General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Lloydspharmacy, East Leeds Advanced Care Centre, Osmondthorpe Lane, LEEDS, West Yorkshire, LS9 9EF

**Pharmacy reference:** 1093005

**Type of pharmacy:** Community

**Date of inspection:** 26/11/2019

## Pharmacy context

This community pharmacy is within a large medical centre in a suburb of Leeds. The pharmacy dispenses NHS prescriptions and some private prescriptions. The pharmacy supplies multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the flu vaccination service and the Human Papilloma Virus (HPV) vaccine 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 | N/A | N/A | N/A |
| **3. Premises** | Standards met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Standards met | 4.1 | Good practice | The pharmacy team members provide services that support people's health needs. And they reach out to the community to promote health and wellbeing. The pharmacy team works with community groups to actively promote health and wellbeing of the local population. And the pharmacy creates attractive themed displays to improve people’s awareness about the benefits of healthy living. |
| **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. And it has up-to-date written procedures that the team follows. The pharmacy has suitable arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The pharmacy keeps the records it needs to by law. The team members have training, guidance and experience to respond well to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members record the errors they make when dispensing. And they act appropriately to prevent future mistakes.

### Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team were reading the recently updated SOPs. And signing the SOP signature sheets to show they understood and would follow them. The team had read and signed the previous SOPs. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error, their learning from it and actions they had taken to prevent the error happening again. The team reviewed these records each month to spot patterns and make changes to processes. Recent reviews reminded the team to check prescriptions for abbreviations used for the dose. And when labelling the prescription to ensure dose instructions were clear to read and understand. The team members were also asked to use the correct basket size to hold medicines when dispensing. So, medicines from different prescriptions did not get mixed up. The pharmacy team recorded dispensing incidents electronically. And sent the report to head office. The team were alert to medicines that looked and sounded alike (LASA). The LASA medicines included amlodipine and amitriptyline.

The team completed a weekly SaferCare checklist that included checks for uncluttered benches and completion of team training. Key points from the SaferCare checklist fed into the monthly SaferCare briefing. The accuracy checking technician (ACT) led on the SaferCare process. And had trained one of the dispensers on the process especially capturing the notes from the SaferCare briefing. A sample of notes from the briefings found that the dispenser captured detailed information. And the names and signatures of the team members who attended. The dispenser shared the notes with all the team to ensure everyone was aware of the issues discussed. A SaferCare notice board was displayed in the dispensary which recorded key points from the briefings and other relevant information to be shared with the team. The dispenser who generated the notes from the SaferCare briefing was responsible for updating the notice board. The team members were encouraged to add information to the notice board to discuss at the next briefing. And any learning they wanted to share with the team.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy displayed the results in the

retail area and published them on the NHS.uk website. The pharmacy received positive comments about the efficient service provided. And how the team dealt with people's queries. The comments from the survey included having somewhere to speak in private with the team. The pharmacy had a clearly signed consultation room located in the main retail area. And the team often used this to have private conversations with people.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. The pharmacy did not display a privacy notice in line with the requirements of GDPR. The team separated confidential waste for shredding offsite. The team noticed people often crowded around the pharmacy counter waiting for their prescriptions. The team members realised that people may see or hear other people's confidential information. So, they asked people to move away from the counter and to take a seat in the waiting area.

The pharmacy had information and guidance for the team members to follow when they had safeguarding concerns. The team had read and signed the guidance to show they understood and would follow it. The team members had access to contact numbers for local safeguarding teams. The pharmacist manager and ACT had completed level 2 training in 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team responded well when safeguarding concerns arose.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy provides the team members with opportunities to develop their knowledge. And it gives team members regular feedback on their performance. The team members are good at supporting each other in their day-to-day work. And they discuss their errors and how they can prevent mistakes from happening again. So, they can improve their performance and skills. The pharmacist sometimes struggles to complete some of the tasks specific to her role during the working day. She is comfortable to raise this as a concern.

### Inspector's evidence

A full-time pharmacist manager covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of a full-time pharmacy technician who was also an accuracy checking technician (ACT), four full-time dispensers, three part-time dispensers, two part-time healthcare partners and a part-time delivery driver. At the time of the inspection a regular locum pharmacist, the ACT, two of the dispensers and two healthcare partners were on duty. The ACT helped the pharmacist manager and provided a supportive role for the team. This extended to locum pharmacists who had not worked at the pharmacy before. To ensure they followed procedures and to answer any questions they had. The pharmacy trained the team to complete a range of tasks. So, everyone could keep their knowledge and skills on how to complete these tasks up to date. And completion of these tasks was not affected by team absence. The team member rotated the tasks throughout the day. To reduce the risk of them becoming tired and less alert when doing the same task. Some of the dispensing team were to be trained on the procedure for providing the multi-compartment compliance packs. And sending prescriptions to the Lloyds off-site pharmacy. The ACT was planning time after the busy Christmas period to train these dispensers. The company had recently changed the process for managing uncollected prescriptions from a six-week check to a four-week check. The healthcare partners were given the responsibility of managing this change.

The pharmacist manager used to have double pharmacist cover, but this had decreased from three days a week, to two days a week and then once a month. And now there was no double pharmacist cover. The pharmacy was the highest performing in the area for the New Medicines Service and it was the main provider in the area of the HPV vaccine. The pharmacist manager sometimes struggled to complete tasks during the working day. And spent much of their personal time completing these tasks. This was discussed with the pharmacy cluster manager. The team members worked together to provide solutions to workload pressure issues. The pharmacist manager and ACT identified several people were due to receive the HPV vaccine the following week. So, they discussed how to manage this along with the day-to-day workload. And as a result, the ACT contacted the online GP service that provided the HPV consultation asking for approval for additional pharmacist cover. The ACT received the approval and forwarded the request to the locum pharmacist co-ordinator for Lloyds Pharmacy.

The pharmacy provided extra training through e-learning modules. And the team members had protected time to complete the training. The team held regular meetings. These included the monthly SaferCare briefings. And daily huddles to discuss the tasks for the day. The team also met at the time of a dispensing incident or when a prescribing concern arose so everyone in the team was aware. And to discuss what steps to take to prevent further incidents. The local manager group used WhatsApp to

share up-to-date information. And to ask questions such as how teams were managing clinical audits. The company conducted an employee opinion survey and one had recently been completed. But the team was not aware of the outcome from this survey or previous surveys. The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. Team members could suggest changes to processes or new ideas of working. The pharmacy had targets for services such as Medicine Use Reviews (MURs). And the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is clean, secure and adequate for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

### Inspector's evidence

The pharmacy was clean and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink, disposable gloves and alcohol gel for hand cleansing. The team used the floor to store baskets containing checked prescriptions waiting to be placed on to the shelves awaiting collection. The team stored the baskets next to the drawer unit to reduce the risk of trip hazards.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy team members provide services that support people's health needs. And they reach out to the community to promote health and wellbeing. The pharmacy team works with community groups to actively promote the health and wellbeing of the local population. And the pharmacy creates attractive themed displays to improve people's awareness about the benefits of healthy living. The team members manage the pharmacy services well. They keep records of prescription requests and deliveries made to people's home. So, they can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately.

### Inspector's evidence

People accessed the pharmacy via an automatic door operated with a press pad. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role. The ACT was the healthy living champion and used a section of the retail area to promote healthy living advice and information. The ACT created a range of eye-catching displays on health matters such as indigestion and smoking. And had adapted the display following comments from people about the information displayed. So, it was suitable for all people accessing the pharmacy. The displays had triggered several conversations with people about health matters. The current focus was the Movember campaign raising awareness of prostate cancer. And the use of antibiotics. The team spent time at local businesses and attended community groups to provide health checks such as blood pressure and BMI checks. The pharmacy was amongst several local businesses who had signed up to the Manbassador project. This project reached out to isolated men to support their mental health. And the network of local businesses acted as health advocates supporting people they come across on a regular basis. The Manbassador organisation provided leaflets containing signposting information about social activities, health and leisure opportunities and details of people the person could talk to. The team displayed the leaflets on the pharmacy counter for people to read and take away. The team members found the leaflets were popular. And they had signposted several people to this support group.

The pharmacy had up-to-date patient group directions (PGDs). These provided the pharmacists with the legal authority to administer the flu vaccine and the Human Papilloma Virus (HPV) vaccine. The HPV vaccination service was very popular. People received a consultation from the online GP company used by Lloyds Pharmacy. And a prescription for the HPV vaccine was sent to the pharmacy. The person contacted the pharmacy to arrange an appointment for the administration of the vaccine. The pharmacy had trained the team on the process for the HPV vaccine service. This included asking the person when they contacted the pharmacy if it was their first or second vaccine. So, the team would know how long the appointment would take. The team supported this service by asking how many people would be coming as often they came in groups. So, the pharmacist knew how many to expect and how long they would be unavailable for other services such as checking prescriptions. The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply.

The pharmacy provided multi-compartment compliance packs to help around 130 people take their medicines. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. And they were working two weeks ahead in preparation for the busy Christmas period. The team had a list of the packs due for dispensing so when a team member was free from other tasks, they could check the list and see what packs needed to be done. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. The pharmacist manager developed the medicine list from the standard company template. This template was bigger so the team could record more information. The medication list included medicines not in the packs such as inhalers and whether the person had these medicines weekly or monthly. The team used the back of the form to record changes to the medicines in the packs. This information included when the change occurred and who had asked for the change. The team used a small section of the main dispensary to dispense the medication. The team kept the packets the medicines were removed from for the pharmacist or ACT to refer to when checking the packs. The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets. The pharmacy had a section of shelves to store completed packs awaiting supply. The shelves were full of packs. And several packs were stored on top of each other. So, there was a risk of the team selecting and supplying the wrong pack. The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge summary for changes or new items. And kept the discharge summary for reference to when queries arose. The team had recently used the discharge summary when contacting a GP team who stated a person's medicines had not changed. But the discharge summary showed the medicine had changed.

The team members provided a repeat prescription ordering service. The team asked the person to mark the repeat prescription form against the medicines they wanted ordering. And to sign the form to show the person had done this. The team used this as evidence that the person, not the pharmacy team, had requested the medicine when the GP team queried why a person had ordered an item. The team rang people who had their medicines delivered to ask what medicines they wanted for the next supply. The team usually ordered the prescriptions five days before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team kept a record of requests and checked the record to identify missing prescriptions and chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. This included highlighting the information when it appeared on the repeat prescription slip.

The pharmacy used the Lloyds off-site dispensary to dispense some of its prescriptions. After receiving the prescriptions, the pharmacy team entered the details into a dedicated programme. The pharmacist did a clinical check of the prescription before sending the information for dispensing to the off-site dispensary. The pharmacist had a separate log-in for this system when completing these checks. This prevented other team members attempting to send the prescription to the off-site dispensary without completing the pharmacist check. The team checked if the prescription was urgent before sending to the off-site dispensary. And any urgent prescriptions were done at the pharmacy. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack to provide people with information when required. The team asked people prescribed high risk medicines such as warfarin when they had last had a blood test and their current dose. The team recorded this information on to the electronic patient record (PMR). And referred to this information when talking to the person to identify any changes. The team had discussed an incident when a person who had their medicine delivered contacted the pharmacy to ask about their warfarin supply. The team member had not asked the person what their target test result (INR) was. And the

team member had not asked the person their current INR and dose before telling the person the supply was correct. The team identified that this approach may have resulted in the person taking the wrong dose. As a result, all team members were reminded of the warfarin high risk protocol. So, they always obtained the correct information from the person and shared this with the pharmacist. And the person would be correctly advised on what dose to take.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. And they used this as a prompt to check what they had picked. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacy also had a stamp to record who had clinically checked, and accuracy checked the prescription. A sample of prescriptions looked at found that the team usually used this stamp. But a few prescriptions for multi-compartment compliance packs did not have the stamp. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy had a text messaging service to inform people when their repeat prescriptions or owings were ready. The pharmacy kept a record of the delivery of medicines to people. This included an electronic signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 08 November 2019. The team used colour stickers to highlight medicines with a short expiry date. No out of date stock was found. The team members recorded the date of opening on liquids and the date the medicine should be used by. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of melatonin 1mg/1ml oral solution with two months use once opened had a date of opening of 14 November 2019 recorded on a sticker. And on the same sticker the date the product was to be used by, namely 14 January 2020. The team recorded fridge temperatures each day. A sample looked at 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 had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). And the team had not been informed when this would happen. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, 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 protect people's private information.

### Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a large fridge to store medicines kept at these temperatures. The fridge had a glass door to enable the team to view stock without prolong opening of the door. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team kept the computer screen in the consultation room locked when not in use. The team used cordless telephones to make sure telephone conversations were held 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. |