

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Oaks Park Primary Care Centre,
Thornton Road, Kendray, BARNSELY, South Yorkshire, S70 3NA

Pharmacy reference: 1091476

Type of pharmacy: Community

Date of inspection: 11/03/2020

Pharmacy context

The pharmacy is in a health centre in a residential area. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). They supply medicines to people in multi-compartment compliance packs. And deliver medicines to people's homes. The pharmacy provides a substance misuse service, including supervised consumption.

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 have a proactive approach to identifying medicines and prescriptions that are more likely to be involved in errors during dispensing. They record and discuss any mistakes that do happen. And they read about mistakes that happen elsewhere to improve their practice. They use this information to help inform the changes they make to reduce errors.
2. Staff	Standards met	2.2	Good practice	The pharmacy provides access to comprehensive training materials. Pharmacy team members complete training regularly, in various ways, to improve their knowledge and skills.
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. Pharmacy team members follow them to complete the required tasks. The pharmacy protects people's confidential information. It keeps the records it must by law. And pharmacy team members know how to help safeguard the welfare of children and vulnerable adults. Pharmacy team members have a proactive approach to identifying medicines and prescriptions that are more likely to be involved in errors during dispensing. They record and discuss any mistakes that do happen. And they use this information to learn and reduce the risk of further errors.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The sample checked were last reviewed in 2019. And the next review was scheduled for 2021. Pharmacy team members had read and signed the SOPs in 2019 after the last review. The pharmacy defined the roles of the pharmacy team members in each SOP. The pharmacy had an accuracy checking technician (ACT) who was accredited to perform final accuracy checks of prescriptions. The ACT reaccredited her skills every two years by completing a checking log. And the items checked as part of the log were double checked by the pharmacist. The pharmacist reaccredited the ACT to be able to check after they had successfully completed their checking log with no mistakes. The pharmacist clinically checked prescriptions before they were dispensed. And they annotated the prescriptions to confirm they had completed their check. The ACT explained that she would return any prescriptions to the pharmacist that had not been annotated before performing her final accuracy check. The pharmacist and ACT agreed which items could not be checked by the ACT. The ACT explained that she was not permitted to check prescriptions for methotrexate or controlled drugs (CDs) that required storage in the CD cabinet. Pharmacy team members carried out a 'Safer Care' audit process each month. The audit was split into four sections, each completed over a four-week period, covering a different part of the operation each week, such as the pharmacy environment, the pharmacy's people, and whether key governance tasks were being completed. Week four of the process was reserved for a Safer Care briefing with the team, where the months findings were discussed, along with the findings from errors that had occurred. Some examples of audits were available. And these were properly completed.

The pharmacist and ACT highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. The pharmacy team discussed the errors made. And they sometimes discussed and record details about why a mistake had happened. They used this information to help make changes to prevent the mistake happening again. The pharmacist and pharmacy manager analysed the data collected about mistakes every month as part of the Safer Care audit process. Their analysis was based on quantitative information collected, such as the number of strength or quantity errors being made. Or the number of times a medicine was involved in an error. They did not record any analysis of the data for patterns of causes. But they discussed patterns they found with the whole team. And used the information to help them decide on the most appropriate changes to make. One example was the pharmacy separating amlodipine and amitriptyline after a pattern of picking errors. The pharmacist said a recent pattern identified had been an increase in quantity errors across the team. And they were currently exploring the causes of the pattern. The pharmacy had a process for dealing with dispensing errors that had been given out to people. It recorded incidents using an electronic system called PIMS. And the pharmacist printed copies of the

electronic records submitted. The sample of reports seen recorded comprehensive details about each error. Pharmacy team members clearly explained what had caused the mistakes. And the changes they had made to prevent similar mistakes happening again. They had completed a root cause analysis and a reflective statement for some dispensing errors. These provided comprehensive information about the causes of the mistakes. And the changes they had made to prevent a recurrence. Pharmacy team members had created a list of common look-alike and sound-alike (LASA) medicines. And they displayed the list in various areas of the dispensing area. The list included medicines that had been identified by head office after mistakes elsewhere in the company. Pharmacy team members had added medicines after they had been involved in errors in the pharmacy, for example hydroxyzine and hydralazine. And they had also proactively added medicines they felt were at risk of being involved in a mistake, for example lorazepam and loperamide. When the pharmacist carried out their clinical check of the prescription, they stamped the prescriptions with "LASA" if it included any item on the list. This helped to highlight the risk or error to anyone involved in dispensing or checking the prescription. The stamp also included boxes to record who had dispensed and checked the LASA medicine. The pharmacist also used a highlighter pen to highlight elements of a prescriptions that were likely to cause an error. For example, an uncommon formulation. The pharmacist said she also highlighted things based on her experience of where pharmacy team members had made mistakes. Pharmacy team members explained the system had helped prevent them from making mistakes. And they had also noticed a reduction in various common near miss errors since the system was implemented six months ago.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people verbally. One example of feedback had been about the pharmacy's waiting times for prescriptions to be dispensed. Pharmacy team members explained they tried to manage people's expectations by stating a waiting time when they handed in their prescriptions. But they said this was sometimes difficult when the pharmacy was very busy.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept CD registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity weekly, including methadone. It kept and maintained a register of CDs returned by people for destruction. And this was complete and up to date. The pharmacy maintained a responsible pharmacist record electronically. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. The pharmacy team monitored and recorded fridge temperatures daily in three fridges. 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 contractor and sent for secure destruction. Pharmacy team members were trained to protect privacy and confidentiality. They read the pharmacy's privacy and information security policies every year. And they had signed confidentiality agreements. Pharmacy team members were clear about how important it was to protect confidentiality.

When asked about safeguarding, a dispenser 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. The pharmacist said they would assess the concern. And would refer to the company's internal process or local safeguarding teams to get advice. The process was displayed in the dispensary. The pharmacy had contact details available for the local safeguarding service and the company's

internal safeguarding advisors. Pharmacy team members completed mandatory training every year. They had last completed training in 2019. Registered pharmacists and pharmacy technicians also completed distance learning via The Centre for Pharmacy Postgraduate Education (CPPE) every two years, in addition to the company's mandatory training.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. The pharmacy provides access to comprehensive training materials. Pharmacy team members complete training regularly to improve their knowledge and skills. 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 learning goals. Pharmacy team members feel able to raise concerns and use their professional judgement.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist, two pharmacy technicians, one with accuracy checking responsibilities (ACT), two dispensers and a medicines counter assistant. Pharmacy team members completed mandatory e-learning modules each month, called My Knowledge Check. The modules covered various pharmacy topics, including mandatory compliance training covering health and safety, customer service and information governance. And, other health related topics often related to seasonal or current health conditions. Recent examples included sepsis and Coronavirus. The pharmacy received a Safer Care case study from the superintendent's office every month. Each case study highlighted a scenario for pharmacy team members to read and discuss. And, these were often drawn from real incidents that had happened elsewhere in the company. The most recent was about errors involving look-alike and sound-alike (LASA) medicines. Pharmacy team members had a yearly appraisal with the pharmacy manager. They discussed their performance and were given the opportunity to identify any learning needs. They then set objectives to address their needs. One example of an objective set was for a team member to keep up to date with their mandatory training. The dispenser explained she had been supported by the manager and colleagues to achieve this by being provided with 30 minutes of protected learning time each week. And this facility was also given to the other pharmacy team members.

A dispenser explained that she would raise professional concerns with the pharmacist, pharmacy manager or cluster lead. 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 process was clearly displayed to team members. Pharmacy team members communicated with an open working dialogue during the inspection. They explained a change they had made after they had identified areas for improvement. Previously, pharmacy team members quoted waiting times to people when they handed in their prescriptions to help manage their expectations. And they varied the time they quoted depending on how busy the pharmacy was. But pharmacy team members were sometimes giving waiting times that put additional pressure on completing the dispensing tasks quickly. So they changed their process for quoting waiting times so pharmacy team members didn't feel rushed. This provided pharmacy team members with more time to carry out dispensing tasks. And they explained they felt more confident spending time carrying out checks of their work more thoroughly.

The pharmacy asked the team to achieve targets. Targets included the number of patients who nominated the pharmacy to receive their electronic prescriptions, the number of medicine use review and new medicines service consultations completed, and the number of prescription items dispensed. Pharmacy team members discussed progress with the area manager, who supported them to reach

their goals. And they felt the targets were achievable.

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. Pharmacy team members kept all areas of the pharmacy tidy and well organised. They kept floors and passage ways free from clutter and obstruction. And they kept equipment and stock on shelves throughout the premises. The pharmacy had a safe and effective workflow in operation. It had clearly defined dispensing and checking areas. It had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The pharmacy identified the room with a sign on the door.

The pharmacy had a clean, well maintained sink in the dispensary. And pharmacy team members used the sink for medicines preparation. The pharmacy had a toilet which provided a sink with hot and cold running water and other facilities for hand washing. The pharmacy kept heat and light to acceptable levels. The pharmacy's overall appearance was professional, including the exterior which portrayed a professional healthcare setting.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are generally accessible to people, including people using wheelchairs. And the pharmacy has systems in place to help provide its services safely and effectively. It stores, sources and manages its medicines appropriately. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. They manage this service well. And they provide these people with the information they need to identify their medicines in the devices in case of queries. They take steps to identify people taking high-risk medicines. And they provide these people with suitable advice to help them take their medicines safely.

Inspector's evidence

The pharmacy had level access from the car park. It advertised its services in various location around the pharmacy. And it clearly displayed public health information about coronavirus to people on the door so they could see the information from outside. The pharmacy had a hearing induction loop installed to help people with a hearing impairment. Pharmacy team members explained they would also use written communication to help someone with a hearing impairment. They were unsure about how to help people with a visual impairment.

The pharmacy sent a proportion of its prescriptions to the company's off-site dispensing hub, where most medicines were picked and assembled by a dispensing robot. Pharmacy team members explained that prescriptions sent to the hub were usually for regular repeat medication. The pharmacy computer system and pharmacy team members determined which prescriptions could be sent to the hub. And whether the whole prescription or only part could be dispensed at the hub. Examples of prescriptions dispensed locally were for medicines such as liquids or controlled drugs (CDs). Prescriptions were then placed in a queue and a dispenser inputted the information from the prescription for each one. The pharmacist clinically checked all prescriptions that were to be sent to the hub. And they signed each prescription token to confirm they had performed the clinical check. The data from the prescription added by the dispenser was checked for accuracy by the pharmacist. The information was sent to the hub, so the prescription could be dispensed by the robot. Pharmacy team members then filed the prescriptions to wait for the medicines to be returned from the hub two days later. Prescriptions dispensed at the hub were returned to the pharmacy in dedicated totes. Pharmacy team members married up all returned bags with their prescription tokens. And with any items they had dispensed locally. They updated the computer system to show that the correct medicines had been received. They then placed the bags in the retrieval area ready for collection.

Pharmacy team members used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. They 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. They stored CDs and fridge items, such as insulin, in clear plastic bags. This helped facilitate a final visual check by the pharmacist before the medicine was handed out. And it allowed people to see their medicines and raise any queries before they left the pharmacy. 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. The pharmacy had a stock of printed information material to give to people and to help them manage the risks. Pharmacy team members alerted the pharmacist to any

prescriptions for warfarin. And the pharmacist asked people for their latest blood monitoring results when they handed out their prescription. The pharmacy supplied medicines in multi-compartment compliance packs when requested. It attached backing sheets to each pack, so people had written instructions of how to take the medicines. And these included 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. They documented any changes to medicines provided in packs on the patient's master record sheet. The pharmacy delivered medicines to people using a hub driver based at another store. Pharmacy team members populated the delivery records. And the driver added the information to their hand-held electronic device. They also printed each run sheet, which was 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.

The pharmacy obtained medicines from three licensed wholesalers. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). And they had been trained about the requirements. They explained some of the features of compliant products, such as the 2D barcode and the tamper evident seal on packs. And the pharmacy had the right equipment and software in place. Pharmacy team members said they were expecting a phased rollout of the system soon. But they did not know when this would be. The pharmacy 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 CDs. Pharmacy team members kept the CD cabinets 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. Pharmacy team members kept the contents of three pharmacy fridges tidy and well organised. They monitored minimum and maximum temperatures in the fridges every day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members checked medicine expiry dates every 12 weeks. Completed records were seen. They highlighted any short-dated items with a sticker on the pack up to six months in advance of its expiry. And expiring items were removed from the shelves at the date check before their expiry. The pharmacy responded to drug alerts and recalls. Any affected stock found was quarantined for destruction or return to the wholesaler. Pharmacy team members recorded any action taken. And their records included details of any affected products removed.

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 had a set of clean, well maintained measures available for medicines preparation. It positioned computer terminals away from public view. And, these were password protected. The pharmacy stored medicines waiting to be collected in the dispensary, also away from public view. It had three dispensary fridges that were in good working order. And pharmacy team members used them to store medicines only. They restricted access to all equipment. And they stored all items 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.