General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, St Michael Green, Normanton, WAKEFIELD, West Yorkshire, WF6 1PX

Pharmacy reference: 1039954

Type of pharmacy: Community

Date of inspection: 01/09/2022

Pharmacy context

This community pharmacy is next door to a medical centre close to Normanton town centre. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy provides the NHS Community Pharmacy Consultation 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	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
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 generally identifies and manages the risks associated with its services. The pharmacy completes the records it needs to by law and it protects people's private information properly. The pharmacy identifies potential risks to the safe dispensing of prescriptions and it acts appropriately to prevent mistakes. But it doesn't keep full records of mistakes or the outcomes from reviews of mistakes so team members can learn and improve their practice.

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 team had read and signed the SOPs signature sheets to show they understood and would follow them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. They referred queries from people to the pharmacist when necessary.

The pharmacy had procedures for managing errors that occurred during the dispensing of prescriptions. For example, errors the pharmacist identified when completing the final check of a prescription known as near misses. The pharmacy had a record for the team to capture the near miss errors. A sample of errors found the team members usually recorded the cause of the error along with their learning. The pharmacy completed electronic dispensing incidents reports that were sent to the head office team. The team members discussed the incident and identified actions they could take to prevent the error from happening again. For example, following a recent dispensing incident the team was reminded to have different colleagues labelling and picking the medicines. If this wasn't possible to have a break between the two tasks and to not rush the process when there was a large number of prescriptions waiting to be dispensed. The pharmacy completed weekly checks of the team's compliance with the SOPs and a review of errors. But the team members didn't always record the outcome from the weekly checks, the last record was completed in May 2022. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. A leaflet provided people with information on how to raise a concern with the pharmacy and this information was also displayed on the front door of the pharmacy.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacy kept records of the supply of unlicensed medicines. The team had completed training about the General Data Protection Regulations (GDPR). The team separated confidential waste for shredding offsite. The pharmacy displayed a separate privacy notice but this was behind the pharmacy counter so people couldn't clearly see it.

The pharmacy had safeguarding procedures and guidance for the team to follow. 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the appropriate range of experience and skills to safely provide its services. Team members work well together and are good at supporting each other in their day-to-day work. They discuss ideas and identify ways to support the effective delivery of the pharmacy's services. The team members have some opportunities to complete training to develop their knowledge and skills.

Inspector's evidence

Locum pharmacists covered the pharmacy's opening hours. A recently qualified pharmacist had recently been recruited and was due to start in post a few days after the inspection. The pharmacy team consisted of a full-time pharmacy technician who was the pharmacy manager and four qualified dispensers. Three team members were absent from work at the time of the inspection and the pharmacy manager had recently returned after an extended absence. At the time of the inspection the pharmacy manager, one of the dispensers, a locum pharmacist, a company relief pharmacy technician and a locum dispenser were on duty.

The team members worked well together and supported each other but often had to break away from tasks such as dispensing to help people presenting at the pharmacy counter. The pharmacy had been allocated additional hours and the pharmacy manager was arranging to recruit a new team member. The pharmacy manager and regional manager discussed training the team members to complete key tasks to ensure pharmacy services were not significantly impacted by team absences in the future.

The pharmacy had undergone a planned IT system upgrade in August 2022. The pharmacy manager had requested the upgrade to happen over two stages, to accommodate the care home service and the other dispensing activities. And the long-term team absences the pharmacy was experiencing, but this didn't happen. The team had completed online training and a company trainer had attended for a half a day to provide onsite advice and support. However, due to team absences the team members on duty had little time with the trainer as they were busy helping people presenting at the pharmacy. The relief pharmacy technician had experience with the system and provided some training for the team. The team members reported issues since the upgrade which impacted on the team's workload as they attempted to manage them and dispense people's prescriptions. And they'd had to change the process they'd had in place for ordering medicine stock specifically for dispensing medication to the care homes. The team reported the delays with processing people's prescriptions had been significant and led on occasions to queues developing and people were very unhappy with this. The team had worked hard to reduce the delays and at the time of the inspection prescriptions sent the day before were being dispensed.

The team members used company online training modules to keep their knowledge up to date. The team members had some protected time at work to complete the training. The pharmacy sometimes held team meetings, these usually took place in the morning and were used to plan the day ahead. The pharmacy didn't provide team members with formal performance reviews to give them a chance to receive individual feedback and discuss their development needs. The pharmacy manager gave the team informal feedback when appropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were generally tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and hand sanitiser. The dispensary was small with limited space to work especially at busy times when the team was dispensing large numbers of prescriptions. This led to baskets being stored on top of each other. The team generally kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The pharmacy had a defined professional area and items for sale in this area were healthcare related. The pharmacy had a large, soundproof consultation room. The team used this for private conversations with people. The pharmacy had restricted access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible for people. And it generally manages its services well to help people receive appropriate care. The pharmacy obtains its medicines from reputable sources. And it mostly stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via an automatic door. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team provided people with information on how to access other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away.

The pharmacy supplied medicines to people living in nine care homes. One dispenser usually managed the service with support from the pharmacy manager. Due to team absences the service was being managed by a relief pharmacy technician who worked extra hours to ensure the supplies were made in time. In addition to the monthly supplies the pharmacy dispensed many acute prescriptions that were sent each day. The team asked the care home teams to send the prescriptions before the cut-off time of 3pm unless it was an urgent prescription. The team divided the preparation of medication across the month and kept a record of when the supply to each care home was due. The care home teams ordered the prescriptions each month and usually started the process two weeks before supply. This generally allowed the team time to deal with issues such as missing items and the dispensing of the medication. The care homes typically sent the pharmacy a list of the medication ordered for each person. The pharmacy team checked received prescriptions against the list to identify missing items. The team sent reminders to the care home teams if the prescriptions hadn’t arrived within the agreed timescale. Occasionally the care home team sent the prescriptions late which put pressure on the team to dispensing the prescriptions on time. The pharmacy team used an upstairs room to dispense the medication for the care homes. This meant the pharmacist had to move between this room and the dispensary downstairs to check prescriptions. The pharmacy usually allocated set periods of time for the pharmacist to check a batch of care home prescriptions. The team was asked, wherever possible, to not disturb the pharmacist and to advice people presenting prescriptions of the time the prescription would be ready.

The team provided people with clear advice on how to use their medicines. The team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information that should be provided. The pharmacy did not have anyone prescribed valproate who met the criteria. The computer on the pharmacy counter had access to the electronic patient medication records (PMR). So, when a person presented the team member could check what stage their prescription was at. The pharmacy received copies of hospital discharge summaries via the NHS discharge medicines service (DMS). The team checked prescriptions sent from the GP team against the discharge summary to identify any discrepancies.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people’s medicines and prescriptions to help prevent them becoming mixed up. 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 found that the team usually completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The pharmacy kept a record of the delivery of medicines to people.

The pharmacy obtained medication from reputable sources. The pharmacy team generally checked the expiry dates on stock. The pharmacy had a document to record this activity but this was incomplete. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The team checked and recorded fridge temperatures each day. A sample of these records found they were within the correct range. The team recorded the dates of opening for medicines with altered shelf-lives after opening. This meant the team could assess if the medicines were still safe to use. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored controlled drugs (CDs) in a CD cabinet that met legal requirements. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually 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 to appropriately protect people's confidential information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date clinical information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication and had fridges to store medicines kept at these temperatures. The fridges had a glass door that enabled the team to see the stock inside without prolong opening of the door. 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. It stored completed prescriptions away from public view and it held most private information in the dispensary and rear areas, which had restricted access.

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.