General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 195/197 Butcher Hill, LEEDS, West Yorkshire, LS16 5BQ

Pharmacy reference: 1087134

Type of pharmacy: Community

Date of inspection: 17/03/2022

Pharmacy context

This pharmacy is amongst a small parade of shops in a suburb of Leeds. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs to help several people take their medicines. And it delivers medication to people's homes. The pharmacy was inspected during the COVID-19 pandemic.

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 identifies and manages the risks associated with its services well. The pharmacy has up-to-date written procedures for the team to follow to help ensure it provides pharmacy's services safely. The pharmacy team members respond appropriately when errors happen. They generally identify what caused the error and they act to prevent future mistakes. The pharmacy protects people's private information. And it mostly keeps the records it needs to by law.

Inspector's evidence

The pharmacy had systems in place to manage the risk from the COVID-19 pandemic. Most team members wore Personal Protective Equipment (PPE) face masks. And the pharmacy had installed a plastic screen on the pharmacy counter to provide them with extra protection. The pharmacy had bottles of hand sanitiser gel located in different sections of the pharmacy for the team and people entering the pharmacy to use. The retail area provided space for people to be socially distanced from each other. And the floor of the pharmacy was marked to show people where to stand to support the social distancing requirements. The size of the dispensary enabled team members to adhere to social distancing requirements.

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 kept the SOPs in a dedicated folder but this was untidy which made it difficult to locate certain SOP especially new ones. The team had read and signed the SOPs signature sheets to show they understood and would follow the SOPs. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions. For example, when the pharmacist spotted an error when completing their check of the dispensed prescription. The pharmacist usually asked the team member involved to find their own error which provided them with an opportunity to reflect and learn from their error. The pharmacy kept records of these errors known as near misses. The team members recorded the cause of the near miss error, their learning from the error and the actions they'd taken to prevent the error from happening again. A sample of near miss records showed the same details recorded for several entries which indicated the team members were not always capturing their own thoughts on the error. The pharmacy had a procedure for managing errors that reached the person known as dispensing incidents. The procedure included the team completing an electronic dispensing incident report to send to head office. The team members involved with the dispensing incident completed a reflective statement and an action plan to identify what caused the error and how to prevent it from happening again. All team members were informed of the dispensing incident and the actions taken to prevent the same error happening again. Following an incident when a person was supplied another person's medication the team discussed the error and identified what had caused the error. And put in place additional steps to the process of selecting completed prescriptions and handing them over, to reduce the risk of the error from happening again.

The pharmacy completed weekly checks of the team's compliance with the SOPs. These checks included the work environment such as keeping the shelves tidy and the floor free of clutter. The outcome from

the weekly checks fed into a monthly team briefing that included a review of the near miss errors and dispensing incidents. The team used the briefings to discuss case studies sent from the head office team. The pharmacy manager kept notes from the briefings that detailed the discussions held and who in the team had attended. The notes from a recent briefing recorded that the team members were reminded to fully complete the near miss record. And to make the entry as soon as possible after the error was identified so details such as the reason for the error and the learning from it could be fully captured. 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 team who responded well when complaints were raised.

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 pharmacist regularly checked the balance of CDs to spot errors such as missed entries. The pharmacy records for the receipt and supply of unlicensed products were kept in accordance with the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). But some of the records of supplies from private prescriptions didn't have the date of the prescription or the date of supply. The pharmacy displayed details on the confidential data it kept and how it complied with legal requirements. The team members had completed training about the General Data Protection Regulations (GDPR). And they separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. The team members had completed internal safeguarding training and had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. And had responded well when a safeguarding concern was raised with them. The team members were aware of the Ask for ANI (action needed immediately) initiative but had not had an occasion when a person presented at the pharmacy asking about it.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with a good range of experience and skills needed to support its services. Team members work well together and are good at supporting each other in their day-to-day work. They frequently discuss ideas to enhance the delivery of the pharmacy's services. The team members take opportunities to complete additional training courses and they receive some level of informal feedback on their performance. So, they can develop their skills and knowledge.

Inspector's evidence

The pharmacy team included a part-time Lloyds relief pharmacist, a full-time dispenser who was a Lloyds relief pharmacy manager, a full-time locum dispenser, a part-time dispenser and a new part-time team member. At the time of the inspection the relief manager, the relief pharmacist, and the locum dispenser were on duty. The relief manager and locum dispenser had supported the pharmacy for around five weeks after several team members had left. The team was not aware of the plans being made for the team structure in the future. And the relief manager was often asked to attend other pharmacies to provide similar support. However, the locum dispenser had been asked by the area manager to work full-time at the pharmacy. And was offered the opportunity to take on the responsibility of managing the pharmacy.

The three team members on duty at the time of the inspection worked very well together and supported each with the completion of tasks. For example, when one team member was dealing with prescription queries the other two team members ensured people presenting at the pharmacy counter were promptly served. The locum dispenser had encouraged the part-time dispenser to help support the preparation of multi-compartment compliance packs. And was providing training to the dispenser on the process. The part-time dispenser had been mostly working in the retail area and was concerned they may lose some of their dispensing skills and knowledge.

The team members used company online training modules to keep their knowledge up to date. The pharmacy had introduced a new IT system and the team had received some level of training. But the team members had learnt most about the system from regular use and discovering what worked and what they needed support with. The team members shared any learning of the new system with each other. So, everyone knew how to use the system. The pharmacy didn't provide team members with a formal performance review process. But they did receive some informal feedback.

The team held regular meetings and team members could suggest changes to processes or new ideas of working. The pharmacy's IT upgrade occasionally caused delays to the downloading of prescriptions. The team members identified that whilst the IT team fixed the issues there could be a delay with supplying some people's medication. So, they had worked with the teams at the nearby medical centres to enable prescriptions that may be affected to be sent in time for the supply to be made.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were hygienic and tidy. The pharmacy had separate sinks for the preparation of medicines and hand washing. The consultation room didn’t contain a sink but alcohol gel for hand cleansing was available for the team to use. The team mostly 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 was secure and it 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. The pharmacy had a soundproof consultation room. The team used this for private conversations with people and when providing services such as the seasonal flu vaccination.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. The pharmacy keeps detailed records to help monitor the services it provides. This enables the team to deal with queries effectively. And it makes sure people receive their medicines when they need them. The pharmacy gets its medicines from reputable sources and it stores them properly. The team generally carries out checks to make sure medicines are in good condition and suitable to supply.

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 wore name badges detailing their role so people using the pharmacy knew who they were speaking to. The pharmacy had received several referrals from local GP teams using the Community Pharmacist Consultation Service (CPCS). However, on a few occasions the referral had been outside the criteria for CPCS. The team explained this to the GP who made the referral to ensure people were not being inappropriately referred. The pharmacy offered a private weight loss service providing the treatment Saxenda. The pharmacy had a dedicated set of SOPs for this service and the supplies were made against a patient group direction (PGD). The team members supporting the service had completed relevant training and had guidance to refer to.

The pharmacy provided multi-compartment compliance packs to help around 50 people take their medicines. The locum dispenser had experience with providing the service and was tasked with managing the service to ensure it was delivered safely and efficiently. The team divided the preparation of the packs across the month. And clearly displayed a list of people receiving the packs and the days of the week the supply was made. The team used the list to record when different stages of the processing of the packs had been completed. The team also kept a record of completed packs to show when they were ready and when they'd been supplied. These records helped all team members to know the different stages the packs were at when dealing with queries from people about their medication. The team ordered prescriptions in time to deal with issues such as missing items and the dispensing of the medication. Each person had a record listing their current medication and dose times. The locum dispenser was checking everyone had an updated list. And was liaising with the GP teams to ensure all the medication a person received in a pack was synchronised. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The pharmacy usually received copies of hospital discharge summaries which the team checked for changes or new items. Following a recent incident when a person received another person's pack the team discussed the incident and the importance of following the procedure for bagging completed packs. This included the pharmacist bagging the completed pack once they had completed the final check. And the team stored the sealed bags holding the packs on shelves labelled with the person's name.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The pharmacist prepared the doses in advance of supply to reduce the workload pressure of dispensing at the time of supply. The pharmacist stored the prepared doses in the controlled drugs cabinet with the prescription attached.

The pharmacy sent some prescriptions to Lloyds offsite dispensary. The team followed procedures and had received some level of training on how to process prescriptions this way. The team regularly printed of the electronic prescription (EPS) tokens sent to the pharmacy and put them in alphabetical order. This enabled one team member to sort through the tokens and identify prescriptions that could be, with the person's consent, sent to the offsite dispensary. And ones that had to be dispensed at the pharmacy such as split packs, CDs and fridge lines, along with any prescriptions the person needed urgently. The process of sending prescriptions to the offsite dispensary included a clinical check by the pharmacist that was captured electronically before the prescription was submitted. The team scanned the prescriptions returned by the offsite dispensary. This identified any incomplete prescriptions that the team separated from complete prescriptions. The team dispensed the missing item which was checked along with all the other dispensed items by the pharmacist. The team members reported the offsite dispensary helped to reduce their workload especially for prescriptions with many items.

The team provided people with clear advice on how to use their medicines. The team highlighted high-risk medicines such as warfarin to the pharmacist who provided the person with appropriate counselling. The pharmacist used the pharmacy's electronic patient medication record (PMR) to capture details of the conversation with the person. The team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had PPP information to provide to people when required. The pharmacy didn't have anyone prescribed valproate that met the PPP criteria.

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 to help prevent them becoming mixed up. The team usually scanned picked items as part of the dispensing process. The system alerted team members to an incorrect product. The team members reported a reduced number of near miss errors involving an incorrect product since they started using this system. The team reported the common errors were now related to incorrect quantities. And the team members had been reminded to accurately check quantities when dispensing.

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 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 fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And the team kept the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. And had separate records for the delivery of fridge lines and CDs. The record of CD deliveries captured the name of the person receiving the CD and that confirmation of the address had been obtained. The record also indicated if the person wanted to speak to the pharmacist.

The pharmacy obtained medication from several reputable sources. The pharmacy team checked the expiry dates on stock and usually kept a record of this. But the last record was dated August 2021. 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 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. For example, an opened bottle of Oramorph oral solution with 90 days use once opened had a date of opening of 09 March 2022 recorded. The team checked and recorded fridge temperatures each day. A sample of these records looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and medication returned by people. And it stored out-of-date and CDs returned by people separate from in-date stock in a CD cabinet that met legal

requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via the company communication portal. The team usually printed off the alert and read it before taking appropriate action and recording this activity.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably 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 had equipment available for the services provided, including a range of CE marked equipment to accurately measure liquid medication. The pharmacy completed safety checks on its electrical equipment.

The pharmacy 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 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.