General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Lloyds Pharmacy, 24 Market Street, Dudley, Cramlington, Tyne and Wear, NE23 7HR

Pharmacy reference: 1087438

Type of pharmacy: Community

Date of inspection: 31/07/2019

Pharmacy context

The pharmacy is in a parade of shops in the village of Dudley. Pharmacy team members mainly dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MUR) and the NHS New Medicines Service (NMS). They provide a substance misuse service, including supervised consumption. And, they provide a minor ailments service, called Pharmacy First, and medicines in multi-compartmental compliance packs.

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	1.2	Good practice	Pharmacy team members read about mistakes that happen elsewhere to improve their practice. And, they are good at using this information, and information from their own mistakes, to learn and reduce the risk of further errors. They regularly audit pharmacy processes to make sure they are operating safely.
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 has procedures to identify and manage risks to its services. And, pharmacy team members follow them to complete the required tasks. They consistently record and discuss mistakes that happen. And, they read about mistakes that happen elsewhere to improve their practice. Pharmacy team members are good at using this information to learn and reduce the risk of further errors. And, they regularly audit pharmacy processes to make sure they are operating safely. Pharmacy team members regularly ask people using the pharmacy for their views. And, they act to improve the quality of services in response. Pharmacy team members protect people's confidential information. And, they keep the records they must by law. They know how to 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 August 2017. And the next review was scheduled for August 2019. Pharmacy team members had read and signed the SOPs since the last review. The pharmacy defined the roles of the pharmacy team members in a record of competence for each pharmacy team member.

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. And, they discussed and recorded some detail about why a mistake had happened. The pharmacy team members appointed a Safer Care Champion, who analysed the data collected about mistakes every month. The Safer Care Champion looked for patterns in the data and applied any patterns found to four different areas of the operation. These were environment, people, process and other. Pharmacy team members discussed the patterns found at a monthly briefing and planned how to address these patterns and reduce the risks of recurrence of the same or similar mistakes. They wrote the proposed actions on a noticeboard in the dispensary for everyone to see. One example for the current month was for pharmacy team members to slow down when dispensing and not to rush, particularly when busy. Pharmacy team members said they often separated medicines involved in errors on the shelves, for example different strengths of amlodipine. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using an electronic reporting system. And, pharmacy team members completed a root cause analysis and a reflective statement for each error they made. These were recorded on paper and kept in the pharmacy. The sample of records seen were comprehensive about what had happened and why. And, pharmacy team members proposed actions to help prevent recurrence. One example was a member of the team being distracted by thinking about other tasks left to do while dispensing, preventing her from concentrating fully on the prescription she was preparing. In response, she was in the process of developing a checklist of tasks that needed to be completed on a Friday afternoon, to help her keep track of tasks. And, to prevent her having to remember everything and losing concentration when dispensing.

The pharmacy had received a list from head office of look-alike and sound-alike (LASA) medicines that had been involved in common errors across the organisation. Pharmacy team members had acted to separate, for example different strengths of amlodipine tablets. And, they had moved pregabalin and gabapentin to different locations in the drawers. They had highlighted the locations where all medicines on the list were kept with an alert sticker. And, this helped to draw pharmacy team member's attention

to the risks of making a mistake while they were dispensing the items. The list was also accompanied by a chart, which pharmacy team members displayed. The chart explained what each LASA medicines was used for. And, helped pharmacy team members understand when to expect to see the items being prescribed.

Pharmacy team members completed a Safer Care audit process each month. The audit was split into four sections. And, pharmacy team members completed one section per week over a four-week period, each covering a different part of the operation. On the first week, they audited the pharmacy environment. And, they looked at, for example, whether benches were tidy and organised and whether floors were clean, tidy and clear of obstruction. They also checked whether caution and short-dated stickers were being used on shelves. In week two, pharmacy team members audited people, determining for example, whether monthly training had been undertaken. During week three, they scrutinised processes, determining whether, for example, near miss incidents were being recorded and whether controlled drug (CD) register running balances were being regularly audited. And, in week 4, they carried out a "Safer Care" briefing with the team, where they discussed the months findings, including findings from errors that had occurred. The pharmacy had recorded that pharmacy team members were completing the audits. And, in the records seen, there had been no findings that required improvement, other than changes made after near miss errors.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. One feedback point from the last set analysed was having the right stock available. Pharmacy team members explained that in response, they had fully implemented a system where they made sure they always had a minimum quantity in stock of the most popular 150 medicines they used. They determined the minimum quantity from how many they had used per month previously. Pharmacy team members said they were also actively encouraging people to have their prescriptions sent to the pharmacy electronically. They said this helped them to prepare the prescriptions and order any stock ready for people to collect their medicines.

The pharmacy had up to date professional indemnity insurance in place. They 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 it 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 specialist contractor and sent for secure destruction. Pharmacy team members completed training about how to protect privacy and confidentiality each year. They were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR). Pharmacy team members determined whether the pharmacy continued to comply with GDPR requirements in each Safer Care audit.

When asked about safeguarding, pharmacy team members 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 and to local safeguarding contacts if necessary. They displayed local safeguarding contact information in various locations in the pharmacy. The pharmacist said they would assess the concern. And would refer to the most appropriate source of help. Pharmacy team members trained via the electronic My Knowledge system. And, they were required to complete safeguarding training as part of their induction. But, they did not know how often they were required to refresh their training. Registered pharmacists and pharmacy technicians were also required to complete distance learning via the Centre for Pharmacy Postgraduate Education (CPPE) every two years.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. They undertake training regularly. 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 goals. Pharmacy team members feel able to raise concerns and use their professional judgement. They communicate well together. And, they can discuss issues and act on ideas to support the delivery of services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist, a dispenser, a trainee dispenser and a trainee medicines counter assistant. Pharmacy team members completed training regularly using an online system called “My Knowledge". They completed a training module approximately each month. And, the topics were varied including modules about new products, seasonal health conditions and high-risk medicines such as sodium valproate. Pharmacy team members completed an assessment of their knowledge after each module. And, they were required to achieve at least 80% correct answers. If they did not pass the assessment, they were supported with further training and then they would re-take the test. Pharmacy team members explained they received an appraisal with the pharmacy manager every year. And, they completed a self-assessment questionnaire before their appraisal. They discussed their responses to the questionnaire with the manager and set objectives to help address any needs they identified.

A dispenser explained she would raise professional concerns with her colleagues, the pharmacy manager, the cluster lead or head office if necessary. 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 team knew how to access the policy. Pharmacy team members communicated effectively during the inspection. And, they were keen to convey how well they felt they were managing considering a recent spell of staff shortages. They said they continually discussed how best to carry out tasks throughout the day. And, they were each observed to demonstrate flexibility in their approach during the inspection. Pharmacy team members explained a change they had made after they had identified areas for improvement. They had changed the way the prepared medicines in multi-compartmental compliance packs. They explained that previously, packs for the whole month had been prepared over one week. And, this approach had caused pressure and a significant increase in workload for one week every month. So, they had discussed the issue and changed the system. Now, they prepared packs in two cycles each month, approximately two weeks apart. Pharmacy team members explained this had helped to reduce stress and pressure. But, it had also provided them with more time to plan ordering and processing of prescriptions. And, it had given them more time to assemble and prepare packs, so they were ready approximately a week before they were due to be supplied to people.

The pharmacy asked team members to achieve targets in various areas, such as the number of MUR and NMS consultation provided, prescription dispensing volume and the number of people nominating the pharmacy to receive their prescriptions. They explained that target compliance was discussed with their cluster lead and manager. And, area coaches were available to help them change their approach to reach specified targets more effectively.

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 and in drawers throughout the premises. The pharmacy had a private consultation room available. The pharmacy team 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, with a sink which provided 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 is generally easily accessible to people, including people using wheelchairs. And, it has systems in place to help provide its services safely and effectively. It stores, sources and manages its medicines safely. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. And, they provide them with the information they need to identify their medicines. They take steps to identify people taking high-risk medicines. And they provide these people with advice to help them take their medicines safely.

Inspector's evidence

The pharmacy was accessed via a ramp from the street, through an automatic door. Pharmacy team members gave an example of a person who used the pharmacy that had a hearing impairment. They said they used written communication and made sure the person was able to see their lips, so they could lip read. Pharmacy team members were unsure about how to help someone with a visual impairment.

Pharmacy team members 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. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy obtained medicines from three licensed wholesalers. It 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. The pharmacy supplied medicines in multi-compartmental compliance packs when requested. Pharmacy team members attached backing sheets to each pack, so people had written instructions of how to take the medicines. And, these included the 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. And, they documented any changes to medicines provided in packs on the patient's electronic record and in a communications diary. They used a tracker to monitor the progress of each pack at the various stages of preparation. Pharmacy team members explained this helped them to easily determine details such as whether prescriptions had been ordered, whether a pack had been assembled, or whether the person was in hospital and didn't require a pack.

Pharmacy team members highlighted all prescriptions they received for valproate with a sticker on the prescription. And, if necessary, they placed printed information material in the basket for the pharmacist to hand out. 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. Pharmacy team members also attached stickers to various other prescriptions to highlight the risks of certain medicines. For example, prescriptions for warfarin, methotrexate and medicines that required storage in the fridge. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They had all completed training via the eLearning system. They explained some of the features of compliant products, such as the 2D barcode

and the tamper evident seal on packs. And, they said they were routinely checking packs for evidence of tampering. The pharmacy had equipment and software in place to scan medicines packs. But, they said they were not scanning packs until the system that had been installed went live. They did not know when this would be. So, the pharmacy was not legally compliant with FMD.

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 at least six months in advance of its expiry. Any short-dated items were removed if expiring before the next date check, unless they were a commonly used item, which were left and removed in the month before their expiry. Pharmacy team members explained they checked all stock for expiry dates and short-dated sticker when each stock order was put away. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It 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.

The pharmacy delivered medicines to people using a hub driver based at another store. Delivery records were populated by staff and uploaded to driver's electronic device. Each run sheet was also printed and 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.

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 team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone. The pharmacy positioned computer terminals away from public view. And they were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. The dispensary fridges were in good working order. And the team used them to store medicines only. Access to all equipment was restricted and all items were stored 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.