General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 83-85 Burnley Road, Padiham, BURNLEY, Lancashire, BB12 8BL

Pharmacy reference: 1084196

Type of pharmacy: Community

Date of inspection: 27/11/2019

Pharmacy context

The pharmacy is in a parade of shops in Padiham. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). The pharmacy provides flu vaccinations. Pharmacy team members supply medicines to people in multi-compartment compliance packs. The pharmacy provides a substance misuse service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	The pharmacy provides access to comprehensive training materials. Pharmacy team members complete training regularly, in various ways, to improve their knowledge and skills.
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 has procedures to identify and manage risks to its services. And pharmacy team members follow them to complete the required tasks. The pharmacy protects people's confidential information. And it keeps the records it must by law. Pharmacy team members record and discuss mistakes that happen during dispensing. They use this information to learn and reduce the risk of further errors. And they read about mistakes that happen elsewhere to improve their practice. But they don't always fully collect information about the causes of mistakes to help inform the changes they make. So, they may miss opportunities to improve. The pharmacy team members know how to help safeguard the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The sample checked were last reviewed in 2019. And the next review was scheduled for 2021. Pharmacy team members had read and signed the SOPs in 2019 after the last review. The pharmacy defined the roles of the pharmacy team members in each SOP. The pharmacy had up-to-date SOPs and signed documents for the flu vaccination service being delivered via patient group direction (PGD). It had a declaration of competence from the authorised pharmacist confirming their training was up to date. Pharmacists completed theoretical training every two years. And, flu vaccination training every year, which included practical vaccination administration training. Then pharmacist had completed a checklist before they started delivering the service. This was to make sure the necessary equipment was in place. And that pharmacy team members had completed the necessary training and reviewed the procedures. The pharmacist had highlighted some other risks that she had not documented, but which she had managed. One example was the different types of vaccinations being used for the 2019/2020 season. Pharmacy team members had separated the vaccinations in the fridge and highlighted the different types, to help prevent them from selecting the wrong one.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. They discussed the errors made. But they did not discuss or record much detail about why a mistake had happened. They usually documented that rushing or misreading the prescription had caused the mistakes. They made changes to prevent errors happening again, such as separating look-alike and sound-alike (LASA) medicines to prevent picking errors, for example amlodipine and amitriptyline. The pharmacist analysed the data collected about mistakes every month. They recorded their analysis and discussed their findings with pharmacy team members at a monthly "Safer Care" briefing. In the examples of analysis seen, the results lacked detail about the causes of the patterns identified. For example, distractions. Pharmacy team members had not discussed or recorded any further information about what the distractions were or how the distractions could be managed. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using an electronic system called PIMS. And the pharmacist printed copies of the electronic records submitted. Some of the sample of report seen did not record or discuss any information about the causes of the mistakes. Some of these examples were discussed. And pharmacy team members clearly explained what had caused the mistakes. And the changes they had made to prevent similar mistakes happening again. Pharmacy team members had completed a root cause analysis and a reflective statement for some dispensing errors. These provided comprehensive information about the causes of the mistakes. And the changes they had made to prevent a recurrence.

The pharmacy identified look-alike and sound-alike (LASA) medicines. Some of these medicines had been involved in errors in the pharmacy. And, some had been identified by head office and communicated to all their pharmacies after a mistake had happened elsewhere in the company. Pharmacy team members had highlighted the shelves in front of LASA medicines to raise awareness of the risks while they were dispensing. Pharmacy team members carried out a 'Safer Care' audit process each month. The audit was split into four sections, each completed over a four-week period, covering a different part of the operation each week, such as the pharmacy environment, the pharmacy's people, and whether key governance tasks were being completed. Week four of the process was reserved for a Safer Care briefing with the team, where the months findings were discussed, along with the findings from errors that had occurred. Some examples of audits were available. The pharmacy had created a Safer Care wall in the dispensary. Pharmacy team members used the wall to display key pieces of information from the Safer Care process. And they displayed a list of actions they had agreed after analysing their errors the month before. They used the wall to display the latest Daily Dose bulletin from head office. The bulletin communicated key pieces of operational news from the company. And patient safety incidents that had happened elsewhere in the organisation. The pharmacist had created a quick reference guide for the team, also displayed on the wall. She explained she had introduced the guide to give pharmacy team members an easy reference to the key steps in some commonly used processes in the pharmacy. The topics included safeguarding, fridge temperature monitoring and responding to prescriptions for valproate. She explained the list had been created soon after she had been appointed. And after she had discussions with pharmacy team members about the processes listed. The topics listed were chosen because pharmacy team members were not confident in those areas. So, she had created the list to help remind them of the key steps in the process easily. Pharmacy team members explained they found the quick reference guides useful to help remind them about what to do quickly.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. Pharmacy team members could not give any examples of any changes they had made in response to feedback to improve their services.

The pharmacy had up-to-date professional indemnity insurance in place. It had a certificate of insurance displayed. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity weekly, including methadone. It kept and maintained a register of CDs returned by people for destruction. And this was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. And they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. The bags were sealed when they were full. And they were collected by a contractor and sent for secure destruction. Pharmacy team members were trained to protect privacy and confidentiality. They read the pharmacy's privacy and information security policies every year. And they had signed confidentiality agreements. Pharmacy team members were clear about how important it was to protect confidentiality.

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to the company's internal process or local safeguarding teams to get advice. The process was displayed in the dispensary. The pharmacy had contact details available for the local safeguarding service and the company's internal safeguarding advisors. Pharmacy team members completed mandatory training. But they were unsure about how often training was completed. They had last completed training in July 2019. Registered pharmacists and pharmacy technicians also completed distance learning via The Centre for Pharmacy Postgraduate Education (CPPE) every two years.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. The pharmacy provides access to comprehensive training materials. Pharmacy team members complete training regularly to improve their knowledge and skills. They reflect on their own performance, discussing any training needs with the pharmacist and other team members. And they support each other to reach their learning goals. Pharmacy team members feel able to raise concerns and use their professional judgement.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist and three dispensers. Pharmacy team members completed mandatory e-learning modules each month, called My Knowledge Check. The modules covered various pharmacy topics, including mandatory compliance training covering health and safety, customer service and information governance. And, other health related topics often related to seasonal health conditions, such as flu, coughs and colds and children's health. The pharmacy received a Safer Care case study from the superintendent's office every month. Each case study highlighted a scenario for pharmacy team members to read and discuss. And, these were often drawn from real incidents that had happened elsewhere in the company. The most recent was about a dispensing error. The pharmacy was also provided with a Learning Zone with each case study. These helped to focus pharmacy team members' attention on a medicine or health condition. The latest example was displayed. And, it was about sepsis. Pharmacy team members said they discussed each learning zone at their monthly Safer Care briefing. Pharmacy team members had a six-monthly appraisal with the pharmacy manager. They discussed their performance and were given the opportunity to identify any learning needs. They then set objectives to address their needs. One example of an objective set was for a team member to be more comfortable dispensing prescriptions for end-of-life care. The dispenser explained she had been supported by the manager and colleagues to learn and put herself forward to dispense more of that type of prescription. And, she now felt more comfortable and confident to dispense these prescriptions.

A dispenser explained that she would raise professional concerns with the pharmacist or superintendent pharmacist (SI). She felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. And the process was clearly displayed to team members. Pharmacy team members communicated with an open working dialogue during the inspection. They explained a change they had made after they had identified areas for improvement. Previously, all prescriptions for controlled drugs (CD) had been sent to the pharmacy as physical prescriptions, rather than electronically. But the local GP surgeries had now started to prescribe CDs electronically. And, pharmacy team members were concerned that prescriptions for CDs would not been found as clearly amongst a batch of electronic prescriptions for other items. So they had changed their process to make sure that batches of printed electronic prescription tokens were checked for CDs. And any prescriptions for CDs were highlighted. Pharmacy team members said this was primarily to avoid errors in the CD registers. And to help prevent prescriptions for CDs being handed out after the prescription had expired.

The pharmacy asked the team to achieve targets. Targets included the number of patients who

nominated the pharmacy to receive their electronic prescriptions, the number of medicine use review and new medicines service consultations completed, and the number of flu vaccinations provided. Pharmacy team members discussed progress with the area manager, who supported them to reach their goals. And they felt the targets were achievable.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. And it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy also had a cellar. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people, including people using wheelchairs. And the pharmacy has systems in place to help provide its services safely and effectively. It stores, sources and manages its medicines appropriately. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. They generally manage this service well. And they provide these people with the information they need to identify their medicines in the devices in case of queries. They take steps to identify people taking high-risk medicines. And they provide these people with suitable advice to help them take their medicines safely.

Inspector's evidence

The pharmacy had level access from the street. It had a hearing induction loop to help people with a hearing impairment. And, pharmacy team members said they would also use written communication to help someone with a hearing impairment. They could produce large-print labels and instructions sheets to help people with a visual impairment.

The pharmacy sent a proportion of its prescriptions to the company's off-site dispensing hub, where most medicines were picked and assembled by a dispensing robot. Pharmacy team members explained that prescriptions sent to the hub were usually for regular repeat medication. The pharmacy computer system and pharmacy team members determined which prescriptions could be sent to the hub. And whether the whole prescription or only part could be dispensed at the hub. Examples of prescriptions dispensed locally were for medicines such as liquids, controlled drugs (CDs), or for people who had requested for their medicines to be delivered. Prescriptions were then placed in a queue and a dispenser inputted the information from the prescription for each one. The pharmacist clinically checked all prescriptions that were to be sent to the hub. And they signed each prescription token to confirm they had performed the clinical check. The data from the prescription added by the dispenser was checked for accuracy by the pharmacist. The information was sent to the hub, so the prescription could be dispensed by the robot. Pharmacy team members then filed the prescriptions to wait for the medicines to be returned from the hub two days later. Prescriptions dispensed at the hub were returned to the pharmacy in dedicated totes. Pharmacy team members married up all returned bags with their prescription tokens. And with any items they had dispensed locally. They updated the computer system to show that the correct medicines had been received. They then placed the bags in the retrieval area ready for collection.

Pharmacy team members used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. They signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. Pharmacy team members highlighted bags containing CDs to make sure they were not supplied after the 28 day expiry. They also stored CDs and fridge items, such as insulin, in clear plastic bags. This helped facilitate a final visual check by the pharmacist before the medicine was handed out. And it allowed people to see their medicines and raise any queries before they left the pharmacy. The pharmacist counselled people receiving prescriptions for valproate if appropriate. And she said she would check if the person was aware of the risks if they became pregnant while taking the medicine. She advised she would also check if they were on a pregnancy prevention programme. The pharmacy had a stock of printed information material to give to people and to help them manage the risks. The pharmacy supplied medicines in

multi-compartment compliance packs when requested. It attached backing sheets to each pack, so people had written instructions of how to take the medicines. And these included descriptions of what the medicines looked like, so they could be identified in the pack. Pharmacy team members provided people with patient information leaflets about their medicines each month. They documented any changes to medicines provided in packs on the patient's master record sheet. But they did not record information about the prescriber who had initiated the changes, to help deal with future queries. The pharmacy delivered medicines to people using a hub driver based at another store. Pharmacy team members populated the delivery records. And the driver added the information to their hand-held electronic device. They also printed each run sheet, which was signed by the driver to confirm collection. Deliveries were signed for by the recipient on the driver's electronic device and records were held centrally. Records of receipt could be requested if necessary. CD deliveries were signed for on a separate, paper docket and records were returned to the pharmacy after each delivery run.

The pharmacy obtained medicines from three licensed wholesalers. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). And, they had been trained about the requirements. They explained some of the features of compliant products, such as the 2D barcode and the tamper evident seal on packs. And, the pharmacy had the right equipment and software in place. Pharmacy team members said they were expecting a phased rollout of the system soon. The pharmacy stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet(s) tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to six months in advance of its expiry. And, expiring items were removed from the shelves at the date check before their expiry. The pharmacy responded to drug alerts and recalls. And any affected stock found was quarantined for destruction or return to the wholesaler. Pharmacy team members recorded any action taken. And records included details of any affected products removed. The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well maintained measures available for medicines preparation. It had a separate set of measures to dispense methadone. It positioned computer terminals away from public view. And, these were password protected. The pharmacy stored medicines waiting to be collected in the dispensary, also away from public view. It had a dispensary fridge that was in good working order. And, pharmacy team members used it to store medicines only. They restricted access to all equipment. And, they stored all items securely.

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.