

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 34 High Street,
KNARESBOROUGH, North Yorkshire, HG5 0EQ

Pharmacy reference: 1091327

Type of pharmacy: Community

Date of inspection: 19/02/2020

Pharmacy context

This is a community pharmacy in Knaresborough. A market town in North Yorkshire. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as flu vaccinations, the New Medicines Service and medicines use reviews. It supplies some medicines in multi-compartment compliance packs to people living in their own homes. And it provides a home delivery service.

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	2.2	Good practice	The pharmacy encourages and supports its team members to complete regular training to help them keep their knowledge and skills refreshed and up to date. It achieves this by providing its team members with protected training time and regular performance appraisals.
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 the services it provides to people. And it has a set of written procedures for the team members to follow. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The team members regularly discuss and record any mistakes that they make when dispensing. So, they can learn from each other. They discuss how they can improve, and they make changes to minimise the risk of similar mistakes happening in the future. Some of the errors recorded lacked detail. So, this could mean that opportunities for change are lost. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy was generously sized. With a long retail area to the front. And a good-sized dispensary which was to the rear of the pharmacy counter. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The pharmacist checked prescriptions on the bench nearest the counter. This allowed him to hear conversations at the front counter and he could intervene if necessary.

The pharmacy had a set of written standard operating procedures (SOPs). The pharmacy's superintendent pharmacist's team reviewed the SOPs every two years. Some of the SOPs had documented review dates of August 2021. The SOPs were being reviewed and updated in phases. The manager said that he liked the new layout of the SOPs because they were concise and easy to read. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team. The team members had read and signed each SOP that was relevant to their role.

There was a process in place to highlight near miss errors made by the team when dispensing. And the details of each near miss error were recorded onto a paper near miss log by the team member who made the error. The team members recorded the date, time and type of the error. But the action taken to prevent a re-occurrence section was hardly ever completed. So, this could mean that changes are not being made to prevent a similar error happening again. The near misses were analysed each month by a team member for any trends and patterns. And each month the findings were discussed with the team members. And a report was made. The report was kept in the dispensary for future reference. They had recently focused on reducing the number of errors involving medicines that sounded alike or looked alike (LASAs). For example, the team members had separated amlodipine and amitriptyline on the dispensary shelves. The pharmacy had a process to record dispensing errors that had been given out to people. And copies of the reports were kept in the pharmacy for future reference. The report included details of who was involved, what happened and what actions they pharmacy completed to prevent a similar error from happening again. The most recent report, completed this month, detailed an occasion where the pharmacy had supplied a compliance pack with an extra tablet in it. A reflective statement had been done and a root cause analysis. The manager said that a contributory factor was that the accuracy checking technician (ACT) had dispensed it and the pharmacist had checked it for accuracy. And a clinical check was done at the same time. So, he thought that when checking the prescription, he was concentrating on the clinical check. So, it was decided that the clinical check and accuracy check functions should be split.

The pharmacy completed a check on professional standards over a four-week cycle. They focused on a specific area of the pharmacy each week. For example, week one involved looking at the pharmacy environment. The checks were designed to make sure the pharmacy was following set processes and highlighted any areas where it could make improvements. The pharmacy was up to date with the checks and regularly held a 'Safer Care' meeting which involved all the team members. And they talked about near miss errors and dispensing incidents during the meetings.

The pharmacy displayed the correct responsible pharmacist notice. And it was easy to see from the retail area. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The pharmacy had a formal complaints procedure in place. And it was available for people to see via the pharmacy's customer charter leaflet which was available in the retail area for self-selection. The pharmacy collected feedback through an annual patient satisfaction survey. The team members discussed the findings of the survey with each other. The findings were generally positive, and 98% of people thought that the service they received was either very good or excellent. An area highlighted for improvement was giving lifestyle advice to people. The pharmacy was now a healthy living pharmacy, promoting a healthier lifestyle. And they offered advice to people about alcohol awareness and diet.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete electronic records of private prescription and emergency supplies. The pharmacy kept CD registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. A physical balance check of a randomly selected CD matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team members were aware of the need to keep people's personal information confidential. They had all undertaken General Data Protection Regulation (GDPR) training. And there was an information governance booklet of guidance kept in the dispensary for the team members to access if they needed any further information. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate yellow bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor. The responsible pharmacist and pharmacy technicians had completed training on safeguarding vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). Team members explained how they would discuss any concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had written guidance on how to manage or report a concern and the contact details of the local support teams. A copy of this was on the wall in the pharmacy.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload and to ensure people receive a quality service. And they feel comfortable to raise professional concerns when necessary. The pharmacy encourages and supports its team members to complete regular training to help them keep their knowledge and skills refreshed and up to date. It achieves this by providing its team members with training time and regular performance appraisals.

Inspector's evidence

At the time of the inspection, the responsible pharmacist was the manager who had been working in the branch for about three years. At the time of the inspection he was supported by one ACT, one pharmacy technician, one dispensary assistant and one medicine counter assistant. The pharmacy also employed a part-time delivery driver who collected prescriptions from local surgeries and delivered medicines to people's homes. The pharmacy manager felt he had enough team members to ensure the pharmacy provided a high quality of service. He explained he was fully staffed and that they usually managed without additional support when members of the team were on holiday. The team members were observed managing the workload well and there was a manageable workflow. They were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various e-learning modules. The modules covered various topics, including mandatory compliance training covering health and safety and various other processes. Other modules were based on various healthcare related topics and could be chosen voluntarily in response to an identified training need. The team members received training time during the working day to complete the modules. So, they could do so without any distractions. The team had recently completed training on Viagra which was now for sale over the counter. And they completed a short quiz at the end of each module to test their understanding. The team members received a performance appraisal annually with a mid-year review in October. The appraisals were an opportunity for the team member to discuss which aspects of their roles they enjoyed and where they wanted to improve.

The team members felt comfortable to raise professional concerns with the manager initially. The pharmacy had a whistleblowing policy. The team were aware of it. And so, they could raise concerns anonymously. The team was set various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements. And the manager thought that these were achievable.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is secure and well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and professional in its appearance. The dispensary was a good size, and it was kept tidy and well organised during the inspection. The team used the bench space well to organise the workflow. Floor spaces were kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with a sink with hot and cold running water and other facilities for hand washing in the upstairs staff room. The pharmacy had a sound-proofed consultation room with seats where people could sit down for private conversations with the team member. There was a desk and computer. The room was smart and professional in appearance and was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are easily accessible to people. The pharmacy manages its services appropriately and delivers them safely. It supports some people to take their medicines at the right time by providing them with medicines in multi-compartment compliance packs. And it suitably manages the risks associated with this service. The pharmacy sources its medicines from licenced suppliers. And it stores its medicines appropriately. Sometimes out of date medicines are not removed from the shelves. So, this may result in them being supplied to people. The team members identify people taking high-risk medicines. And they support them to take their medicines safely. The pharmacy may not always record the advice given to people taking high risk medication. So, it may not be able to refer to this information in the future if it needs to.

Inspector's evidence

The pharmacy was accessible through double doors from the street. So, people with wheelchairs could easily access the pharmacy. It stocked a wide range of healthcare related leaflets in the retail area, which people could select and take away with them. And it used a small section of the retail area to promote healthy living advice. The team had access to the internet to direct people to other healthcare services.

The team members regularly used stickers to attach to bags containing dispensed medicines, and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. So, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. And they were of different colours to help the team manage the workload efficiently. For example, red baskets were used for prescriptions for waiters. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept records of the delivery of medicines it made to people. The records included a signature of receipt. So, there was an audit trail that could be used to solve any queries.

The pharmacy supplied medicines in multi-compartment compliance packs to around one hundred people living in their own homes. And they were permitted to order prescriptions for these. They kept all documents related to each person in separate folders. The documents included master sheets which detailed the person's current medication and time of administration. The team members used these to check off prescriptions and confirm they were accurate. The team members held all prescriptions, documents and stock in separate baskets during the dispensing process. They kept records of conversations that they had with people's GPs. For example, if a treatment was to be stopped. They supplied the packs with backing sheets which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. They also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. The pharmacist 'pharmacist'

stickers to attach to people's dispensed medicines bags when he was checking. The stickers were a reminder to discuss the person's treatment when handing out the medicine. For example, the pharmacist checked people's INR if they were prescribed warfarin. And checked if they had been having regular blood tests. The manager said that he sometimes makes records of these conversations on the patient record. But not always. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. No one had been identified. The pharmacy dispensed insulin in clear bags. This helped the team members and the person collecting the insulin to complete a final visual check.

The pharmacy stored pharmacy medicines (P) to the side of pharmacy counter in clear closed but unlocked cabinets. The pharmacy counter was manned throughout the inspection, and the manager said that there was always a member of the team on the counter. And so, a team member could easily see if a person needed help selecting a P medicine from the cabinets. The pharmacy stored its medicines in the dispensary tidily. Every three months, the team members were scheduled to check the expiry dates of its medicines to make sure none had expired. A random check of four areas in the pharmacy was made. One item was found that was out of date in November 2019 and another in December 2019. There were also two items found that were due out of date in February 2020. The manager confirmed that it was usual practice to remove short date items before the month they expired. These were removed for destruction. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. Metoclopramide liquid was found on the shelf which was out of date 20 January 2020. The manager thought that because all the medicines were stickered with the expiry date it was unlikely that they would have been supplied to people because they always check the date at the time of dispensing. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits. There were no out of date or patient returned CDs.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received some information on how to follow the directive and had completed a basic my learn training unit. The manager was aware that this was coming. But was unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinets were secured and of an appropriate size. The medicines inside the fridge and CD cabinets were well organised.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. And there were separate cylinders used to dispense methadone. The team members used tweezers to help dispense multi-compartment compliance packs. The fridge used to store medicines was of an appropriate size. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people 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.