General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Longhill Healthcare Centre, 162-164 Shannon Road, HULL, North Humberside, HU8 9RW

Pharmacy reference: 1092639

Type of pharmacy: Community

Date of inspection: 02/03/2023

Pharmacy context

This community pharmacy is in a large medical centre in a suburb of Hull. The pharmacy dispenses NHS prescriptions and provides some people with their medication in multi-compartment compliance packs to help them take their medication. It helps people treat a variety of medical conditions via the NHS minor ailments scheme. And it provides some private services including weight loss and the Hepatitis B vaccination. The company's offsite hub pharmacy dispenses medicines for some of the pharmacy's NHS prescriptions.

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 identifies and manages the risks associated with its services well. It generally completes the records it needs to by law and has comprehensive procedures in place to support the safe delivery of its services. Team members respond correctly when errors occur, and they suitably protect people's confidential information. They provide people with information on how to raise a concern and they have training and guidance to help them understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. Most SOPs were kept electronically for team members to access through personal logins. They answered a few questions related to each SOP to demonstrate they'd understood the SOP and would follow it, and they had protected time to do this. The completion of this process was monitored by the pharmacy manager who received notification of new SOPs or when changes were made to existing SOPs. Team members demonstrated a clear understanding of their roles and worked within the scope of their role.

On most occasions the pharmacist when checking dispensed prescriptions and spotting an error asked the team member involved to find and correct the error. This meant they had an opportunity to reflect on their error. The pharmacy kept records of these errors known as near misses which were completed by the team member involved. The details recorded enabled the team to identify patterns, learn from the error and take action to prevent a similar error from happening again. The pharmacy had a separate process for recording errors that were identified after the person received their medicines, known as dispensing incidents. Team members regularly reviewed the near miss errors and dispensing incidents to identify patterns and they discussed the actions they could take to prevent similar errors from happening again. Recent reviews identified the importance of ensuring the dose instructions were clear. For example, if the dose on the prescription was '1od' to change it to 'one to be taken daily'. Following an error when one person's medication was supplied to another person all team members were informed. And an additional check was introduced at the point when team members confirmed the person's identification at the point of handing the medication over. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services and a leaflet provided people with information on how to raise a concern.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers generally met legal requirements. An IT issue over a few days had prevented access to the electronic RP record but a paper version had not been used during this time, so there were records missing. Team members regularly checked the balance of the CD registers against the physical stock to identify errors or missed entries. The pharmacy displayed details on the confidential data it kept and how it complied with legal requirements. It also displayed a separate privacy notice. Team members completed training about General Data Protection Regulations (GDPR), and they separated confidential waste for shredding offsite. The pharmacist had reminded the team when returning uncollected dispensed medicines to stock to remove the dispensing label with the person's name on. Or to transfer the stock to a white box with the product's details written on.

The pharmacy had safeguarding procedures and guidance for the team to follow. And team members completed safeguarding training. The pharmacist had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. And all team members were aware of the Ask for ANI (action needed immediately) initiative, which supported people experiencing domestic abuse. They’d not had an occasion to raise a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work very well together, and they are good at supporting each other in their day-to-day work. They discuss ideas and identify ways to support the effective delivery of the pharmacy's services. And they complete ongoing training to help them develop their knowledge and skills.

Inspector's evidence

A full-time pharmacist covered most of the pharmacy's opening hours with locum pharmacist support when required. The pharmacy team consisted of six part-time dispensers and one part-time medicines counter assistant. One of the part-time dispensers had recently taken on the role of pharmacy manager whilst the full-time manager was on a planned absence. The dispenser had previously been the pharmacy supervisor and had experience of supporting the team.

Team members worked well together and supported each other with tasks such as the dispensing of the multi-compartment compliance packs. They rotated key tasks to ensure they all knew how to complete these tasks especially at times of unplanned absence which may impact on the team's workload. And the pharmacy manager monitored the workload throughout the day. For example, when there was a build-up of baskets containing dispensed items waiting to be checked team members paused their dispensing activity. This enabled the pharmacist to complete their checks and prevented baskets from being on top of each other, which could create a risk of errors. The team in the dispensary spent time in the retail area to maintain their knowledge of over-the-counter medicines.

Team members used company online training modules to keep their knowledge up to date. And the pharmacist regularly tested team members knowledge on a range of subjects by setting quizzes for them to complete. The team held regular meetings and team members could suggest changes to processes or new ideas of working. Morning meetings were used to assess the workload for the day and assign tasks to the team members. The team was given in the moment feedback from the pharmacy manager and pharmacist. But team members had not received a formal performance review for several months.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and provide a suitable environment for the delivery of pharmacy services. The pharmacy has good facilities to meet the needs of people requiring privacy when accessing its services.

Inspector's evidence

Team members kept the pharmacy premises tidy and hygienic. And the pharmacy provided separate sinks for them to use when preparing medicines and washing their hands. In response to the COVID-19 pandemic the pharmacy had installed a clear plastic screen on the pharmacy counter. And there was hand sanitising gel for the team to use. There was enough storage space for stock, assembled medicines and medical devices and team members ensured the floor spaces were clear to reduce the risk of trip hazards.

The pharmacy had a defined professional area and items for sale in this area were healthcare related. There was a large, soundproof consultation room which the team used for private conversations with people and when providing services. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible and help people to meet their healthcare needs. And it manages its services well to make sure people receive their medicines when they need them. The pharmacy gets its medicines from reputable sources, and it stores them properly. Team members carry out checks to make sure medicines are in good condition and appropriate to supply.

Inspector's evidence

People accessed the pharmacy through an automatic door from the car park or a direct entrance from the medical centre. And there was plenty of room in the retail area for people to move around. The pharmacy had an information leaflet providing people with details of the services it offered and the contact details of the pharmacy. And team members gave people information on how to access other healthcare services when required. Team members wore name badges detailing their role, so people knew who they were speaking to. They asked appropriate questions of people requesting over-the-counter (OTC) medicines and they monitored people's requests to buy OTC medicines to ensure the supplies were suitable. Any concerns regarding a person's request to buy an OTC medicine were referred to the pharmacist. The NHS minor ailments service was popular as it helped people obtain medication such as head lice treatment without delay.

The pharmacy's private services were delivered against up-to-date patient group directions (PGDs) that provided the pharmacist with the legal authority to supply prescription only medicines or administer a vaccine. The private weight loss service included an appointment with the pharmacist who undertook the necessary checks to identify the treatment suitable for the person. And gave the person instructions on how to administer the medication. Healthy living advice was also provided to people attending the weight loss service and the pharmacist monitored the person's progression with managing their weight loss. Several people had commented that the face-to-face contact with the pharmacist provided support and encouragement for them to lose weight. Team members were kept up to date with the services provided so they could identify people who may benefit from a service. And to support the pharmacist when they were providing the service.

The pharmacy provided multi-compartment compliance packs to help around 35 people take their medicines. To manage the workload the team ordered prescriptions two weeks before supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication and dose times which the team regularly referred to during the dispensing and checking of the prescriptions. Team members recorded the descriptions of the medication within the packs, and they supplied the manufacturer's packaging leaflets. So, people could identify the medicines in the packs and had information about their medicines. Completed packs were kept in containers labelled with the person's details and held on a dedicated set of shelves. The pharmacy supplied a few people's medicines daily as supervised and unsupervised doses. The doses were prepared in advance to reduce the workload pressure of dispensing at the time of supply. And were stored securely with the prescription in tubs labelled with the person's name to help ensure the correct person's dose was selected.

The pharmacy used the company's offsite pharmacy hub to help dispense many of its NHS

prescriptions. The team followed procedures on how to process prescriptions in this way. This involved the team entering the prescription data into the system which was checked for accuracy by the pharmacist who also clinically checked the prescribed medicines before the data was submitted. Urgent prescriptions such as antibiotics were dispensed at the pharmacy. The team scanned the barcode on the sealed bags containing the dispensed items returned by the offsite pharmacy hub to confirm receipt. And to identify any incomplete prescriptions highlighted by the offsite pharmacy hub that were to be dispensed at the pharmacy. Following a few incidents when people reported missing items team members completed an external check of the contents of the sealed bag. And matched the number of containers with the prescription to identify any missing items. The team advised people to request their prescriptions a week in advance of needing their medication to allow time for the team to receive the prescriptions, send the data to the hub and receive the dispensed medication.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Team members were reminded to keep the workspaces clear of clutter to help reduce the risk of errors and to ensure one task was completed before starting another. The pharmacy had checked by and dispensed by boxes on dispensing labels to record who in the team had dispensed and checked the prescription. A sample found that the team completed both boxes. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines which allowed the team, and the person collecting the medication, to check the supply. Team members stored the dispensed medicines requiring cold storage, in alphabetical order, in the fridge to help them easily locate the medicine when the person presented. And they used fridge stickers on bags and prescriptions to remind them when handing over the person's medication to include these items. The pharmacy marked the prescriptions for CDs to prompt the team to check that supplies were within the 28-day legal limit. When the pharmacy didn't have enough stock of a person's medicine, it provided a printed slip detailing the owed item. Team members provided people with clear advice on how to use their medicines. And they were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) along with the information to be provided to people who met the criteria. The pharmacy stored valproate medicines in a dedicated, clearly labelled drawer.

The pharmacy obtained medication from several reputable sources. Team members checked the expiry dates on stock but there were no recent records of this activity. They marked medicines with a short expiry date to prompt them to check the medicine was still in date before supply. No out-of-date medicines were found from a sample checked. The dates of opening were recorded for medicines with altered shelf-lives after opening so the team could assess if the medicines were still safe to use. Team members checked and recorded fridge temperatures each day and were reminded to do this by a notice on the fridge door. A sample of these records found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email which the team actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people’s private information.

Inspector's evidence

The pharmacy provided team members with current reference sources and access to the internet so they could obtain up-to-date information. There was a range of equipment available for the team to use including CE equipment to accurately measure liquid medication. And a large fridge with glass door that enabled the team to view the stock held without prolong opening of the door.

The pharmacy’s computers were password protected and access to people’s records restricted by the NHS smart card system. They were positioned in a way to prevent disclosure of confidential information. Team members stored completed prescriptions away from public view and they held private information in the dispensary and rear areas, which had restricted public access. They used cordless phones to ensure conversations with people could not be overheard.

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.