General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Duke Medical Centre, 26 Talbot Road, SHEFFIELD, South Yorkshire, S2 2TD

Pharmacy reference: 1039373

Type of pharmacy: Community

Date of inspection: 15/01/2020

Pharmacy context

This is a community pharmacy next to a GP surgery close to the city centre of Sheffield. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as the New Medicines Service and medicines use reviews. The pharmacy provides a flu and human papillomavirus (HPV) vaccinations service. It supplies some medicines in multi-compartment compliance packs to people living in their own homes. And it provides a home delivery 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	The pharmacy encourages and supports its team members to complete regular training to help them keep their knowledge and skills refreshed and up to date. It achieves this by providing its team members with protected training time and regular performance appraisals.
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 the services it provides to people. And it has a set of written procedures for the team members to follow. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The team members openly discuss and record any mistakes that they make when dispensing. So, they can learn from each other. They discuss how they can improve, and they make changes to minimise the risk of similar mistakes happening in the future. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had a small retail area and a small dispensary which was to the side of the pharmacy counter. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The dispensary was enough distance away from the retail counter to allow the team members to discuss confidential matters without being overheard by people in the retail area. The pharmacy was busy at the time of the inspection with several people bringing prescriptions to be dispensed and people asking for advice from the team.

The pharmacy had a set of written standard operating procedures (SOPs). The pharmacy's superintendent pharmacist's team reviewed the SOPs every two years. Some of SOPs had documented review dates of August 2019. The SOPs were being reviewed and updated in phases. And there were some newly issued SOPs seen which had replaced some of the older ones. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team. The team members had read and signed each SOP that was relevant to their role.

There was a process in place to highlight near miss errors made by the team when dispensing. And the details of each near miss error were recorded onto a paper near miss log by the team member who made the error. The team members recorded the date, time and type of the error. And the reason why the error might have happened. The most commonly recorded reasons were 'rushing' or 'not concentrating'. The team were unable to be specific as to why they were rushing or not concentrating. But they described some basic steps they took to help them stop rushing the dispensing process. These included making sure they gave more realistic waiting times to people who were waiting for their prescriptions to be dispensed. The team members demonstrated how they had separated medicines to reduce the risk of them being selected in error. For example, the separation of Spiriva and Spiolto inhalers. They showed the inspector how the two inhalers were packaged very similarly and had similar names. And so, they were at a greater risk of being mixed up during the dispensing process. The pharmacy had a process to record dispensing errors that had been given out to people. And copies of the reports were kept in the pharmacy for future reference. The report included details of who was involved, what happened and what actions they pharmacy completed to prevent a similar error from happening again. The most recent report detailed an occasion where the pharmacy had supplied a person hydralazine instead of hydroxyzine. The pharmacy reported it had separated the two items on the dispensary shelves. But they had since returned to their original location.

The pharmacy completed a check on professional standards over a four-week cycle. They focused on a

specific area of the pharmacy each week. For example, week on involved looking at the pharmacy environment. The checks were designed to make sure the pharmacy was following set processes and highlighted any areas where it could make improvements. The pharmacy was up to date with the checks and regularly held a 'Safer Care' meeting which involved all the team members. And they talked about near miss errors and dispensing incidents during the meetings.

The pharmacy displayed the correct responsible pharmacist notice. And it was easy to see from the retail area. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn't do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist.

The pharmacy had a formal complaints procedure in place. And it was available for people to see via the pharmacy's customer charter leaflet which was available in the retail area for self-selection. The pharmacy collected feedback through and annual patient satisfaction survey. The team members discussed the findings of the survey with each other. But they were unable to give any examples of improvements made to the pharmacy following the feedback.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept CD registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. A physical balance check of a randomly selected CD matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team members were aware of the need to keep people's personal information confidential. They had all undertaken General Data Protection Regulation (GDPR) training. And there was an information governance booklet of guidance kept in the dispensary for the team members to access if they needed any further information. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor.

The responsible pharmacist had completed training on safeguarding vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). And when asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. Two team members explained how they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage or report a concern and the contact details of the local support teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload and to help ensure people receive a high-quality service. And they feel comfortable to raise professional concerns when necessary. The pharmacy encourages and supports its team members to complete regular training to help them keep their knowledge and skills refreshed and up to date. It achieves this by providing its team members with protected training time and regular performance appraisals.

Inspector's evidence

At the time of the inspection, the responsible pharmacist was the pharmacy manager who had been working at the pharmacy for several years. He was well supported by a locum pharmacist, three full-time NVQ level two qualified pharmacy assistants, a part-time NVQ level two pharmacy assistant and a full-time trainee pharmacy assistant. One of the full-time pharmacy assistants was also the pharmacy's supervisor. The pharmacy also employed a part-time delivery driver who collected prescriptions from local surgeries and delivered medicines to people's homes. The pharmacy had double cover on Wednesdays and Thursdays to help the pharmacist complete services such as flu and HPV vaccinations. The pharmacist felt he had enough team members to ensure the pharmacy provided a high quality of service. He explained he could always speak to the pharmacy's area manager or cluster manager if he felt he needed additional staffing support. And there had been occasions when the pharmacy had used staff from other Lloyds pharmacies within the local area. The team members often worked additional hours to cover absences and holidays. The team made sure that no more than two team members were absent at any one time. And they did not take time off in the run up to Christmas as this was the busiest time of the year for the pharmacy. The team members were observed managing the workload well and had a manageable workflow. The team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various e-learning modules. The modules covered various topics, including mandatory compliance training covering health and safety and various other processes. Other modules were based on various healthcare related topics and could be chosen voluntarily in response to an identified training need. The team members received protected training time during the working day to complete the modules. So, they could do so without any distractions. The team members had recently completed training on topics such as pain relief, smoking cessation and the sale of CBD oil. And they completed a short quiz at the end of each module to test their understanding. If they did not pass the quiz, they were given additional training time or received some one-to-one support with the pharmacist. The team members received a performance appraisal twice a year. The appraisals were an opportunity for the team member to discuss which aspects of their roles they enjoyed and where they wanted to improve. One team member had recently discussed wanting to be enrolled on an accuracy checking training course. They could also take the opportunity to give feedback to improve the services the pharmacy offered. But no examples were given.

The team members felt comfortable to raise professional concerns with pharmacist or the pharmacy's cluster manager, or area manager. The pharmacy had a whistleblowing policy. And so, the team members could raise concerns anonymously. The team was set various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and professional in its appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was small, but it was kept tidy and well organised during the inspection and the team used the bench space well to organise the workflow. Floor spaces were kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member. The room was smart and professional in appearance and was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. The pharmacy manages its services appropriately and delivers them safely. Such as the flu and HPV vaccination services. It provides medicines to some people in multi-compartment compliance packs to help them take them correctly. And it suitably manages the risks associated with this service. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately. The team members identify people taking high-risk medicines. And they support them to take their medicines safely and give them appropriate advice.

Inspector's evidence

The pharmacy was accessible from some steps and ramp outside. So, people with wheelchairs and prams could easily access the building. The pharmacy advertised its services and opening hours in the main window. It stocked a wide range of healthcare related leaflets in the retail area, which people could select and take away with them. For example, leaflets about diabetic footcare, smoking cessation and dementia. And it used a small section of the retail area to promote healthy living advice. The team had access to the internet to direct people to other healthcare services. The pharmacy could supply people with large print dispensing labels if needed. And there was a hearing loop for people who used hearing aids.

The team members regularly used stickers to attach to bags containing dispensed medicines, and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. And they were of different colours to help the team separate the prescriptions and to improve workflow. For example, blue baskets were used for prescriptions for home delivery. The team members attached 'CD' stickers to the dispensed medicines bags. And they wrote the last day the CDs could be handed out to people on the stickers. This system helped prevent the team members from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept records of the delivery of medicines it made to people. The records included a signature of receipt. So, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy supplied medicines in multi-compartment compliance packs for a small number of people living in their own homes. The pharmacy had previously supplied the packs for a larger number of people. But following a risk assessment, most of the packs were recently transferred to another local Lloyds store. The main reason for this was because there was not enough space in the dispensary to suitably manage the workload. The pharmacy managed the workload for dispensing the packs across four weeks. The team was responsible for ordering people's prescriptions. And this was done in the third week of the cycle. Which gave the team members a week to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They did not order any medicines that were

not able to be dispensed in the packs. For example, any creams or eye drops. The responsibility of ordering these types of medicines was left with the person. The team members explained this helped them reduce medicinal wastage. They dispensed the packs in a segregated part of the dispensary. This was to minimise distractions. And they kept all documents related to each person on the service in separate folders. The team members used progress charts. The charts helped the team visually assess the progress of the dispensing. The documents included master sheets which detailed the person's current medication and time of administration. The team members used these to check off prescriptions and confirm they were accurate. The team members held all prescriptions, documents and stock in separate baskets during the dispensing process. They kept records of conversations that they had with people's GPs. For example, if they were told about a change in directions or if a treatment was to be stopped. And they kept a record of the person they spoke to. So, an audit trail was in place. They supplied the packs with information which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used green 'pharmacist' stickers to attach to people's dispensed medicines bags. The stickers were a reminder to discuss the person's treatment when handing out the medicine. For example, the pharmacist checked people's INR if they were prescribed warfarin. And if they had been having regular blood tests. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. No one had been identified. The pharmacy dispensed insulin in clear bags. This helped the team members and the person collecting the insulin to complete a final visual check.

The pharmacy offered flu and HPV vaccination services. Both services were popular with the local community. The pharmacist had completed appropriate training to provide the services and evidence was seen. The pharmacist managed the services on an appointment basis. And the appointments were generally booked when the pharmacy had another pharmacist working. This allowed one pharmacist to administer the vaccinations while the other managed the dispensing workflow. The pharmacist first completed a brief consultation with each person who wanted a vaccination. And the vaccinations were administered in the consultation room. The pharmacist kept several items in the consultation room to help him manage the service safely. These included a sharps bin, gloves, alcohol gel, plasters and cotton wool.

The pharmacy stored pharmacy medicines (P) behind the pharmacy counter to avoid self-selection and so the pharmacist could oversee sales and advice given. The pharmacy stored its medicines in the dispensary tidily. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check. And the team members used alert stickers to help identify medicines that were expiring within the next six months. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received some information on how to follow the directive. The team members were unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts

were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinets were secured and of an appropriate size. The medicines inside the fridge and CD cabinets were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. And there were separate cylinders used to dispense methadone. The team members used tweezers and rollers to help dispense multi-compartment compliance packs. A blood pressure monitor was kept in the consultation room. And it was due to be replaced every two years. The fridges used to store medicines were of an appropriate size. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private.

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.