the pharmacists said that the batch numbers of unlicensed medicines were documented on the person's electronic medication record, but this information could only be accessed if the person's details were known. She said she would review this process to ensure that supplies could be traced back if there was a batch issue. A sample of controlled drug (CD) registers was inspected, and these were filled in correctly. The physical stock of a CD was checked and matched the recorded balance.

People were able to give feedback or raise concerns online or verbally. The pharmacy had received complaints about waiting times. The previous pharmacy manager, who was called in to support the pharmacy while the inspection was underway, believed that the company was in the process of recruiting more staff but was not entirely sure.

Members of the team had completed training on the General Data Protection Regulation and the NHS information governance toolkit. Confidential waste was collected in a separate bag and computers were password protected. A consultation room was available for private conversations. The RP described how the team tried to protect people's confidentiality, for example, by not taking out certain medicines in front of other people.

Members of the team had completed online training on safeguarding children and vulnerable adults. Team members said they would report concerns online and to the Trust. There had not been any safeguarding concerns so far.

## Principle 2 - Staffing **Standards not all met**

### Summary findings

The pharmacy does not have enough staff to operate effectively. It has a backlog of work and people using the pharmacy have very long waiting times. There is insufficient contingency planning for when team members are off work. However, team members are provided with ongoing training to help keep their knowledge and skills up to date. The pharmacy team can provide feedback and concerns relating to the pharmacy's services.

### Inspector's evidence

At the time of inspection, the pharmacy was staffed by 17 team members instead of the 30 that had been planned in. A relief pharmacist and two locum dispensers had been drafted in to help. Normally, 40 members of staff worked over four shifts: 8am to 4.30pm, 9am to 5.30pm, 10.30am to 7.30pm, and 11.30 to 8pm. Staff members included five regular pharmacists, two regular locum pharmacists, a technician, 12 dispensers and 10 HCAs as well as locum dispensers. Some staff were on annual leave, and some were off work with sickness.

Several team members said that there was insufficient staff cover for the number of items dispensed. People were provided with long waiting times, up to three hours on some days. During the inspection, the waiting time reached up to one hour and a half, and at one point, there were approximately 70 people seen waiting in the small retail area and queueing up in the corridors either side of the pharmacy, with no social distancing measures in place. People were overheard complaining about the waiting time. The RP said that normally, additional cover was arranged by the area manager, however, she was on leave. The pharmacy manager and another regular pharmacist arranged cover if the area manager was off, however, both were also on annual leave. The previous pharmacy manager was called in to attend the inspection and provide additional support to the team.

The previous pharmacy manager said that new members of staff underwent a two-week induction, during which they would complete training modules and read the pharmacy and Trust procedures. They were not planned into the rota to ensure they completed the training. Members of the team understood their roles and responsibilities. The HCAs said they would not hand out dispensed medicines or sell Pharmacy-only medicines in the absence of the RP. They were aware of higher-risk medicines and maximum sale limits for these.

One person oversaw the deliveries of non-urgent medication. The Trust target to process these was 72 hours, however, the pharmacy was currently taking five days to process them. There were large amounts of undispensed prescriptions piled in trays on the workbenches and on the dispensary floor.

The RP had done some specialist oncology training with the Trust. Members of staff had access to online training modules and completed these at least once a month to help keep their skills and knowledge up to date. Appraisals were held twice a year. Staff were happy to raise concerns to the pharmacy manager. The hospital Trust set some targets for the pharmacy, including waiting times, which the pharmacy was currently struggling to meet.

## Principle 3 - Premises **Standards not all met**

### Summary findings

The premises are cluttered, and there are tripping hazards which represent a risk to staff. Workspaces are congested and trays of dispensed medicines are stored on top of each other. This could increase the risk of dispensing mistakes. However, the premises are otherwise suitable for the pharmacy's services and are clean. People can have a conversation with a team member in a private area. But the pharmacy could do more to make sure that it keeps its confidential information and prescription-only medicines secure at all times.

### Inspector's evidence

The pharmacy was spacious with designated areas to carry out tasks. Fittings were well maintained. There was limited work and storage space for the number of items being dispensed. Workbenches were cluttered with large numbers of part-dispensed prescriptions. These were placed in trays which were piled one over the other. This could increase the chance of transfer between peoples' prescriptions. Trays were also placed on the dispensary floor. There were a number of plastic delivery boxes and other boxes on the dispensary floor, which presented tripping hazards for the team.

There was a spacious consultation room for private conversations. The room was fitted with a Digi-lock and was kept locked when not in use. There was paperwork and boxes on the chairs, including some patient-sensitive information. The pharmacist said that these would be stored more securely. A staff room was available, and this was fitted with a fridge, lockers and a microwave.

There were designated areas to hand in and collect prescriptions. These were clearly signposted. Pharmacy-only medicines were stored behind the 'hand-in' counter. Both counters were fitted with plastic screens. There were several chairs in the retail area for people wanting to wait for a service. Access into the dispensary was via a locked door just off the retail area. Several couriers were seen to enter and wait inside the dispensary, and could potentially see prescriptions and POMs. The previous pharmacy manager said that she would discuss this arrangement with the current pharmacy manager to help reduce the chance of product diversion or the sharing of confidential information.

Cleaning was shared by all team members as well as a cleaner. A Covid-19 cleaning rota was displayed in the dispensary and had been filled in by team members up until mid-March 2022.

## Principle 4 - Services ✔ Standards met

### Summary findings

People with a range of needs can access the pharmacy's services and the pharmacy has some systems in place for making sure its services are organised. People taking higher-risk medicines are provided with the information they need to take their medicines safely. Medicines are generally well managed and appropriate action is taken where stock is not fit for purpose.

### Inspector's evidence

The pharmacy was located on the ground floor of the hospital and had step-free access. Access into the hospital was via wide automatic doors. There were two entrances into the pharmacy, one on either side of the retail area. There was sufficient space in the retail area, but this sometimes became very congested with people. The pharmacy had a small seating area for people to use when they wanted to wait. A translating service was available from the hospital Trust.

HCAs confirmed the person's details and asked several questions when taking in prescriptions, including allergy status and medical history. Prescriptions were ticked by the HCAs to confirm that checks had been made. They were booked into an electronic system and people were provided with a numbered ticket. There was a screen in the waiting area which was updated with the ticket number and status of the prescription. They were then placed in colour-coded trays to allow the team to prioritise prescriptions. The trays were placed in a designated area for the pharmacist to screen. The RP checked the dose, indication, length of supply and if the medicine was in the formulary. They were then handed to a dispenser who assembled the medicines and placed them in a designated area for another pharmacist to conduct a final check. An additional check was conducted by a third pharmacist for cytotoxic medication. There was a backlog of work and trays of part-dispensed medicines were piled high on top of each other.

Two dispensers were paired up in each workstation. One dispenser generated the labels and the other assembled the medicines. This helped reduce the likelihood of mistakes. Each dispenser signed the prescription and the medicine label.

Prescriptions for CDs were handed directly to a pharmacist once they were dispensed. Dispensed CDs and fridge items were stored in clear plastic bags to allow for an additional check at hand out. Uncollected prescriptions were cleared after four weeks. Prescriptions were filed away should the person return later. The person was informed if their prescription had expired.

People taking higher-risk medicines such as methotrexate were asked for their monitoring books. These were seen to be checked by the pharmacist completing the final check. Team members were aware of checks to make when dispensing valproate-containing medicines. A valproate folder was available, and this contained leaflets and cards, which the team said they supplied to people in the at-risk group. A note of the conversation the pharmacist had with the person was also made on the person's medication record.

People were contacted to arrange delivery of their medicines. Couriers signed a log to confirm that they had collected the medicines from the pharmacy. Failed deliveries were returned to the inpatient pharmacy department who would then arrange another delivery.

Oncology medicines were dispensed in a separate section, at the back of the dispensary. Prescriptions were sent electronically from the wards and printed off by the dispenser. These prescriptions were screened by a Trust pharmacist. Members of the team were able to check if a prescription had been screened by a Trust pharmacist or not. The pharmacy team completed a 'quarantined' sheet with patient and medicine details if the medicines were urgently required before a clinical screen was done. The pharmacy would then follow up to check if the prescription had been screened, which was normally the same day. The pharmacy team would also check if an electronic 'Prescriptions Authorisation Form' was signed by the person to confirm that they were aware of the known risks of certain medicines, such as pomalidomide, lenalidomide and thalidomide. Prescriptions were placed in colour-coded baskets according to the ward and whether the medicine prescribed was cytotoxic or not. Any queries or issues were raised with the prescriber and the prescription was annotated with the relevant information. These were also raised by the regular pharmacist who attended weekly Trust meetings. The dispenser said gloves and separate counters were used when dispensing cytotoxic medicines. Patient information leaflets were supplied, and additional copies for the most common medicines were also pre-printed.

Most medicines were dispensed from the robot. Several split boxes were found on some shelves. And, various medicines were piled on top of each other, which could increase the likelihood of picking errors. The RP said that the pharmacy's storage would be reviewed. The team were able to contact the robot's manufacturer easily. Quick guides and problem shooting were displayed on the robot and most staff had received training on the robot and were able to trouble shoot minor issues. Medicines with short expiry dates were highlighted automatically by the robot. Members of the team said that the robot broke down frequently and the engineer was being called out every week. The team had to select stock manually when the robot broke down. This was sometimes time consuming as some medicines were stored on very high shelves which required the use of a ladder. The previous pharmacy manager did not know if team members involved had completed health and safety training, in particular, working at height, and said she would follow up on this. Expiry date checks for medicines stored outside the robot were done regularly and documented. Waste medicines were stored in appropriate containers and collected by a licensed waste carrier.

Medicines requiring cold storage were stored in several fridges. Each fridge was labelled with its contents to help ensure that medicines were stored in the correct fridge. Fridge temperatures were seen to be recorded daily. But the team did not always document any action taken in response to temperature deviations. The pharmacist was able to describe the process which the team followed in this instance. She said that she would ensure any action was clearly documented. Drug alerts and recalls were received electronically, printed out and filed for reference. A recall response log was also filled in to confirm that the alert had been actioned.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

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

### Inspector's evidence

The pharmacy had several glass measures and tablet counting triangles, including separate triangles for cytotoxic medicines. This helped avoid cross-contamination. There were several fridges in the dispensary. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. The dispensing robot was serviced once a year. Members of the team had access to the internet and several up-to-date reference sources.

## 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. |