General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 531 Tong Road, Farnley, LEEDS, West Yorkshire, LS12 5AT

Pharmacy reference: 1039827

Type of pharmacy: Community

Date of inspection: 26/06/2019

Pharmacy context

The pharmacy is in a small parade of shops in the Leeds suburb of Farnley. The pharmacy dispenses NHS and private prescriptions. And it sells a range of over the counter medicines. The pharmacy supplies medicines in multi-compartmental compliance packs to help people take their medication. And it delivers medication to people's homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	2.4	Good practice	The team members have identified internal and external factors contributing to increased workload and work pressures within the team. And with the help and support from the pharmacy supervisor and others they have made changes and put plans in place to improve their efficiency. And reduce their workload pressure. So, they can help provide a safe and effective delivery of services.
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy stores large boxes containing medicines on the floor in a narrow corridor that the team use as a fire escape. This could risk the team's safety.
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 generally 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. And it has appropriate arrangements to protect people's private information. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and they act to prevent future mistakes. But they don't always fully complete the records or review the errors. This means the team may not have the information it needs to effectively identify patterns and help reduce 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 members had read the SOPs and signed the signature sheets to show they understood and would follow the SOPs. The pharmacy had up to date indemnity insurance.

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. One of the dispensers encouraged the other team members to record their errors. And explained to them that this information was used to help support safe dispensing. A sample of error reports looked at found that they did not provide details of what had been prescribed and dispensed to help spot patterns. The entries usually included the reasons for the mistake, the learning and actions to prevent the same error. But, these were often the same. For example, slow down, read the prescriptions or need more staff. So, didn't show individual reflection. The team had not recently reviewed these records to spot patterns and make changes to processes. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. The team printed the reports for reference. And completed a root cause analysis and reflective account. The pharmacy used a weekly checklist known as SaferCare to track compliance with safe practice. One of the team led on this. And they shared the results with the team. Key points from the SaferCare checklists fed into the monthly SaferCare briefing. The pharmacy kept notes from the briefings and usually listed the team members who attended. A recent briefing alerted the team to medicines with similar packaging. And asked the team to tidy the drawers and complete the date checking record.

The pharmacy had information on how to make a complaint. 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 retail area for people to see.

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. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found 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. The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data it kept and how it complied with legal requirements. And it displayed a privacy notice in line with the requirements of GDPR. The team separated confidential waste for shredding offsite.

The pharmacy had a safeguarding policy. The team members had signed a signature sheet to show they had read the policy. The team had access to contact numbers for local safeguarding teams. The pharmacist and accuracy checking technician 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 team took appropriate action in response to safeguarding concerns.
concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has team members with the qualifications and skills to support the pharmacy's services. The team members have identified internal and external factors contributing to increased workload and work pressures within the team. And with help and support they have made changes and put plans in place to improve their efficiency. And so, reduce their workload pressure and help provide safe and effective delivery of services. The pharmacy provides continuous training and gives feedback to team members on their performance. And they share information and learning particularly from errors when dispensing. So, they can improve their performance and skills.

Inspector's evidence

Lloyds relief pharmacists covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of three pharmacy technicians, who were also an accuracy checking technicians (ACTs), seven qualified dispensers, one who was the supervisor, a trainee dispenser, a trainee medicines counter assistant (MCA) and delivery drivers. At the time of the inspection one of the regular pharmacists, the supervisor, an ACT, four qualified dispensers, the trainee dispenser and the trainee MCA were on duty.

The supervisor was taking on the role of acting pharmacy manager after the previous manager left. And was getting support from the cluster manager. The company were recruiting for a pharmacy manager. The team had contacted the cluster manager after a full-time dispenser left, to plan how to manage this. This included opportunities for the team to do overtime. One of the dispensers had come in on their day off to support the team. And occasionally the team had a relief dispenser working at the pharmacy. The supervisor was planning to have double ACT cover. So, on the days the regular ACT was off the pharmacist didn't have to check the multi-compartmental compliance packs usually done by the ACT.

Two of the dispensers and the trainee dispenser provided the care home service. Another dispenser, with support from the supervisor, worked in a separate room providing the multi-compartmental compliance packs to people living at home. The ACTs worked mainly with the care home team but would also check the community packs. One full-time dispenser and one part-time dispenser worked in the main downstairs dispensary with the pharmacist and part-time trainee MCA. Since the full-time dispenser left the team were often breaking off from dispensing duties to serve people at the pharmacy counter. The pharmacy recruited the part-time trainee MCA to support the team working in the main dispensary. One of the dispensers had experience with the retail part of the pharmacy and provided support to the trainee MCA. At the time of the inspection there was one dispenser with the pharmacist and trainee MCA in the main dispensary. The team here were very busy with telephone calls and people collecting prescriptions. The dispenser was responsible for ordering people's prescriptions and was struggling to complete this task and dispense prescriptions.

The pharmacy provided extra training through e-learning modules. The team had to complete the modules within a set time. The pharmacy team had not had a performance review for three years. The supervisor gave teams members individual, informal feedback.

The supervisor arranged an evening meeting, so all the team could attend. The cluster manager also attended. The team members responsible for the multi-compartmental compliance packs held regular huddles. The supervisor used these meeting to discuss concerns and to remind team members what was expected of them. The supervisor passed on key points from the discussions to team members who couldn't attend the huddle. The team had raised concern about a care home team that always provided the prescriptions close to the day the team supplied medication to the care home. This put the pharmacy team under pressure. The team had liaised with colleagues from Lloyds Head Office who arranged a meeting with the care home team. The pharmacy team members were not asked to attend the meeting. But they had been asked for the key issues they wanted to raise. The pharmacy team were not told of the outcome of this meeting. The supervisor asked a team member to change their hours to cover more days in the week. The team member agreed and had trialled this. The team member informed the supervisor that the shorter days often meant tasks were not completed. And explained that full days helped them to complete their tasks. The supervisor agreed to return to the previous work pattern. But would review the shift patterns as part of the work on improving the team's efficiency.

The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was some pressure to achieve them. The pharmacist offered the services when they would benefit people.

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

Summary findings

The pharmacy is clean and secure. But some areas in the pharmacy are small and provide restricted work space for the team. The pharmacy stores large boxes containing medicines on the floor in a narrow corridor that the team use as a fire escape. This could risk the team's safety. The pharmacy has good arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was divided into a retail area, a downstairs dispensary and two upstairs rooms used for the supplies of multi-compartmental compliance packs. The downstairs dispensary was small with limited space to work. And the dispensing benches were cluttered with baskets and stock. The team used the floor to store boxes holding stock. The pharmacy stored tote boxes containing medicines in the narrow corridor leading to the stairs. This was a fire escape route. So, the tote boxes created a safety risk to the team.

The pharmacy had separate sinks for the preparation of medicines and hand washing. The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The consultation room didn't contain a sink, but the pharmacy had alcohol gel for hand cleansing.

The premises were secure. 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 most of its services well to make sure it provides them safely. It has systems to adequately manage the dispensing of multi-compartmental compliance packs. And the pharmacy team reviews its way of working to improve the delivery of this service to ensure people receive their medication safely. The pharmacy 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 the pharmacy had a hearing aid loop. The window displays detailed the opening times and the services offered. The pharmacy had a leaflet with this information on for people to pick up and take away. It also had a small range of healthcare information leaflets for people to read or take away. The team members wore name badges detailing their role.

The pharmacy provided multi-compartmental compliance packs to help people take their medicines. The pharmacy provided this service to 12 care homes of varying size. The pharmacy team members managing the care home service divided the preparation of the packs across the month. But, one week had more work than other weeks. The team were moving a few care homes to another branch to help reduce the workload pressure. And to reallocate dispensing for some of the care homes to a quieter week. The pharmacy aimed to send the packs to the care home teams around five days before the next cycle started. This gave the care home team time to check for missing medicines and raise this with the pharmacy team. One of the team was responsible for preparing the paper work, producing the backing sheets sent with the packs, and generating labels. Another team member dispensed the medication in to the packs. The third member of the team was responsible for acute prescriptions. But spent most of their time dispensing missing medicines from the monthly supplies. An accuracy checking technician (ACT) did the final check of the packs. The care home teams ordered the prescriptions. These were usually sent electronically to the pharmacy. Most care home teams sent charts detailing the medication ordered, medicines not ordered but still used and ones that had stopped. The pharmacy team checked the prescriptions against the charts to spot changes or missing items. One of the care homes did not send the charts. This meant that the pharmacy team had nothing to refer to when checking the prescriptions. And to identify missing items to chase up with the GP. Missing items were only identified by the care home team after supply. This added to the number of calls coming into the pharmacy from care homes team asking for the missing medicines. The team had raised this matter with the care home team. The pharmacy team copied the prescriptions and sent them to the care homes teams for them to check that everything requested was prescribed. But the pharmacy team were behind with this. So, the care home teams were not always getting the prescription copies before the next supply. This resulted in the pharmacy team receiving many calls from the care homes teams asking for missing items or to alter medication that had changed. The team member responsible for acute prescriptions spent most of their

time managing these calls. And dispensing the missing medication for supply the same day. The team prepared several packs the day before or on the day of supply. This put pressure on the team to ensure the packs were ready to go and increased the risk of errors.

During the inspection the telephone constantly rang and often took time to answer. The care home teams sent the pharmacy team faxes listing missing items from the monthly supply. But the regular issue of missing medicines meant the care homes teams also telephoned the pharmacy. This was to check the pharmacy had received the fax and to go through the list. This added to the number of telephone calls to the pharmacy and added extra time to the processing of these requests. The team had a daily cut off time for the care home teams to ask for medication for that day. This was before the ACT left around 5pm. The ACT explained that most errors were with the administration chart rather than the medication dispensed.

The team members were working together to manage the workload by getting ahead with tasks such as doing some of the work from the busy week the week before, when they were less busy with other activities. The team members were also training each other on their specific roles. So, they could rotate tasks and ensure issues such as absence did not affect the service. The supervisor was working to improve the efficiency of the process. To reduce the workload pressure for the team and help reduce the risk of errors. The changes the supervisor was introducing included reducing the volume of stock. And reminding the team members that the ordering system allowed them to order stock for each care home. And have the stock sent in separate boxes labelled with the care home name. So, the pharmacy team could easily locate the medication when dispensing. The supervisor identified that the team were behind with processing the electronic prescriptions. This caused delays with dispensing the packs. The supervisor highlighted this to the team. And allocated the task to a member of the team.

One of the dispensers managed the multi-compartmental compliance packs provided to 117 people living at home. And received support from the supervisor. The team used an upstairs room, separate to the one for the care home service, for preparing and storing these packs. The pharmacy team often prepared and checked the packs the day before supply or on the day. This put the team under pressure and increased the risk of errors. The team identified one of the factors for this was when the GP teams sent the prescriptions to the pharmacy. The supervisor was changing the computer system to list people individually rather than under the day their supply was due. The supervisor identified that this would help the team see who was due their medication. And help chase up missing prescriptions. The supervisor was planning to meet with the GP teams to discuss concerns about how they sent prescriptions to the pharmacy. The supervisor identified that the delays with processing the packs was linked to the team not promptly processing the electronic prescriptions. This meant the team could not downloaded the next set on time. The supervisor had raised this with the team with the aim to get ahead with this task. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list and the electronic record. And queried any changes with the GP team. The team recorded the descriptions of the products put in to the packs and supplied the manufacturer’s patient information leaflets. The ACT checked these packs when free from checking the care home packs. If the ACT was busy with the care home service, they asked the pharmacist to check the packs. Usually the pharmacist could not leave the main dispensary. The team brought the unsealed packs from the upstairs dispensary down a steep set of stairs to the main dispensary. This

meant there was a risk of dropping the packs or losing items during transit. The supervisor had asked for extra ACT hours and double pharmacist cover to prevent the ACT from breaking off from checking the care home packs. And to prevent the team having to move the packs. The team stored completed packs in baskets labelled with the person's name and address on shelves labelled with the day of the week. Occasionally the team had communications from the GP team about changes to medication. And sometimes received the hospital discharge summary. The team updated the medication list with any changes.

The pharmacy prepared methadone in advance. This reduced the work pressure of dispensing at the time of supply. The team stored prepared doses separately in clear bags with the prescription attached. The team stored the doses in the controlled drugs cabinet. The pharmacist took appropriate action when people missed their doses. This included contacting the person's key worker and leaving information for other pharmacists to know what had happened.

The pharmacy provided a repeat prescription ordering service. The team kept a record of the request to help identify missing prescriptions. The team ordered the prescriptions in advance of the supply. This gave time to chase up missing prescriptions, order stock and dispense. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The pharmacy had completed checks for people prescribed valproate. This was in response to the Pregnancy Prevention Programme (PPP). The check found one person within the PPP category and referred this person back to the prescriber. The pharmacy had the PPP pack to provide people with information. And the team members attached PPP stickers to the drawers holding these products. This prompted them to check the treatment was correct for the person and provide the information.

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. The care home pharmacy team used different coloured baskets for each care home. And stored the baskets in dedicated sections for each care home. Baskets labelled with the person's name and care home address held the dispensed pack, the empty packs for the ACT to refer to, the administration chart, the prescription and reminder cards for external medicines. The reminder cards sent with the packs prompted the care homes team to administer medicines such as creams. The team stored dispensed packs on specific shelves for the ACT to know what packs to check. The ACT had a separate work bench to check the packs.

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 the 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 pharmacist wrote 'in bag' on to the CD sticker so the team knew it was not a CD kept in the CD cabinet. 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. The pharmacist had a large volume of prescriptions to clinically check. These were for the multi-compartmental compliance packs. The team placed the prescriptions in a basket on a bench in the downstairs dispensary. The pharmacist was often under pressure to clinically check these prescriptions because they arrived at the pharmacy close to the date of supply. 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 record for the upstairs dispensary showed the last date check was in April 2019. The record for the downstairs dispensary was not available to view. The team used a coloured sticker to highlight medicines with a short expiry date. No out of date stock was found. The team members recorded the date of opening on liquids using date opened stickers. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, Zantac oral solution with 28 days use once opened had a date of opening of 31 May 2019. The team recorded fridge temperatures each day. A sample looked at found recent temperatures were over the maximum. The team was monitoring this and had reported the matter to Lloyds Pharmacy head office. 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 team used denaturing kits to destroy CDs.

The pharmacy had 2D scanners and it was waiting for a computer update to meet the requirements of the Falsified Medicines Directive (FMD). 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 members 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 fridges to store medicines kept at these temperatures. The fridges had glass doors that allowed the viewing of stock without the door being open for a long time. The pharmacy completed safety checks of electrical equipment.

The computers were password protected and access to peoples' records restricted by using 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 team used cordless telephones to make sure telephone conversations were held in private.

What do the summary findings for each principle mean?

✔ 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.