General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 39 High Street, Yeadon, LEEDS, West Yorkshire, LS19 7SP

Pharmacy reference: 1039732

Type of pharmacy: Community

Date of inspection: 08/05/2019

Pharmacy context

The pharmacy is in the centre of Yeadon. A large town in West Yorkshire. The pharmacy dispenses NHS and private prescriptions. It provides medication in multi-compartmental compliance packs to help people take their medicines. And it provides a travel vaccination 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	1.2	Good practice	The pharmacy team members respond well when errors happen. They are good at discussing what happened and they act to prevent future mistakes.
		1.7	Good practice	The pharmacy has good arrangements to protect people's private information. And the team have training and are knowledgeable on how to safeguard people's confidential information.
2. Staff	Standards met	2.2	Good practice	The pharmacy team gives support to new members. Who have opportunities to access a range of training experiences. Team members receive feedback on their performance and have opportunities to complete more training. So, they can keep their skills and knowledge up-to-date.
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. And it keeps the records it needs to by law. The pharmacy has written procedures that the team follows. The pharmacy has good arrangements to protect people's private information. And the team have training and are knowledgeable on how to safeguard people's confidential information. The pharmacy team members respond well when errors happen. And they discuss what happened and they act to prevent future mistakes. People using the pharmacy can raise concerns and provide feedback. The pharmacy team has training, guidance and experience to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.

Inspector's evidence

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. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read and signed the SOPs to show they understood and would follow them. The pharmacy had up to date Indemnity insurance.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. This helped to ensure they picked the correct item. 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. And the team member involved recorded their own error. If they were not on duty the pharmacist started the record. And then asked the team member to complete it when they were next on duty. A sample of records looked at found that details included reasons for the mistake, learning and actions to prevent the same error. For example, one entry captured the error caused by the person breaking off to answer the telephone. The team member involved stated they would finish dispensing before breaking off to do other tasks. And to double check their own work before passing to the pharmacist to check.

The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. The team printed the reports for reference. The team also completed a root cause analysis and reflective statement. The records captured reasons for the error and learning from the mistake. And the actions taken to prevent similar errors. Following a delivery error when one person had received another person's medication. The team identified the cause as they had placed the wrong delivery label on the delivery sheet. This happened as the team had re-printed the label but chosen the wrong patient. The team now check re-printed labels with the prescription before attaching them to the delivery sheet. The team had also printed a copy of the SOP for the preparation of deliveries. And highlighted key sections. The team members signed the back to show they'd read the SOP again. The pharmacy team reviewed the error records to spot patterns. And to take appropriate action. A recent review reminded the team to not always use rushing as a reason for dispensing errors. To be more specific with the cause of the error.

The pharmacy used a weekly checklist known as SaferCare to track compliance with safe practice. One of the dispensers led on this. Key points from the SaferCare checklists fed into the monthly SaferCare briefing. The pharmacy kept notes from the briefings and listed the team members attending. The dispenser passed on information to team members not at the briefing. And ensured everyone read and signed the meeting notes. Recent briefings included reminding the team members to clearly mark split boxes. And to check the multi-compartmental compliance packs for delivery against the delivery list to ensure they'd placed the correct person's medicines into the delivery box. The dispensary contained a SaferCare notice board. This provided key points from the SaferCare process and case studies sent from Lloyds Head Office. The pharmacy completed an annual patient safety report. The latest one included the team members separating medication that looked and sounded alike (LASA). The team found that this produced a reduction in the number of errors with LASA items.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And the pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. And it displayed them in the pharmacy. Positive comments included the service provided by the team.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The pharmacy had an information governance (IG) folder. This contained several company documents for the team to meet IG requirements. And a log evidenced that the team had completed IG training in 2018 and 2019. The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. The pharmacy displayed a privacy notice in line with the requirements of the General Data Protection Regulations. 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 team separated confidential waste for shredding offsite.

The pharmacy had a safeguarding policy. The team members had signed to show they had read the policy. The team had access to contact numbers for local safeguarding teams. The pharmacist and pharmacy manager had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The delivery driver completed this training in 2019. The team took appropriate action in response to safeguarding concerns. The driver reported concerns to the team about people they delivered to. This included finding unused multi-compartmental compliance packs. In such instances the team spoke to the GP. And reviewed the person’s medication or frequency of supplying the packs from monthly to weekly.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has the right qualifications and skills for the roles and services provided. The pharmacy team gives support to new members. Who have opportunities to access a range of training experiences. Team members receive feedback on their performance and have opportunities to complete more training. So, they can keep their skills and knowledge up-to-date. The team members discuss what they can improve or agree new roles to help deliver the pharmacy's services. The pharmacy team make suggestions and get involved in improving services. The pharmacy team members are comfortable sharing their errors and learning from their own and other people's mistakes.

Inspector's evidence

The branch pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of a pharmacy technician, who was also an accuracy checking technician (ACT) and the pharmacy manager, five qualified dispensers known as healthcare partners, and a new member of staff who started three weeks earlier. The team rotated jobs throughout the day such as doing the walk-in prescriptions. This helped to keep the team focused and maintain their skills. The pharmacy manager was also a cluster manager providing support to local branches.

The new member of the team only worked on a Saturday. And in a conversation with one of the dispensers asked for more experience. The dispenser advised attending for a day or two over the school holidays. So, they'd get to experience more than they did on a Saturday, as the pharmacy was quieter than during the week. And they could learn from the other team members.

The pharmacy provided extra training through e-learning modules. The team had to complete the modules within a set time. The team members had protected time to complete the training. And they supported each other to do this. Recent topics included a new Syndol product and the changes to pregabalin and gabapentin. The pharmacy provided administration charts to help people know when to take their medication. But only a few team members knew how to do this. The other dispensers were being trained to support the service. The pharmacy provided performance reviews to the team. So, they had a chance to receive feedback and discuss development needs. The pharmacist asked about prescriber training. So, they could provide extra services. One of the dispensers was the supervisor and spent time in the retail area or doing tasks such as cashing up. This dispenser had asked the pharmacy manager for more time in the dispensary. So, they could keep their skills in this area up to date. This was agreed.

The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic with separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The pharmacy had notices next to the sinks describing effective hand washing techniques. There was enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a sound proof consultation room for private conversations. The team regularly used the room. And had cordless telephones for confidential conversations.

The premises were secure. The pharmacy arrangements for storing medicines for sale meant that the team may not be able to intervene when people attempted to access these items. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. The pharmacy manages its services well. It keeps records of prescription requests and deliveries it makes to people. So, it can deal with any queries effectively. The pharmacy gets its medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via a small step and through an automatic door operated with a press pad. The design of the dispensary meant that it was difficult to see people entering the pharmacy. And presenting at the pharmacy counter. So, a buzzer in the dispensary alerted the team to someone coming through the door. The pharmacy leaflet contained details of the services offered, the opening times and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And used a section of the pharmacy to promote health living advice. This included oral health and dementia. The team wore name badges detailing their role.

The pharmacy was part of a local inhaler technique service. The service included checking the person's understanding of how to use the inhaler and that they could show this. The pharmacist had discussed the service with the GP practice-based pharmacist. And asked them to refer anyone suitable to the service. The pharmacist linked this service with others such as medicine use reviews (MURs). The pharmacist had found several people who needed a different inhaler. The pharmacy provided the travel vaccination service against prescriptions issued by Lloyds online prescribing service. The prescription was generated after an online consultation with the prescriber. And after the person had chosen the pharmacy they wanted their prescription dispensed at, a notification was sent to the pharmacy. The pharmacist rang the person to arrange an appointment and ordered the vaccine. The pharmacy offered a blood pressure checking service which was popular. All the dispensary team were trained to provide this service. The team gave the person appropriate health advice and directed them to the GP when required.

The pharmacy provided multi-compartmental compliance packs to help people take their medicines. People received monthly or weekly supplies depending on their needs. Two of the dispensary team managed the service. And got support from others in the team. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the trays. The team kept prescription ordering slips in sections marked with the week it was due. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team.

The team used a section of the main dispensary to dispense the medication. The pharmacy had several rooms upstairs that the team could use for this activity. The team had raised this with the company. As it would provide more space and be away from the distractions of the main dispensary. But to date no plans had been made.

The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets. Following an error with the wrong description on a pack the team members now checked the medication used against the description on the backing sheet. These checks were done at all stages of dispensing and checking the packs. And the team amended the description when necessary. The pharmacist when doing the final check also ensured the descriptions matched the contents of the pack. The team member dispensing the packs didn't break off from this task until they completed it.

The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge for changes or new items. And it shared this with the GP with a request for prescriptions when required. The team members asked for prescriptions so new packs could be dispensed and supplied when changes occurred. The team used the medication list to record whether the person ordered items such as inhalers or when there had been changes to the medication. The pharmacy had folders labelled weeks one to four. These held the medication lists and other documents such as the discharge summary. The folders had a list of people due their medication that week.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the doses before supply. This helped to reduce the workload pressure of preparing when the person presented. The pharmacy stored the doses in the controlled drugs cabinet in clear bags labelled with the person's details. This separated people's doses, reducing the risk of picking errors. The team entered the instalment details as soon as the prescription arrived. The team kept the prescriptions in a dedicated folder in alphabetical order. Completed prescriptions were immediately claimed and filed. This was in place to reduce the risk of a person's prescription going missing or supplying against old prescriptions.

The pharmacy provided a repeat prescription ordering service. The team kept a record of the request to help identify missing prescriptions. The team ordered prescriptions a week before the supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy monitored patients on high risk medication such as warfarin. And recorded information on the electronic patient medication record. The pharmacy had completed checks of people prescribed valproate. This was in response to the Pregnancy Prevention Programme (PPP). The check found no-one who met the criteria of PPP. The pharmacy had the PPP pack containing information cards and leaflets to pass on to patients. But the sections holding the valproate products didn't state where to find the pack.

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 CD and 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 had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The team used a stamp on the prescription to record when the pharmacist had clinically checked the prescription. This enabled the ACT to complete their check. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The team rang people to inform them that the outstanding item was ready to collect. The pharmacy kept a record of the delivery of medicines to people. This included an electronic signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 21 April 2019. The team used a sticker to highlight medicines with a short expiry date. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of Sytron liquid with three months use once opened had a sticker stating the date of opening was 16 April 2019. And to not use after 14 July 2019. The pharmacy had medicinal waste bins to store out of date stock and patient returned medication. And it stored out of date and patient returned controlled drugs (CDs) separate from in date stock in a CD cabinet that met legal requirements. The pharmacy recorded patient returned CDs and used denaturing kits to destroy them.

The pharmacy had 2D scanners and it was waiting for a computer update to meet the requirements of the Falsified Medicines Directive (FMD) that came out on 9 February 2019. The pharmacy had no procedures to cover FMD. And the team hadn't received any training. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and 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 used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. The fridge had a glass door to enable the team to view stock without prolong opening of the door.

The computers were password protected and access to peoples' records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The team kept the computer in the consultation room locked when not in use.

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.