General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 168 West Road, NEWCASTLE UPON TYNE, NE4 9QB

Pharmacy reference: 1090540

Type of pharmacy: Community

Date of inspection: 26/01/2023

Pharmacy context

This is a busy community pharmacy on a high street in Newcastle. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It provides a range of services including supplying medicines for people in multi-compartment compliance packs to help them take their medicines correctly. And it provides vaccination services.

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	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 to help team members work safely and effectively. They reflect on any errors they make and share learnings as a team to improve working practices. The pharmacy mostly keeps the records required by law, and it has a robust complaints procedure so people can easily feedback about their experiences. Team members keep confidential information secure. And they know how and when to act to protect vulnerable adults and children in their community.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help the team work safely and effectively. And team members had signed to say they understood and would follow them. But some of the signatures had not been countersigned by the pharmacist to confirm that they had reviewed the team's understanding of the SOPs. Sampling of the SOPs highlighted that the SOP held in the pharmacy relating to stock checking of controlled drugs (CDs) was due to have been updated in 2021. The folder was not well organised and so team members may find it difficult to find a specific SOP if required.

Team members regularly recorded errors made and identified during the dispensing process known as near misses. Each team member was responsible for recording their own near misses and reflected on the potential cause. Learnings from near miss records were discussed amongst the team to help prevent any reoccurrence. Once a month, the records were used to identify any trends and actions taken to minimise risk. And these were recorded formally under the company's patient safety management process. The team explained that previous analysis had identified a trend whereby medicines known as look-alike and sound-alike medicines (LASAs) were selected incorrectly. These were therefore separated in the drawers to help prevent incorrect selection. Learnings and improvements from incidents that had occurred in other pharmacy premises were communicated and shared by the pharmacist with team members. And they showed how they had implemented improvements. The team also discussed and recorded errors that had been identified after a person had received their medicines, known as dispensing incidents. Records showed that a recent dispensing incident had been thoroughly investigated and a root cause analysis carried out. As a result, the team members reviewed the SOP for handing out prescriptions and had changed their process to ensure they were asking people to confirm their address.

Team members had clearly defined roles and responsibilities and they supported each other to complete tasks. They understood what to do in the absence of the responsible pharmacist (RP) and were able to refer to a SOP detailing this if required. The RP notice was prominently displayed in the retail area and reflected the correct details of the pharmacist on duty.

The pharmacy had a practice leaflet which detailed the complaints procedure, contact details for the pharmacy and services offered. The pharmacist explained that any complaints were usually dealt with by her in the first instance and were mostly resolved at this level. But any complaints that were not resolved were escalated. Customer feedback was also received via an online platform and responses were seen to be positive.

The pharmacy kept electronic RP records. These were mostly accurate and reflected the details of the pharmacist on duty. But the pharmacist had already signed the record ahead of time to say she would

cease to be the RP later that day. The pharmacy provided private prescriptions for people and had a contract with the Ministry of Defence (MOD) to supply medicines to members of the Armed Forces. MOD prescriptions were sent to the pharmacy via email and the original prescription was received when the person collected their medicine. Sometimes, there were delays in receipt of the original prescription. And this meant that the team supplied medicines before the original prescipription was received, a process known as an “emergency supply”. Occasionally, the emergency supply record did not include the date the original prescription was received. Additionally, there were private prescription supplies waiting to be recorded. It was not clear as to when they had been supplied to people so the team may miss opportunities to capture the correct information. The pharmacy provided unlicensed medicines known as “specials”. It kept records detailing who prescribed the medicine and who received it. The pharmacy kept records of controlled drugs which complied with regulations and team members carried out weekly checks of the stock balance against the register running balance. Controlled drugs waiting to be supplied to people and patient returns were kept separately so that they couldn’t be mixed up. Robust records of these patient returns were maintained. And the pharmacist regularly destroyed the returned medicines to ensure that medicine did not build up. The pharmacy had current indemnity insurance.

Team members completed data protection and information governance training annually. They were aware of their responsibilities surrounding confidentiality and kept confidential waste separate for off-site shredding. A poster was displayed in the retail area informing people of the company’s compliance with General Data Protection Regulations (GDPR). Team members also understood their responsibilities around safeguarding vulnerable adults and children. This included the delivery driver, who knew to report any concerns back to the pharmacist and team, who then contacted the appropriate people, such as the GP, with the concerns. The team were also aware of the “Ask for ANI” initiative, which supported people experiencing domestic abuse, and one team member had planned in updated training for the team. The pharmacist had completed a level 3 course for safeguarding children and adults.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably trained team members who work safely and effectively together to manage the workload. And they complete ongoing training to keep their skills up to date. They can make suggestions to improve working practices. And they feel comfortable raising concerns if necessary.

Inspector's evidence

Pharmacy team members included the regular RP, a trainee pharmacist, a qualified pharmacy technician who was training to become an accuracy checking technician (ACT), four dispensers, a medicines counter assistant, and a delivery driver. The pharmacy was busy at the time of the inspection, and team members were observed to be working safely and effectively together and supported each other to complete tasks. Team members reported that the IT upgraded system was working slowly and at times reduced their dispensing efficiency. Team members had received online training when the system had been installed and a company trainer attended for two days to provide onsite help and support.

Team members were observed giving suitable advice to people and referred to the pharmacist when necessary. They were provided with regular company training and development. But workload pressures meant that this training was not completed during the working day and instead was completed at home. The trainee pharmacist was given protected learning time. She made use of learning and development opportunities given to her and explained that she was trained to administer influenza vaccinations to people. A culture of openness and honesty meant that team members felt able to raise concerns and make suggestions to improve working practice. They described how improvements had been made to the way items requiring to be kept in a fridge were handled. The pharmacist regularly gave informal in-the-moment feedback and any learnings from these conversations were shared with the wider team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy and it provides adequate space for dispensing activities. It has a suitably sized soundproofed room where people can access services and have private conversations with the team.

Inspector's evidence

The pharmacy was clean and tidy and free from clutter and trip hazards. The dispensary was well organised with medicines stored neatly in drawers and on shelves. The layout of the dispensary allowed for different dispensing tasks, including dispensing medicines into multi-compartment compliance packs, to be carried out in separate areas. Additional space, if needed, was provided by use of a desk in the middle of the floorspace. This was positioned so team members could easily move around it and it did not create any hazards. The pharmacy had a soundproofed room where people could have private conversations with team members or access services from the pharmacist or trainee pharmacist. The room had a desk and appropriate space to allow services to be carried out. The dispensary had a sink which was used for hand washing and preparation of medicines. And there were toilet facilities within the staffing area which had a sink that provided hot and cold water for hand washing. Lighting throughout the pharmacy was bright and the temperature was comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. And people easily access the services. Pharmacy team members obtain medicines from recognised suppliers. And they mostly store and manage medicines appropriately. But they do not always complete the checks of medicine expiry dates in a timely manner to make sure they are suitable to supply.

Inspector's evidence

The pharmacy had a step free entrance from the street which allowed ease of access for people with limited mobility and with pushchairs. The pharmacy team delivered various NHS services such as the hypertension case finding service, community pharmacy consultation service (CPCS) and private vaccinations services. It routinely received referrals as part of the CPCS service from the GP practice next door and from NHS 111. On the day of the inspection, the pharmacist had received several referrals from the GP practice and was seen carrying out consultations and where necessary referring people onto another healthcare provider. Private vaccination services were prescribed via the company online doctor prescribing platform and included travel vaccinations, human papillomavirus vaccinations and influenza vaccinations. And the pharmacist administered them. Influenza vaccinations were also delivered under the NHS national protocol and the trainee pharmacist had been trained by the company to administer these.

When dispensing, team members kept people's prescriptions and their medicines in baskets. This helped prevent errors where different people's prescriptions and medicines became mixed. And they used stickers to highlight actions needed, such as interventions required by the pharmacist or the inclusion of a fridge line or a controlled drug on the prescription. Team members knew to obtain additional information when dispensing higher risk medicines. Stickers were used for prescriptions containing medicines such as warfarin and methotrexate to highlight additional counselling needs to help ensure people were taking their medicines safely. Team members were aware of the additional counselling requirements people taking valproate in the at-risk group, and they highlighted these prescriptions to the pharmacist.

The pharmacy dispensed medicines into multi-compartment compliance packs to help people take their medicines properly. Team members followed robust procedures to manage the process of dispensing the packs. Each person had a folder containing information such as the medicine they took, and this was checked against their prescriptions. And any discrepancies were queried with the GP surgery. Team members also received notification of changes in people's medicines made by hospitals. The packs were completed a week before they were needed by people, to help manage workload. Each person's pack had a separate storage location which minimised the risk of different people's packs being mixed up. The completed packs had descriptions of the medicines inside, so that they could be easily identified. And the team supplied patient information leaflets with the packs, so that people had all the required information about their medicines.

The pharmacy provided a delivery service, taking medicines to people's homes. The driver mostly delivered multi-compartment compliance packs and collected prescriptions from surgeries. There was an audit trail in place whereby people were asked to sign electronically to say they had received their delivery. The pharmacy retained paper copies of signatures captured for delivery of controlled drugs so

that any queries regarding delivery could be resolved.

The pharmacy sourced medicines from various recognised suppliers. It had a written procedure for checking the expiry dates of medicines, but the record was not up to date and team members confirmed that the process had lapsed recently. The pharmacist explained the team had restarted the process that day and had checked the expiry date of most medicines, except liquid medicines. Team members highlighted medicines that were going out of date in the next twelve months. Liquid medicines with a short shelf life after opening were marked with the date of opening.

The pharmacy kept Pharmacy (P) medicines in the retail area in glass cabinets and team members working on the medicines counter restricted unauthorised access. The pharmacy had a large fridge with a glass door which enabled stock to be viewed without prolonged opening. It kept paper records that showed the temperature of the fridge was maintained between 2 and 8 degrees. But records from December showed that for approximately three weeks the maximum temperature was outwith the range at 9.7 degrees. The pharmacist explained that this was due to the door being left open for a short period of time while a team member checked the expiry dates of stock in the fridge and that they were unsure how to reset the thermometer. The reason had not been recorded on the temperature record sheet.

Team members understood the procedure to manage drug alerts and medicine recalls. These were received electronically by NHS email, directly from the Medicines and Healthcare Regulatory Agency (MHRA) and via the company’s communication hub. The pharmacist showed that historical drug alerts and recalls were actioned on the company's communication hub.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the services it provides. And it generally keeps its equipment well maintained. Team members mostly use the equipment and facilities in a way to ensure people's privacy.

Inspector's evidence

Pharmacy team members had access to up-to-date reference sources. These included electronic copies of the British National Formulary (BNF) and BNFc (for children). It had equipment to provide a range of services, including a blood pressure machine, and this was due to be replaced. It also had equipment to measure people's cholesterol and diabetes. But records showed that monthly calibration checks had not been carried out since July 2022 due to fewer people accessing the service. The pharmacist explained that if they were needed, they would be calibrated the day before to ensure accuracy of results obtained.

The pharmacy had suitable measures for liquids, and these were marked to indicate which were for water and which were for liquid medicines. It had triangles and tablet counters to assist with counting medicines and separate tablet counters were used for cytotoxic medication. And the team ensured that these were cleaned after use. There was a cordless phone so conversations could be kept private. Password protected computers were positioned so that screens could only be seen by team members. And NHS smart cards were used to allow authorised team members access to computer systems.

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.