General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 253 Anlaby Road, HULL, North Humberside, HU3 2SE

Pharmacy reference: 1032047

Type of pharmacy: Community

Date of inspection: 20/05/2021

Pharmacy context

This community pharmacy is on a main road leading from Hull City Centre. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy was inspected during the COVID-19 pandemic.

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	1.8	Good practice	The team members demonstrate a clear understanding of safeguarding the safety and wellbeing of children and vulnerable adults. They have a proactive approach to helping these people. And they respond promptly and suitably when concerns arise.
2. Staff	Standards met	2.2	Good practice	The pharmacy is good at providing team members with opportunities to develop their knowledge and skills. And it is good at giving team members regular feedback on their performance. This means team members benefit from identifying areas of their own practice they wish to develop to keep their skills and knowledge up to date. Team members returning to work after a long absence are well supported through the introduction of a phased return and are allocated tasks they feel confident working with.
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 identifies and manages the risks associated with its services well and especially the risks from COVID-19. The pharmacy has up-to-date written procedures that the pharmacy team follows and it completes all the records it needs to by law. The pharmacy team members respond appropriately when errors occur. They discuss details of the errors and they take appropriate action to prevent future mistakes. The team members demonstrate a clear understanding of safeguarding the safety and wellbeing of children and vulnerable adults. They have a proactive approach to helping these people. And they respond promptly and suitably when concerns arise.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The pharmacy team had completed online risk assessments to identify their personal risk of catching the virus. The pharmacy provided good support for a team member returning to work after shielding. The support included spending a couple of hours with the team during their lunch breaks to chat about their experience of working through the pandemic. And a planned phased return to work. The team member returning was offered the opportunity to work in areas of the pharmacy that had less contact with people as they became accustomed to working in the pharmacy. The team member reported this approach to their return had been supportive and had helped them feel confident about returning to work. The team had identified the steps needed to support social distancing and infection control. The dispensary was large which enabled team members to adhere to social distancing requirements. The team had access to Personal Protective Equipment (PPE) which team members wore at all times. The pharmacy had installed plastic screens in the areas where team members had face-to-face contact with people such as the pharmacy counter to provide them with extra protection. The retail area was large enough to provide space for people to be socially distanced from each other. And the floor of the pharmacy was marked to show people where to stand to support the social distancing requirements. The pharmacy employed a security guard who monitored the number of people in the pharmacy and asked people to wait outside if there were too many inside. The pharmacy manager reported most people complied with the requirements to wait outside and to socially distance from other people in the pharmacy. The pharmacy provided lateral flow tests to people as part of a national service. The team reported these were popular and many tests had been supplied. The team provided people with information on how to use the tests.

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. All team members had read and signed the SOPs signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these errors known as near miss errors. A sample of the near miss error records found the team recorded details of what had been prescribed and dispensed to help spot patterns. The team members recorded the cause of the error, their learning from the error and the actions they had taken to prevent the error happening again. The learnings detailed on the reports included recognising an error that came from rushing the

dispensing of a prescription. And the action to prevent a similar error was to slow down and do one dispensing task at a time. The pharmacy had a procedure for managing errors that reached the person known as dispensing incidents. The procedure included the team completing a dispensing incident report and the completion of a reflective statement by the team members involved. The reflective statement showed the team members learning from the incident and the steps they would take to prevent a reoccurrence of the incident. All team members were informed of the incident to raise their awareness and make any changes to prevent similar incidents such as rearranging stock were shared with the team.

The pharmacy completed a weekly check of the team's compliance with the procedures in place to support the safe delivery of pharmacy services. The checks included the work environment such as making sure the dispensing benches were uncluttered and that team members had completed their training. The outcome from the weekly checks fed into a monthly team briefing that included a review of the near miss errors and dispensing incidents. The pharmacy manager kept notes from the briefings that detailed the discussions held and who in the team had attended. A recent briefing was used to remind the team to take responsibility for completing the near miss log after the error was highlighted to them. The pharmacy had labels attached to shelves holding medicines that looked alike and sounded alike (LASA) such as amlodipine and amitriptyline. The pharmacy used these labels to prompt the team to check the medicine they selected when dispensing.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team encouraged people to provide online feedback about their experience of using the pharmacy. The pharmacy manager printed off the feedback and displayed it in the rear area of the pharmacy for all team members to see. Examples of feedback from people included comments that one team member was knowledgeable on the range of vitamins on sale and had provided helpful advice on what to take. The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacists regularly checked the balance of CDs to spot errors such as missed entries. The team knew what to do if a pharmacist had not arrived at the pharmacy and was not signed in as a RP. The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. It also displayed a separate privacy notice. The team had completed training about the General Data Protection Regulations (GDPR). The team separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. The team members had access to contact numbers for local safeguarding teams. The pharmacist had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had also completed safeguarding training and team members responded well when safeguarding concerns arose. The team members had received training on the Ask for ANI (action needed immediately) initiative. And displayed posters on the front door and the pharmacy counter along with leaflets for people to read and take away. The pharmacy manager had placed a summary of the steps to take when someone asked for ANI in the staff room and the consultation room for the team to refer to. The team had responded in a competent and assured manner to a request to use the ANI initiative.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support its services. The pharmacy is good at providing team members with opportunities to develop their knowledge and skills. And it is good at giving team members regular feedback on their performance. This means team members benefit from identifying areas of their own practice they wish to develop to keep their skills and knowledge up to date. The team members support each other in their day-to-day work. And they identify areas for improvements to the delivery of pharmacy services.

Inspector's evidence

Regular locum pharmacists covered most of the opening hours of the pharmacy. The team consisted of a full-time pharmacy manager who was a dispenser, two part-time dispensers, two part-time medicines counter assistant, one new member of the team who worked part time and a part-time delivery driver. At the time of the inspection one of the regular locum pharmacists, the pharmacy manager and the two dispensers were on duty. The pharmacy held regular team meetings. And it used a WhatsApp group to ensure all team members had up-to-date information such as new company initiatives.

The team members used online training modules to keep their knowledge up to date. The team members had protected time to complete the training. Some of the modules were compulsory and others were optional depending on the learning needs identified by each team member. The online facility provided team members with information on courses they had completed or were in the process of completing. One team member returning to practice after time away from working in pharmacy had found the range of online modules useful to help them get up to date with their knowledge and skills. The pharmacy manager had supported this team member by gradually increasing the volume of work they were involved with.

The pharmacy provided formal performance reviews for the team. This gave team members a chance to receive individual feedback and discuss their development needs. The pharmacy manager had used one of the formal reviews to ask a team member about taking on the role of pharmacy supervisor. New team members had regular one-to- one sessions with the manager when progress to date was discussed and new objectives for the following weeks were set. The pharmacy manager provided informal feedback to the team as when the occasion arose such as comments made by a person using the pharmacy.

The team held regular meetings and team members could suggest changes to processes or new ideas of working. The pharmacy manager encouraged team members to raise concerns about the pharmacy procedures and systems that may be impacted by the pandemic. And extended this to any individual worries the team members may have. The pharmacy manager felt empowered and supported to support the safe delivery of pharmacy services. The manager had introduced several changes to support the safe and effective supply of multi-compartment compliance packs including an audit trail of the supply of the packs to people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were tidy, hygienic and secure. The ceiling in the pharmacy had been refitted and secured following an incident that left the premises exposed to an infestation of rats. The manager reported that since this work was completed the pharmacy had not experienced a similar event. During the pandemic the team increased the cleaning of the pharmacy to twice a day. A rota allocated this task to all team members to ensure it was completed. The pharmacy had separate sinks for the preparation of medicines and hand washing.

The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The premises were secure and the pharmacy had restricted access to the dispensary during the opening hours. The pharmacy had a defined professional area and items for sale in this area were healthcare related. The pharmacy had a large, soundproof consultation room that was easily accessible. During the pandemic the team occasionally used this for private conversations with people and cleaned the room after use. A separate, cordoned off section provided privacy to people receiving their medication as a supervised dose.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy services are well managed so people receive appropriate care. The team reviews and updates systems to support the safe and effective delivery of the pharmacy services. And the pharmacy supports them to do this. The pharmacy gets its medicines from reputable sources and it stores and manages its medicines and appliances correctly.

Inspector's evidence

People accessed the pharmacy via an automatic door. The pharmacy had an information leaflet providing people with details of the services it offered and the contact details of the pharmacy. The team provided people with information on how to access other healthcare services when required. The team wore name badges detailing their role so people using the pharmacy knew who they were speaking to. This also meant people wishing to provide feedback about the service they'd received could name the individual team member. The pharmacy had reduced its opening hours on 18 March 2021. The team had advised people of the new opening hours in December 2020 and invited people to provide feedback on the proposal. The period of consultation ended in February 2021 and the team advertised the new opening hours so people had time to adapt to the changes. The team had liaised with healthcare organisations in the area to advise of the changes.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The pharmacy prepared the doses using an electronic pump. The pump was linked to a laptop that the team updated with the doses on receipt of a new prescription. When the person presented at the pharmacy the pharmacist selected their details from the laptop. And sent the dose to the pump to pour into a cup for the person to take. The person was observed taking their dose and then placed the empty cup directly into a dedicated medicine waste bin which was sealed after use. This meant team members were not handling the cups after the person had taken their dose. The pump was calibrated each morning before the doses were prepared to ensure the correct amount of medication was supplied each time. The team regularly cleaned the pump. The team provided a needle exchange service that was popular as there were few sites in Hull offering the service. The team pre-packed the packs supplied to people in advance. The person placed the bin containing used needles directly into an appropriate waste bag so the team didn't handle it.

The pharmacy provided multi-compartment compliance packs to help around 36 people take their medicines. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions in advance before supply. This allowed time to deal with issues such as missing items and the dispensing of the medication into the packs. The pharmacy team had worked with the team at a local medical practice to ensure a few prescriptions that were arriving on the morning of an afternoon delivery arrived a couple of days earlier to enable the team to safely dispense the packs. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list and queried any changes with the team at the medical practice. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The pharmacy received copies of hospital discharge summaries which the team checked for changes or new items.

The pharmacy manager had rearranged the dispensary to provide space to accommodate large plastic boxes that held each person's packs and the medication used for the packs. Each box was labelled with the person's name and whether they collected their packs or had them delivered. The boxes helped the team identify if a person's pack needed to be prepared. The boxes contained plastic wallets holding documents related to the person such as the medication list and a record of supply. The record of supply developed by the manager captured the dates when the packs were supplied, the number of packs supplied and who in the team had handed them over when the person collected the packs in person. This record helped the team manage queries from people about receipt of their packs and for the team to monitor if people were routinely collecting the packs. The manager used the team briefings to remind the team to complete the record of supply.

The team provided people with clear advice on how to use their medicines. The team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and had PPP information to provide to people when required. The pharmacy asked people on other high-risk medication such as warfarin about their medicines or recent test results.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample found that the team completed the boxes. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose. Due to COVID-19 the delivery driver did not ask people to sign for receipt of their medication. The driver contacted the person before delivering their medication to check that someone would be at home. This helped to reduce the number of failed deliveries and to ensure the person received their medication. The pharmacy manager had created a large space in the dispensary for storing completed prescriptions awaiting collection. This enabled the team to divide the prescriptions across a wide set of shelves. And had helped to reduce hand-out errors as the team could easily locate a prescription. The pharmacy had a text messaging service to inform people when their prescriptions or owings were ready. The team sent a follow-up text message four weeks later if the prescription had not been collected.

The pharmacy obtained its medicinal stock and appliance stock from reputable sources. It regularly checked the expiry dates on stock and the team kept a record when this had taken place. The team used a coloured sticker to highlight products with a short expiry date. The team attached a sticker to open liquids to record the date of opening and the date the product should be used by. This helped to ensure products with a short shelf life once opened were not supplied. The team recorded fridge temperatures each day and recorded the readings. A sample of records showed the readings were within the accepted range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored controlled drugs (CDs) in a CD cabinet that met legal requirements. The team received notification of alerts from the Medicines and Healthcare Regulatory agency and took appropriate action in response to the alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had a range of CE equipment to accurately measure liquid medication. The pharmacy team used two fridges to store medicines kept at these temperatures. The team used one fridge for stock and the other fridge to store completed prescriptions. Both fridges had glass doors that enabled the team to see the stock without prolong opening of the door.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The pharmacy had cordless telephones to help the team ensure telephone conversations were not overheard by people in the retail area.

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.