General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Lloydspharmacy, 11-12 Station Road, CONSETT, County Durham, DH8 5RL

**Pharmacy reference:** 1089469

**Type of pharmacy:** Community

**Date of inspection:** 12/03/2020

## Pharmacy context

The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It provides advice on the management of minor illnesses and long-term conditions. And it delivers some medicines to people's homes. It supplies some medicines in multi-compartment compliance packs. These help people remember to take their medicines. And it provides NHS services such as flu vaccinations.

## 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 has written procedures that the team follows. The team members have a clear understanding of their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. The pharmacy keeps all the records as required, by law in compliance with standards and procedures. It provides people using the pharmacy with the opportunity to feedback on its services. The pharmacy team members look after people's private information. And they know how to protect the safety of vulnerable people. The team members responsibly discuss mistakes they make during dispensing. But the detail they record is sometimes limited. So, they may be missing out on some learning opportunities to prevent similar mistakes from occurring.

### Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which the pharmacy team members had read. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as dispensing and assembly of prescriptions, labelling and controlled drug (CD) management. These were subject to regular review by the company's head office. The team members signed records of competence once they had read any updated SOPs. There were also several other corporate checks undertaken weekly to manage the running of the pharmacy. The pharmacy had two computer terminals in the main dispensary. The team used one for people who walked in with prescriptions and general items, and the other for repeat prescriptions. The team downloaded prescriptions several times a day, labelled and ordered the stock. They worked about two days ahead of people coming in to collect their repeat medicines. So had these ready completed for people to collect. The pharmacy prepared the multi-compartment compliance packs in a separate room upstairs. And the accuracy checking technician (ACT) checked the majority of these. The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used different colours of baskets with red for people waiting, grey and blue for repeats and call backs, and yellow for delivery. This distinguished people's prescriptions by degree of urgency, and this helped plan workload.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The team recorded these on a specific template. Examples included mirtazapine 30mg with the wrong quantity and salbutamol 100mcg Easi-Breathe inhaler instead of normal. The team generally recorded their own. And recorded entries well but some entries lacked detail which could assist in learning if they had recorded some additional information. The pharmacy had few near misses recorded. But the team felt it was a true reflection and the team members noted at the end of a day if they had not made any near miss errors. The pharmacy kept a separate near miss log in the compliance pack room and the team recorded any near miss errors. There were generally two members who worked the room and they discussed any near misses as the occurred. Most of the errors recorded were one item missing or one extra. They discussed that if there was an interruption when doing a pack, they would start again to avoid errors. The supervisor completed the safer care checklist and reviews. And shared briefings each week. They discussed the recording of near miss errors and reminded each other to ensure they recorded any made. They had moved amitriptyline from the usual location in to a drawer following company guidelines. And they discussed case studies provided to raise awareness of possible mistakes. They had a few alerts on shelves and on the front of the drawer system to raise awareness for picking errors.

The pharmacy had a notice displayed in the pharmacy which explained the complaints process. And there was an information leaflet available for people on how to provide comments or raise the complaints. The pharmacy gathered feedback through the annual patient satisfaction survey. The last survey had positive results. There was a procedure to record and report dispensing errors. The team advised they put any complaints on to the company system. And printed off a copy for reference in the pharmacy. The team discussed any learning from any complaints. The pharmacy had a What's App group and the managers in the cluster shared some information for learning. The pharmacy had current indemnity insurance in place.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records as required. A sample of CD registers looked at found that they met legal requirements. The pharmacy usually checked CD stock against the balance in the register at each time of dispensing. This helped to spot errors such as missed entries. The register indicated weekly stock checks had been undertaken. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy kept a record of CDs which people had returned for disposal and it had a process in place to ensure the team destroyed these promptly. And did not allow a build-up in the CD cabinet. The pharmacy kept special records for unlicensed products with the certificates of conformity completed. It maintained records for private prescriptions. The pharmacy displayed information on the confidential data kept and how it complied with legislation. The pharmacy displayed a notice on how it looked after information.

The team had read General Data Protection Regulation (GDPR) information. And had SOPs for information governance and patient confidentially. The pharmacy displayed a privacy notice which explained how it handed confidential information. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. And kept patient sensitive information securely. The pharmacy team stored confidential waste in separate containers for offsite shredding.

The pharmacy had a policy for the protection of vulnerable adults and children. The team kept safeguarding information including contact numbers for local safeguarding agencies in a folder with the policy. The registrants had undertaken level 2 Centre for Pharmacy Postgraduate Education (CPPE) training. And the team members had all completed Dementia friends training. They advised of the company process for safeguarding.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough qualified staff to provide safe and effective services. The pharmacy team members are competent and have the skills and qualifications they need for their role. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. And they feel comfortable raising any concerns they have.

### Inspector's evidence

There was one pharmacist, one accuracy checking technician (ACT), one technician, four dispensers and two medicines counter assistants (MCA) who worked in the pharmacy. The pharmacy had a dispenser as the pharmacy manager and another dispenser as a supervisor. The ACT and one dispenser worked 39 hours weekly, two dispensers worked 16 hours weekly and one dispenser worked 34 hours. The MCAs worked 30 and 24 hours weekly. The technician worked 40 hours a week. The pharmacy did not have a current full-time pharmacist. But had two pharmacists who regularly worked in the pharmacy. One worked three days at this pharmacy and two days at another branch.

The team members had training records. And undertook training on the company system through My Learn. Recent training completed had included Frontline products and sildenafil. The team members in the compliance pack room described how they read through magazines and leaflets. And made notes in a book for reference if they worked in the pharmacy retail part. This ensured they kept up-to-date. They advised they undertook refresher training on products for vaping. And a mystery shopper had been in to ensure the team were giving the correct advice. In particular checking the age of people asking to purchase these items. The team discussed current topics such as the Community Pharmacist Consultation Service (CPCS) and the reminder to ensure the team recorded all urgent supplies in the private prescription register as required.

The team received performance reviews twice a year which gave the chance to receive feedback and discuss their development needs. One of the dispensers advised she would like to undertake the technician training course. And then go on to become an ACT. But this was not possible due to there being no permanent pharmacist. The MCA followed the sales of medicines protocol when making over-the-counter (OTC) recommendations and referred to the pharmacist when necessary. The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacist, manager, supervisor or the area manager. The dispensary team worked closely together and assisted each other as required. There was a formal whistleblowing policy and telephone numbers were available so the team members could easily and confidentially raise any concerns outside the pharmacy if needed.

The pharmacy team had targets for services such as MURs. These were achievable and done when they met the patient’s needs. The team highlighted these on bags. And the pharmacist tried to carry out when time permitted.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy's premises are of a suitable size for the services it provides. And people can have private conversations with the team in a consultation room.

### Inspector's evidence

The pharmacy was clean, tidy and hygienic. And fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines and devices waiting for collection. The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The benches, shelves and flooring were all clean and the team advised they all cleaned as they went along. They undertook general cleaning on Saturday when it was quieter. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. The room temperature was comfortable, and the pharmacy was well lit.

The pharmacy had a good sized, signposted, sound proofed consultation room which the team used. There was a notice about the chaperone policy asking patients if they would like a family member or chaperone present. The pharmacy team kept the consultation room door shut when not in use. But it did not have a lock. The team members ensured the computer screen was on screen-lock when no one was in the room. And they kept any confidential information locked away.

The team were aware of customers in the premises. And when they entered the pharmacy. The pharmacy counter had an unusual layout, with a pillar in between the space at the end of the counter and the dispensary. Some people went to one side of the pillar and to the entrance of the dispensary. The team advised this was sometimes an issue. The team discussed the use of a physical barrier such as a retractable barrier to discourage people trying to enter the dispensary.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy is accessible to people. The pharmacy provides its services using a range of safe working practices. The pharmacy team members take steps to identify people taking some high-risk medicines. And they provide people with additional advice and support. They dispense some medicines into compliance packs to support people to remember to take them correctly. And they manage this service well. The pharmacy gets it medicines from reputable suppliers. It adheres to storage requirements during the dispensing process. It takes the right action if it receives any alerts that a medicine is no longer safe to use.

### Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was a power assisted door at the entrance for easy access. On entrance to the pharmacy there was a notice displaying information relating to the Coronavirus. The pharmacy also displayed information at the counter and on the pharmacy's health care information notice board. The team members were aware of current information and had received and read the NHS SOP on Coronavirus. And they had received some information from company and discussed possible required actions. They were aware to check the live websites for ongoing information. The pharmacy had a ladder in the window with a list of services. And it displayed the GPhC notice 'What you can expect when visiting this pharmacy'. The pharmacy had a display table with some health-related materials and leaflets for people to take away. These included information on healthy heart and alcohol. There was some customer seating.

The pharmacy had a defined professional area. And items for sale were mostly healthcare related. The pharmacy kept pharmacy medicines on shelves behind the counter. The team assisted people who wished to buy these items. The pharmacy undertook Medicines Use Reviews (MURs) and the New Medicine service (NMS). The pharmacist advised that people liked the reviews as it provided them with an opportunity to discuss their medicines. And helped with their understanding in areas such as pain relief and insulin control. The pharmacist completed NMS reviews with follow-up phone calls. And advised these were generally well received. The pharmacy provided flu vaccinations with most people coming in and happy to wait for this service. The pharmacy provided a needle exchange service. It undertook blood pressure checks with a small charge for this service and glucose testing. It provided a smoking cessation service with two of the health care assistants and a dispenser trained for this service. It provided medicines through the Minor Ailments Scheme. The most popular item was paracetamol for children. And the pharmacist undertook Emergency Hormonal Contraception (EHC) through a Patient Group Direction (PGD). The pharmacy provided the Community Pharmacist Consultation Service (CPCS). People accessed the CPCS service through NHS 111 referrals. The CPCS linked people to a community pharmacy as their first port of call. This could be for either the urgent provision of medicines or the treatment or advice for a minor illness. The pharmacy had undertaken a few and one with the supply of medicine. The remainder were advice or referral.

The pharmacy supplied medicines to around 170 people in multi-compartment compliance packs to help them take their medicines. The team prepared four weeks at a time. Around half of the people collected their packs. And the pharmacy delivered the remaining half. The doctors from the local health centre generally referred people to the pharmacy if they required to have their medicines provided in

multi-compartment compliance packs. The team included descriptions of medicines on the packs. It provided people with patient information leaflets (PILs) with the first pack of each cycle. The team had community profile sheets for each person. And kept the records up-to-date. And recorded any changes clearly on the sheets. The surgery sent tasks through the computer system such as to change a dose to the morning slot instead of the night time slot. This showed who had requested the change and when the pharmacy had received it and acted on it. The pharmacy offered a substance misuse service. It had around 14 people who received methadone and about four who received buprenorphine. The pharmacy supervised most of the people's doses on the day they collected.

There was a clear audit trail of the dispensing process. The team completed the 'dispensed by' and 'checked by' boxes which showed who had performed these roles. And a sample of completed prescriptions looked at found compliance with this process. The team used a stamp on the prescription to show that the pharmacist had completed a clinical checked. This allowed the accuracy checking technician to do their accuracy check. This was generally for the compliance packs only. The team members used appropriate containers to supply medicines. And used clear bags for dispensed CDs and fridge lines so they could check the contents again, at the point of hand-out. There were some alerts stickers applied to prescriptions or bags to raise awareness at the point of supply. Or the team placed notes on bags. The team highlighted people who were suitable for MURs. The team members used CD and fridge stickers on bags and prescriptions to prompt the person handing the medication over that they needed to add some medication to complete the supply. The team highlighted prescriptions with CDs and stored any prescriptions in a separate retrieval box. This reminded them to check the last date the pharmacy could supply the medication.

When the pharmacy could not provide the product or quantity prescribed in full patients received an owing slip. And the pharmacy kept a copy with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers if items were unobtainable to ask for an alternative. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. They explained the information they provided to the 'patients in the at-risk' group. They were aware of the cards attached to the original boxes and discussed not to cross over this information when indicating spilt packs. The pharmacy driver used an electronic pod which kept a record of signatures from deliveries. The entry on the pod for the person indicated if there was a CD in the supply.

The pharmacy stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. The pharmacy had a refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. The team members marked short-dated items and they took these off the shelf prior to the expiry date. The team members marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use. The pharmacy used recognised wholesalers such as AAH and Alliance. The team were aware of the Falsified Medicines Directive (FMD). The pharmacy had scanners in place. But had not implemented the FMD process. They were aware of it being trialled in some pharmacies.

The team used appropriate medicinal waste bins for patient returned medication. The contents of the bins were securely disposed of via the waste management contractor. The pharmacy had appropriate denaturing kits for the destruction of CDs. The pharmacy had a process to receive drug safety alerts and recalls. It received emails directly from the company. The team actioned these and kept records of the action taken.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people's privacy.

### Inspector's evidence

The pharmacy team members had access to a range of up-to-date reference sources, including the British National Formulary (BNF). They used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). They had a link to this saved as a favourite and had also printed a few additional leaflets for medicines which they split packs. This meant they had these ready to supply to people. The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It had a separate range of measures for measuring methadone. It also had a range of equipment for counting loose tablets and capsules.

The team members had access to disposable gloves and alcohol hand washing gel. The equipment such as the carbon monoxide monitor, and blood pressure machine appeared in good working order and the team checked these as required. The smoking commissioner came to the pharmacy to test the carbon monoxide monitor and replaced it when required. The team members checked the glucose monitor and they calibrated it regularly to make sure it was providing accurate readings.

The pharmacy stored medication waiting collection on shelves in the dispensary away from view of the public. The team filed prescriptions in boxes in a retrieval system keeping details private. The computer in the consultation room was screen locked when not in use. The computer screens in the dispensary were out of view of the public. The team used the NHS smart card system to access to people's records. The team used cordless phones for private conversations.

## 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. |