

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 569-571 Meanwood Road, LEEDS,
West Yorkshire, LS6 4AY

Pharmacy reference: 1086976

Type of pharmacy: Community

Date of inspection: 09/04/2019

Pharmacy context

The pharmacy is amongst a small parade of shops in a large suburb of Leeds. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies medicines in devices to help people to take their medicines. The pharmacy provides flu vaccinations. And a Sore Throat service. This involves a test for Streptococcal A bacterial throat infection. And supplies of medication depending on the test result.

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	1.8	Good practice	The pharmacy team has training, guidance and experience to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members get opportunities for more training. So, they can keep their skills and knowledge up-to-date. And they discuss what they can improve on or agree new roles to help deliver the services.
		2.5	Good practice	The pharmacy team can make suggestions and get involved with improving services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy identifies and manages the risks associated with its services. And it keeps the records it needs to by law. The pharmacy has written procedures that the team follows. And it has arrangements to protect people's private information. The pharmacy team members respond well when errors happen. And they discuss what happened and they act to prevent future mistakes. People using the pharmacy can raise concerns and provide feedback. The pharmacy team has training, guidance and experience to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a range of up to date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read and signed the SOPs to show they understood and would follow them. The pharmacy had up to date Indemnity insurance.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items or stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. This helped to ensure they picked the correct item. On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these errors. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. The team printed the reports for reference. A sample of error records looked at showed details about the prescription and dispensed item. To help identify patterns. The entries did not always record learning from the errors. And actions taken to prevent similar mistakes. For example, an entry from January 2019 involving the wrong product stated the team member was rushing. But no other details such as what they would do in the future to prevent the same error. The pharmacy team reviewed the error records to spot patterns. A recent review reminded the team to not use rushing as a reason for dispensing errors.

The pharmacy used a weekly checklist known as SaferCare to track compliance with safe practice. One of the pharmacy technicians 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 listed the team members attending. Recent briefings included reminding the team to record dates of opening on liquids. A SaferCare notice board in the dispensary recorded key points from the briefings. And other relevant information for the team. The pharmacy completed an annual patient safety report. This detailed dispensing errors. And the actions taken by the team to reduce the same mistakes happening again. After a delay with the delivery of medication in multi-compartmental compliance packs. The team now ensured patients new to this service were immediately added to the delivery sheets. So, they were not kept waiting for supplies. The pharmacist identified that the

dispensary team should be doing self-checks. And not relying on the final check by the pharmacist or accuracy checking technician. The pharmacist reminded the dispensary team to check the medicines they had dispensed before initialling the label.

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. 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 displayed details on the confidential data kept and how it complied with legal requirements. The team had read and signed company guidance. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team separated confidential waste for shredding offsite.

The pharmacy had a safeguarding policy. The team had signed to show they had read the policy. The team had access to contact numbers for local safeguarding teams. The pharmacist 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 on several occasions in response to safeguarding concerns.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team has the right qualifications and skills for the roles and services provided. The pharmacy team members get opportunities for more training. So, they can keep their skills and knowledge up-to-date. And they discuss what they can improve on or agree new roles to help deliver the services. The pharmacy team can make suggestions and get involved with improving services. The pharmacy team can share information and learning particularly from errors when dispensing.

Inspector's evidence

The branch pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of three pharmacy technicians, two who were also accuracy checking technicians (ACT), one trainee NVQ3 dispenser, three qualified dispensers, a medicines counter assistant and a delivery driver. One of the ACTs was leaving. The pharmacy had recruited a replacement ACT. And the two had some overlap time to share practice. One of the dispensers was the pharmacy supervisor. And the team received support from a cluster manager who was also an ACT. The team rotated jobs throughout the day such as doing the walk-in prescriptions. This helped to keep the team focused and maintain their skills. The team kept a log of when the ACT was doing the final checks. So, they were not disturbed. But the ACT team reported that at busy times colleagues sometimes asked them to help with general dispensing. The ACT leaving led on the weekly checklist of compliance with standards and legal requirements, known as SaferCare. The dispensary team had agreed to rotate this job amongst themselves. This would ensure the team completed the checks. And help team members understand the importance of meeting company and legal standards.

The pharmacy provided extra training through an online portal. The ACT cluster manager monitored completion of the training. One team member identified from a dispensing mistake that they were not aware of different versions of a product. So, was keeping themselves up to date with new products. The pharmacist had passed on training to the team about repeat dispensing prescriptions for the multi-compartmental compliance packs. The pharmacist also used this as a chance to spot any issues with the process.

The pharmacy provided performance reviews to the team. So, they had a chance to receive feedback and discuss development needs. But as there had not been a manager in post these had not been recently done. The cluster manager was planning to do the reviews in the upcoming weeks. Team members could suggest changes to processes or new ideas of working. The pharmacist's review of dispensing errors revealed several linked to interruptions to team members doing walk in prescriptions by locum pharmacists asking questions. The pharmacist asked the team to listen out for these questions and to step in.

The pharmacy had targets for services. There was no pressure to achieve them. The pharmacist used opportunities such as the flu service to offer services like Medicine Use Reviews (MURs). The pharmacist shared outcomes from the MURs with the team. So, they could understand the benefit of

offering the service to people.

Principle 3 - Premises ✓ Standards met

Summary findings

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

Inspector's evidence

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

The pharmacy had two good sized sound proof consultation rooms for private conversations. The team regularly used them. And had cordless telephones for confidential conversations.

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

Inspector's evidence

People accessed the pharmacy via steps or a ramp, both with handrails. And through an automatic door operated with a press pad. The retail area was large. And provided plenty of room for pushchairs or wheelchairs to move around. The pharmacy leaflet contained details of the services offered, the opening times and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role.

The sore throat service involved the person answering several questions. The pharmacist checked the answers to see if they met the criteria for a swab test. A positive test resulted in the supply of penicillin or clarithromycin antibiotics. The pharmacist responded to negative results with advice on treating symptoms such as using paracetamol. Patient group directions (PGDs) provided the legal authority to supply the antibiotics. The pharmacist had completed specific training to provide this service.

The pharmacy provided multi-compartmental compliance packs to help people take their medicines. The pharmacy also provided these packs to care homes. Two of the dispensers managed the service. And got support from others in the team. The pharmacy had not had a manager for a few months. During this time the team members set a limit on the number of packs. Due to concerns that increased numbers of people may impact on the safety of the service. The Accuracy Checking Technician (ACT) developed tracking sheets to record completion of different stages. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the trays. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team recorded the descriptions of the products within the MDS. And supplied the manufacturer's patient information leaflets. The care home teams ordered the prescriptions. But didn't send details to the pharmacy team. This meant the pharmacy team didn't know what had or had not been ordered. To check against when the prescription arrived. The team supplied the care home medication on a Friday for the next cycle starting on Monday. This gave some time for the care home team to check the supply and chase up missing items. The pharmacy stored completed packs in sections labelled with the person's name and address. The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge for changes or new items. And shared this with the GP with a request for prescriptions when required. The ACT and pharmacist made and checked changes to the packs. The ACT had produced a communication sheet. The team used this to record the date and time they received the information, the person's details, the message and who in the team had responded and when. This ensured everyone had up to date information. Communication included new medication and when it

was to start.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared doses at the time of supply. The pharmacy implemented this to manage missed doses

The pharmacy provided a repeat prescription ordering service. The team kept a record of the request to help identify missing prescriptions. The team ordered prescriptions a few days before 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 monitored patients on high risk medication such as warfarin. And recorded information on the electronic patient medication record (PMR). The pharmacy had completed checks of people prescribed valproate. This was in response to the Pregnancy Prevention Programme (PPP). The check found one person within the PPP category had this product. The pharmacy provided the person and their carer with the PPP information.

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 add 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/dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. The team used a stamp on the prescription to record when the pharmacist had clinically checked the prescription. This enabled the ACT to complete their check. When the pharmacy didn't have enough stock of someone's medicine, they 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 pharmacist regularly checked prescription with items owing. So, they could decide if the medication or an alternate was urgently needed. And to ask the team to chase up items not sent from the wholesaler. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 21 February 2019. The team used a sticker to highlight medicines with a short expiry date. And checked expiry dates on uncollected items before returning them to the shelves. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. 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) from in date stock in a CD cabinet that met legal requirements. The pharmacy recorded patient returned CDs and used denaturing kits to destroy them.

The pharmacy had 2D scanners and it was waiting for a computer update to meet the requirements of the Falsified Medicines Directive (FMD) that came out on 9 February 2019. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up to date clinical information.

The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had two fridges to store medicines kept at these temperatures. It used one fridge for stock. And the other for completed prescriptions. This helped the team easily find items or prescriptions when people presented. The pharmacy completed safety checks of electrical equipment.

The computers were password protected and access to peoples' records restricted by the NHS Smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information.

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.