General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 45-49 High Street, Crofton, WAKEFIELD, West Yorkshire, WF4 1NG

Pharmacy reference: 1039944

Type of pharmacy: Community

Date of inspection: 13/11/2019

Pharmacy context

This community pharmacy is in the large village of Crofton. The pharmacy dispenses NHS and private prescriptions and it supplies multi-compartmental compliance packs to help people take their medicines. The pharmacy delivers medication to people's homes. The pharmacy provides the flu vaccination service. And it provides the supervised methadone consumption service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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	1.2	Good practice	The pharmacy team members act competently when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again.
		1.4	Good practice	People using the pharmacy can raise concerns and provide feedback. The team members pro-actively respond when people using the pharmacy raise concerns.
2. Staff	Good practice	2.4	Good practice	The pharmacy supports an open and honest culture within the team. The team members are good at supporting each other in their day-to-day work. And they openly discuss their errors and how they can prevent mistakes from happening again. So, they can improve their performance and skills.
		2.5	Good practice	The team members discuss and share ideas and they proactively identify improvements to the delivery of pharmacy services. The team members introduce processes to improve their efficiency and safety in the way they work.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The team members clearly highlight medicines awaiting collection. So, they can undertake appropriate checks and provide advice to the person collecting their medicines. The team members manage the pharmacy services well. They identify issues that affect the safe delivery of services. And they act to address them.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team members respond well to this feedback. And they use it to improve the efficient delivery of pharmacy services. The team members have training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members act competently when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again. The pharmacy has appropriate arrangements to protect people's private information. And it keeps the records it needs to by law.

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 the SOPs and signed the SOPs signature sheets to show they understood and would follow them. 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 near miss errors. The pharmacist completed the first section of the near miss record. And asked the team member involved to complete the rest of the record that asked for the cause of the error, the learning from the error and the actions taken to prevent the error happening again. So, the team member had an opportunity to reflect on their own error. A sample of the error records looked at found that the team rarely recorded details of what had been prescribed and dispensed to spot patterns. But team members recorded what caused the error, their learning from it and actions they had taken to prevent the error happening again. The team recorded a variety of causes and actions. These included similar packs and to not rely on team members correctly labelling the prescription. The pharmacist developed a spreadsheet to capture a summary of the near misses each month. This detailed the frequency of each type of near miss the individual team members had made. So, the pharmacy team could spot patterns and make changes to processes. This was in addition to the company near miss review. The pharmacy completed an electronic report for dispensing errors. These were errors identified after the person had received their medicines. The team members involved with the dispensing incident also completed a root cause analysis (RCA) and a reflective statement. The team printed off the dispensing incident report for reference. And details of the dispensing incident were shared with all the team members for their learning. When discussing a recent incident involving the wrong strength of levothyroxine the team members spotted the packaging for both strengths looked alike. So, they separated the different strengths of levothyroxine. The team had completed training on how to identify and reduce errors with medicines that looked and sounded alike (LASA).

The team completed a weekly SaferCare checklist that included checks for uncluttered benches and completion of team training. One of the dispensers completed these checks. And shared the results with the team. Key points from the SaferCare checklist fed into the monthly SaferCare briefing. The pharmacy recorded details of the discussions at the SaferCare briefing. And the names of the team members who attended. Recent briefings included a reminder to the team to clearly mark split boxes.

And for team members when labelling a prescription to place a circle around unusual items or formulations of a medicine. So, the team member picking the item was alert to this and would be prompted to double check the medicine selected. A SaferCare notice board in the dispensary recorded key points from the briefings. And other relevant information for the team to be aware of. The team informed each other of issues such as different quantities of a medicine that were in similar size boxes. The team used baskets to separate the different strengths of warfarin. To reduce the risk of picking the wrong strength. The pharmacy completed an annual patient safety report. The latest report highlighted the changes the team made following a dispensing incident with a controlled drug. The team identified a factor contributing to the incident was the untidy CD cabinet. So, the team had tidied and organised the CD stock in the cabinet to easily locate the CDs when dispensing. The team members also asked the pharmacist when labelling a prescription for a CD if they should order replacement CD stock. This helped to ensure the CD stock levels did not build up. The report stated the team members were reminded to take their time when dispensing CD prescriptions. And to perform a self-check of what they had dispensed before passing it to the pharmacist to check.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team 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. The team had introduced an additional signature from people receiving multi-compartmental compliance packs. The team initiated this after a few incidents when people contacted the pharmacy stating they had not received all their packs. But then the person realised they had mislaid their packs. The additional delivery sheet included the number of packs supplied and details of other medicines sent. The team used this form when delivering to all people they identified as vulnerable and at risk of misplacing their packs.

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 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 team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite.

The pharmacy had information and guidance for the team members when they had safeguarding concerns. The team had read and signed the guidance to show they understood and would follow it. The team members had access to contact numbers for local safeguarding teams. The pharmacist had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The pharmacy manager had completed level 1 CPPE training and the rest of the team were completing this training. The team had also completed Dementia Friends training in 2017. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy provides the team members with opportunities to develop their knowledge and skills. And it gives team members regular feedback on their performance. The pharmacy supports an open and honest culture within the team. The team members are good at supporting each other in their day-to-day work. And they openly discuss their errors and how they can prevent mistakes from happening again. So, they can improve their performance and skills. The team members discuss and share ideas and they proactively identify improvements to the delivery of pharmacy services. The team members introduce processes to improve their efficiency and safety in the way they work.

Inspector's evidence

A full-time pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of three full-time qualified dispensers, one who was the pharmacy manager, a part-time trainee dispenser and a new member of the team who started two days earlier. One of the full-time dispensers was the mentor for the trainee dispenser. At the time of the inspection the regular pharmacist, the manager, two dispensers, the trainee dispenser and the new starter were on duty.

The pharmacy provided extra training through e-learning modules. The team members were completing sepsis training provided by CPPE. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. One of the dispensers had taken the opportunity to ask about training to prepare the multi-compartmental compliance packs. So, she could help the team with this service. One of the dispensers was the healthy living champion. The same dispenser was responsible for ensuring all endorsements on the paper prescriptions were accurate to reduce the number returned from the NHS payment authority. And to prevent payments being taken for prescription fees that were incorrect. The dispenser since starting in this role had achieved zero returns. The pharmacy manager met with the pharmacy technician working at the GP practice to discuss delays the pharmacy experienced with getting prescriptions for the multi-compartmental compliance packs.

Team members could suggest changes to processes or new ideas of working. And the team had access to a company telephone number to raise concerns. The team had changed the process for batch labelling repeat prescriptions. One of the dispensers had moved from another pharmacy that used a system to improve the efficiency of dispensing. The dispenser discussed this with the team. And provided training to team members who were not familiar with the process. The pharmacy manager had visited other Lloyds pharmacies who used this system to see how it worked and discussed any problems. The team members found this change helped their workload and enabled them to easily find prescriptions awaiting dispensing when the person presented at the pharmacy. The pharmacy had targets for services such as Medicine Use Reviews (MURs). But the team felt the targets were achievable. 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 facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The team members used disposable gloves when dispensing medicines in to the multi-compartmental compliance packs. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. 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 team members provide services that support people's health needs. The team members clearly highlight medicines awaiting collection. So, they can undertake appropriate checks and provide advice to the person collecting their medicines. The team members manage the pharmacy services well. They identify issues that affect the safe delivery of services. And they act to address them. The pharmacy team members keep records of deliveries made to people's home. So, they can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via a step-free entrance and an automatic door operated with a press pad. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role. The dispenser who was the healthy living champion used a section of the retail area near the pharmacy counter to promote healthy living advice and information. The dispenser created a range of eye-catching displays on health matters such as indigestion and smoking. The displays had triggered several conversations with people about health matters. The pharmacist had spoken to a person about their partner’s health. And the advice given by the pharmacist resulted in the person taking prompt action when their partner became very ill. The pharmacy had up-to-date patient group directions (PGDs) for the flu vaccination service. These provided the pharmacist with the legal authority to administer the flu vaccine. The pharmacy had an adrenaline injection available in case a person had an anaphylactic reaction to the vaccine.

The pharmacy provided multi-compartmental compliance packs to help around 44 people take their medicines. People received monthly or weekly supplies depending on their needs. The pharmacy manager oversaw 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. And were usually a week ahead of supply when preparing the packs. The pharmacist had developed a spreadsheet to record when each person was due their packs. The spreadsheet also showed when the team had to order prescriptions and process the packs. 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 packs. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The GP team sent some prescriptions for the weekly packs on the day of supply. The team knew which packs were affected and planned the workload to manage this. The pharmacy manager met with the pharmacy technician at the GP surgery to discuss this. And it was agreed the pharmacy technician would look at changing the dates the electronic prescriptions were released. The team recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. And liaised with the GP teams when new prescriptions were needed.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet in clear bags

for each person. And kept the prescription with the dose due. This helped to reduce the risk of the team selecting the wrong one.

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. The team members used this as a prompt to check what they had picked. The team generated labels for repeat prescriptions which in turn ordered the medicine stock. The team placed the labelled prescriptions in baskets marked with the time the labels were generated. The following day the stock arrived in boxes labelled with the time it was ordered. The team took the baskets with the prescriptions and matched them up with the delivery box for dispensing. This helped the team members manage their workload and had improved their work efficiency. The system also helped the team easily find a prescription when a person presented for their prescription that had not been dispensed.

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 pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack to provide people with information when required. And kept the PPP pack with the valproate products, so it was available at the point of dispensing. The team wrote valproate on a sticker attached to bags holding dispensed and checked valproate products to prompt the team when handing over the supply to ask the pharmacist to speak to the person. The team followed the same process for other high-risk medicines such as lithium. So, the pharmacist could ask the person for information such as their latest blood test results. The team recorded this information when it was given. The team used a sticker on bags containing dispensed and checked medicines awaiting supply to remind them to ask questions related to the audit the pharmacy was conducting at the time. The current focus was on diabetes and the team asked the person if they'd had an eye test or foot check in the last 12 months. 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 pharmacy had a text messaging service to inform people when their repeat prescriptions were ready. The pharmacy kept a record of the delivery of medicines to people. This included a 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 05 November 2019. 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. 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 dexamethasone 2mg/5ml oral solution with three months use once opened had a date of opening of 18 August 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The team attached a sticker to baskets holding dispensed medicines waiting to be checked that included fridge products. This alerted the pharmacist to take the medicine from the fridge for checking. And it meant the fridge lines were not kept out of the fridge for a prolong period. 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 team used appropriate denaturing kits to destroy CDs. And promptly destroyed patient returned CDs.

The pharmacy had no equipment to meet the requirements of the Falsified Medicines Directive (FMD). The pharmacy manager had been sent FMD procedures and informed that the equipment would be installed in November. Some of the team had read and signed the FMD procedures. Other team members were reading the procedures. The pharmacy manager was arranging for herself and team members to attend pharmacies where FMD was in place. So, they could see how the equipment worked and ask questions of the team who had experience of FMD. 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 it 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. And it used a Lloyds BP machine to measure people's blood pressure. The pharmacy completed safety checks on the electrical equipment. And team members regularly checked the accuracy of equipment such as the BP machine.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team locked the screen on the computer in the consultation room when it was not in use. And team members used cordless telephones to make sure telephone conversations were held 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.