General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Unit 6 Asda Development, Scotter Road, SCUNTHORPE, South Humberside, DN17 2XG

Pharmacy reference: 1032519

Type of pharmacy: Community

Date of inspection: 06/02/2020

Pharmacy context

This community pharmacy is in a retail unit at a supermarket development on the outskirts of Scunthorpe, North Lincolnshire. The pharmacy sells over-the-counter medicines and it dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions through its NHS services. And it offers some private health-check services. It supplies some people with their medicines in multi-compartment compliance packs, designed to help them remember to take their medicines. And it delivers medicines to people's homes.

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	1.2	Good practice	Pharmacy team members act openly and honestly by sharing information when mistakes happen. They contribute to regular safety reviews to share their learning. And they demonstrate how they apply this learning to reduce risk.
2. Staff	Standards met	2.4	Good practice	The pharmacy has developed its open and honest approach to shared learning. Team members are enthusiastic in their roles. And they show how this shared learning approach helps to improve safety across the pharmacy.
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 the risks associated with its services. It keeps people's private information secure. And it has appropriate arrangements for managing feedback and concerns. The pharmacy generally keeps all records required by law up to date. It supports its team members learning associated with the safety and wellbeing of vulnerable people. So, they are able to act to help protect these people if required. Pharmacy team members act openly and honestly by sharing information when mistakes happen. They contribute to regular safety reviews to share their learning. And they demonstrate how they apply this learning to reduce risk.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). These covered dispensing activities, responsible pharmacist (RP) requirements and controlled drug (CD) management. The SOPs were in the process of being reviewed with quarterly updates being received by the pharmacy team. Training records confirmed some members of the team were working through learning associated with recently issued SOPs. A trainee member of the team explained what tasks could and couldn't be completed if the RP took absence from the premises. And dispensary team members were observed working in accordance with SOPs.

Workspace in the pharmacy's dispensary was limited. But pharmacy team members used the available space well. There were designated areas for labelling, assembling and accuracy checking medicines. And an additional space in a back room off the dispensary provided a protected work space for some high-risk tasks such as assembling multi-compartment compliance packs. And pre-assembling doses of substance misuse medicines against prescriptions. Pre-assembling these doses reduced workload pressure during busy periods in the pharmacy. The pharmacy stored its assembled doses in a CD cabinet appropriately.

The pharmacy engaged in the company's 'Safer Care' scheme. This included weekly rolling checks across the pharmacy environment, staffing and procedures. And weekly checks clearly identified any areas for improvement. For example, the need to keep work benches in the dispensary free of clutter. Every four weeks the pharmacy team held a Safer Care briefing. Its team members also completed some quarterly exercises to support their dispensing accuracy. The pharmacy's management team carried out periodic 'Professional Standards' audits. Results from these audits had recognised areas for improvement within the last year. And pharmacy team members had worked hard to refocus on safety and meet the areas identified for improvement. They had responded particularly well to engaging in shared learning opportunities to help reduce risk across the pharmacy.

Pharmacy team members took ownership of their mistakes by discussing them with the pharmacist and recording them in a near-miss error log. Entries did contain some learning points and identified contributory factors. The pharmacy recorded 'no near misses' in the log when no mistakes had been made in a day. It reported dispensing incidents to its superintendent's office through an electronic reporting system. It recorded details of the incidents and actions it had taken to correct the error. Team members directly involved in the incident also supported the completion of a route cause analysis and reflective exercises to help identify what they could learn from the event.

A pharmacist led near miss and Safer Care reviews every four weeks. The review process involved analysing trends in near misses and identified actions to help reduce risk. And pharmacy team members were confident at demonstrating how these actions were put into practice. For example, the team had reviewed the pharmacy's 'look-alike and sound-alike' (LASA) medicines. And had highlighted these in the dispensary. They used two clearly labelled baskets when putting away the stock order. One basket was labelled 'amitriptyline' and the other 'amlodipine'. And pharmacy team members explained stock of the two medicines being received was put into the baskets. A second member of the team then checked the contents of the basket to ensure the two medicines were not put away incorrectly. Pharmacy team members had also re-read SOPs relating to prescription hand-in processes following some identified learning. And they had begun rotating jobs more frequently to avoid the risk of complacency during the working day.

The pharmacy had a complaints procedure. And it provided details of how people could leave feedback or raise a concern about the pharmacy through a customer charter leaflet. A member of the team explained how she would manage a complaint by escalating details of the concern to the pharmacy manager or pharmacist in the first instance. The pharmacy also promoted feedback through their annual 'Community Pharmacy Patient Questionnaire'. It published the results of this questionnaire for people using the pharmacy to see. The inspection process provided some learning opportunities for members of the team as a recent concern was discussed during the visit. And the manager confirmed learning from the event would be shared with all team members to reduce the risk of a similar event occurring again.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice contained the correct details of the RP on duty. Entries in the responsible pharmacist record complied with requirements. A sample of the pharmacy's prescription only medicine (POM) register found private prescription records conformed to legal requirements. And its private prescriptions were held in an exceptionally organised manner. But the pharmacy was not recording emergency supplies of medicines made through the Community Pharmacist Consultation Service (CPCS) in the POM register as required. A discussion took place about the requirement to maintain the legal record as well as the NHS record of supply. The pharmacy's specials records complied with regulatory requirements. The pharmacy maintained running balances in its CD register and a sample of the register checked was maintained in accordance with legal requirements. The pharmacy completed weekly stock checks of the register against physical stock. A physical balance check of Shortec 10mg capsules complied with the balance recorded in the register. The register was maintained in accordance with legal requirements.

The pharmacy displayed a privacy notice. It stored people's personal information in staff only areas of the pharmacy. And a leaflet provided information to people about how it managed their private information. Pharmacy team members discussed the importance of maintaining people's confidentiality. They had completed learning associated with the General Data Protection Regulation (GDPR) and the NHS Data Security and Protection requirements. The pharmacy disposed of confidential waste through transferring it to designated bags which were sealed when full, and the contents securely disposed of via a waste management contractor.

The pharmacy had procedures and information relating to safeguarding vulnerable people. It had contact information for local safeguarding teams available. And pharmacy team members spoken to were confident when explaining how they would identify and report a safeguarding concern. Pharmacy professionals had completed level two safeguarding learning through the Centre for Pharmacy Postgraduate Education (CPPE). And other team members had completed e-learning on the subject.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services safely. It provides its team members with learning time. And its structured review processes encourages pharmacy team members to expand their knowledge and skills. The pharmacy has developed its approach to shared learning. And its team members show how this shared learning approach helps to improve safety across the pharmacy. Pharmacy team members are able to provide feedback and raise a concern at work should they need to.

Inspector's evidence

On duty during the inspection was the RP, who was a regular pharmacist, the pharmacy manager (a qualified dispenser), another qualified dispenser, a pre-registration pharmacist (pre-reg), a pharmacy technician and a trainee dispenser. In addition to the team on duty the pharmacy employed another regular pharmacist, three more qualified dispensers, two healthcare assistants and another trainee dispenser. Support during periods of absence was organised through making changes to the rota. And pharmacy team members were flexible in supporting cover for unplanned absences.

Pharmacy team members worked well together and supported each other's training requirements. A dispenser was enrolled on an NVQ level three course in pharmacy services. And she received some protected time and support during working hours to assist her in completing this learning. The pre-reg regularly spoke with both pharmacists to discuss her training plan. She was enthusiastic and expressed she felt well supported in her role by all team members. As well as attending organised pre-reg learning events, the pre-reg also recognised the importance of learning from each member of the team. All pharmacy team members completed continual learning to support them in their roles. Examples of safeguarding training, sepsis awareness training and monthly 'knowledge checks' were provided during the inspection. Pharmacy team members were also supported through structured appraisals with their line manager.

The pharmacy did have some targets. These related to sales, services, training and customer experiences. The RP explained how targets were monitored. And he provided examples of how he applied his professional judgement when undertaking services such as Medicines Use reviews (MURs). Pharmacy team members also supported pharmacists in meeting service targets by identifying eligible people for services during the dispensing process. The pharmacy had a whistleblowing policy in place. And it displayed details of a confidential helpline for pharmacy team members. Pharmacy team members on duty confirmed they felt supported and were able to provide feedback openly. They were also aware of how to escalate a concern or feedback about the pharmacy should they need to.

Pharmacy team members shared learning through regular Safer Care briefings. The quality of information recorded as part of this shared learning process had increased significantly over recent months. The pre-reg provided an oversight of actions from a recent Safer Care briefing. And pharmacy team members could demonstrate how these actions were working in practice. For example, highlighting key information on prescription forms during the dispensing process. And using a LASA stamp on prescription forms to prompt additional checks when dispensing amitriptyline and amlodipine to reduce the risk of a mistake occurring. There was evidence of pharmacy team members discussing

Safer Care case studies. And a pharmacist had enlisted the support of the pre-reg during the most recent safer Care review to present a local case study following trend analysis of the near miss record. The case study focussed on a near miss involving two LASA medicines, hydroxyzine and hydroxychloroquine. The local case study had prompted the team to explore what each medicine was used for. And what the potential harm could have been had the wrong medication been dispensed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and maintained to the standards required. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was professional in appearance and it was secure. The public area was fitted with wide spaced aisles and was accessible to people using a wheelchair or pushchair. There was seating provided for people waiting for prescriptions or services. The pharmacy had a sign-posted consultation room to the side of the public area. This room allowed staff to maintain confidentiality when providing counselling about medicines and when holding private discussions with people.

The dispensary was small for the activities taking place. But pharmacy team members managed the space effectively. For example, they had created some additional storage space on dispensary shelving for holding baskets of assembled medicines awaiting accuracy checks. This helped to keep work benches free from clutter. An additional dispensing bench in the back room of the pharmacy provided a relatively distraction free area for completing tasks associated with CDs and the multi-compartment compliance pack service. This room was also a store area. For example, designated shelves in the room were used to store overflow retail stock and dispensary sundries. And a purpose-built shelving unit was used to store paperwork and files. Staff kitchen facilities were provided in the corner of this room. And staff toilet facilities led off the back of the room.

The pharmacy was heated by fan heaters and lighting throughout the premises was sufficient. Pharmacy team members completed all cleaning tasks. And the pharmacy was generally clean. But the main computer monitor in the dispensary was marked and required cleaning. Designated handwashing sinks were equipped with antibacterial hand wash and paper towels. Pharmacy team members reported maintenance concerns to their head office. And there were no maintenance concerns outstanding. The owners had acted to replace the pharmacy’s main dispensary drawer unit following some health and safety concerns raised by team members.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It has procedures to help identify and manage the risks associated with providing its services. And it stores and manages it medicines safely and securely. Pharmacy team members provide information to people about the medicines they are taking. And they show how they manage services professionally through following the pharmacy's procedures.

Inspector's evidence

The pharmacy was advertised on the supermarket's roadside signage. It was accessed through a simple push/pull door at street level. Window displays advertised details of its opening times and services clearly. A bright and informative healthy living display was promoting the warning signs of sepsis infection on the day of inspection. The health promotion area also provided names of each pharmacy team member who worked at the pharmacy. Pharmacy team members were knowledgeable about signposting requirements. And could explain how they would refer a person to another pharmacy or healthcare service if the pharmacy couldn't provide a service or dispense a medicine.

The pharmacy had an up-to-date protocol for the supply of medicines through the minor ailments service. And it had up-to-date and legally valid patient group directions (PGDs) for the supply of emergency hormonal contraception (EHC) and flu vaccinations. It also had procedures for the other services provided such as Medicines Use Reviews (MURs) and its health check services. And team members had read and signed these procedures. The RP explained how he was able to support people in managing their health and wellbeing when providing services.

Pharmacy team members demonstrated an understanding of the risks associated with dispensing high-risk medicines. One member of the team discussed the requirements of the valproate pregnancy prevention programme (PPP). And was aware of the need to supply valproate warning cards when dispensing a prescription to a person in the high-risk group. The team had engaged in high-risk medicine audits through the NHS Pharmacy Quality Scheme (PQS). And demonstrated a sound understanding of the monitoring checks associated with dispensing high-risk medicines such as warfarin, lithium and methotrexate. The RP confirmed verbal counselling took place. But the details of these conversations were not recorded on people's medication records. Pharmacy team members highlighted prescriptions for CDs and the pre-reg explained how this prompted safety and legal checks of the prescription prior to handing out assembled medicines. And it reduced the risk of a CD prescription not being entered into the CD register following handout of the medicine.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. And it had a system for monitoring its owings to help ensure stock concerns were regularly chased with its wholesalers. The team used the original prescription throughout the dispensing process when the owed medicine was later supplied. It maintained digital delivery audit trails for the prescription delivery service. People were asked to sign an electronic point of delivery (EPOD) device to confirm they had received their medicine. The pharmacy had an audit trail for the prescriptions it ordered from the surgery. And a team member demonstrated how each person on this service had a care plan. This provided an audit trail of which

prescriptions were ordered. And it allowed the team to chase missing prescriptions or raise queries with surgery teams.

Each person receiving their medicines in multi-compartment compliance packs had individual profile sheets with details of their prescription regimen clearly recorded. The pharmacy team also used the person's electronic medication record to support management of the service. A pharmacy team member demonstrated how the sheets were used to record queries and changes to medication regimens. There were no assembled packs waiting for collection or delivery on the day of inspection. But a pharmacy team member provided an example of backing sheets which would be attached to packs. The sheets contained descriptions of the medicines inside the pack. And the team member explained these would be checked and updated if needed during the dispensing process. The team member also indicated where team members would sign packs to provide a dispensing audit trail and confirmed the pharmacy supplied patient information leaflets at the beginning of each four-week cycle of packs.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members had some awareness of the Falsified Medicines Directive (FMD). They had completed e-learning associated with FMD. And understood the importance of checking tamper proof packaging when receiving medicines. The pharmacy had a scanner fitted. But this was not yet in use.

The pharmacy stored Pharmacy (P) medicines in Perspex units to the side of the healthcare counter. There was clear signage on the units to indicate that staff assistance was required when purchasing any of the medicines within the cabinets. The pharmacy stored medicines in the dispensary in an organised manner and within their original packaging. It held CDs in secure cabinets. Medicines inside the cabinets were kept in an exceptionally organised manner. The use of clearly labelled baskets assisted with this organisation. Assembled medicines were stored in clear bags and were brought to the attention of the RP prior to handout. There was designated space for storing patient returns, and out-of-date CDs. The pharmacy’s fridges were clean and stock inside was stored in an organised manner. It stored assembled bags of cold chain medicines in clear bags within one of the fridges. This prompted additional checks prior to handout. Temperature records confirmed they were operating between two and eight degrees Celsius as required.

The pharmacy had a date checking matrix displayed in the dispensary. But this was not kept up to date with the checks the team explained they had completed. The matrix had last been completed in December 2019. A random check of stock in the dispensary found no out-of-date medicines. And the pharmacy team attached stickers to liquid medicines to highlight the date of opening. Short-dated medicines were identified prominently with red stickers. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste. It had increased its storage capacity for managing medication waste in response to the amount of waste it received from people. The pharmacy received drug alerts and medicine recalls through email. And it printed alerts and kept an audit trail of the actions taken to check an alert. All alerts were up to date at the time of inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It monitors its equipment to ensure it remains in safe working order. And pharmacy team members act with care by using the pharmacy's facilities and equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for children. Pharmacy team members could access additional resources through the intranet and internet. The pharmacy's computer system was password protected. And information on computer screens was protected from unauthorised view through the layout of the premises. The computer screen in the consultation room was switched off between use. Pharmacy team members on duty had working NHS smart cards. The pharmacy stored assembled bags of medicines in drawers behind the healthcare counter. It stored some larger bags to the side of the drawers. Information on bag labels could not be read from the public area of the pharmacy. Pharmacy team members used cordless telephone handsets. This meant they could move out of ear-shot of the public area when having confidential telephone conversations with people.

The pharmacy had a range of clean, crown stamped measuring cylinders for measuring liquid medicines, including separate cylinders for use solely with methadone. Team members checked a set of counting scales in the dispensary for accuracy each time they were used. And a range of counting triangles was also available for counting tablets. The pharmacy stored its counting triangle for cytotoxic medicines in a bag to prevent cross contamination with other equipment. The team had annotated the pharmacy's blood pressure machine with the date it had been put into use and a date it was due for replacing. The team maintained the pharmacy's glucometer through regular calibration checks which it recorded. Equipment to support the needle exchange service was stored securely. Stickers on the pharmacy's electrical equipment indicated portable appliance checks had been completed in May 2019.

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.