General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Coulby Newhan Medical Centre, Cropton Way, Coulby Newham, MIDDLESBROUGH, Cleveland, TS8 0TL

Pharmacy reference: 1093175

Type of pharmacy: Community

Date of inspection: 10/03/2020

Pharmacy context

This 100-hour community pharmacy is next to a medical centre in Coulby Newham, Middlesbrough. 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 through its NHS services. The pharmacy supplies medicines in multi-compartment compliance packs to some people living in their own homes. It provides a substance misuse service and a home delivery service.

Overall inspection outcome

✔ **Standards met**

Required Action: Improvement Action Plan

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	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 discuss and record any mistakes that they make when dispensing. So, they can learn from each other. 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 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 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 pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team. The acting assistant manager thought that all the team members had signed the SOPs but was not one hundred percent sure.

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 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 pre-registration student looked at these with the pharmacist each month, looking for trends. Each month the findings were discussed with the team members. The acting assistant manager was unable to locate February's review. She thought it would have been completed but she couldn't be sure. So, Januarys report was looked at. It was noted on the report that there were a lot of address errors. And these were classed as a major error. But no action points were noted on the safer care review. The actions taken did not relate to the errors recorded. 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 in February when lisinopril 2.5mg was required and bisoprolol 2.5mg was supplied. The incident report form lacked detail. The pharmacist told the inspector that he was in the process of doing a root cause analysis. And this was at home. The RP told the inspector that he had not yet discussed the incident with the team members or made any changes. But it was his intention to do this when the pharmacy was quieter.

The pharmacy had a formal complaints procedure in place. And it was available for people to see via the pharmacy's customer leaflet which was available in the retail area for self-selection. The pharmacy

collected feedback through and annual patient satisfaction survey. The team members were unsure of the areas highlighted for change. But the RP advised that waiting times were sometimes a problem for people. During the inspection a carer complained that a compliance pack was wrong, and this was the second time this had happened. And another person complained about the waiting time. The team thought that this was because they were short staffed.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy displayed the correct responsible pharmacist notice. And it was easy to see from the retail area. The pharmacy kept complete 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. 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 bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor. The responsible pharmacist and accuracy checking technicians (ACTs) 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members do not receive regular appraisals or reviews of their performance. This may mean that individuals training needs are not identified and addressed. Some team members do not feel able to make suggestions to improve the service offered to people. So opportunities to make changes to improve services may be missed.

Inspector's evidence

The responsible pharmacist (RP) was supported by one ACT, two dispensary assistants, one medicine counter assistant. And one trainee. The RP said that there had been some changes. For example, cluster managers were now going back into branch. The team had not been updated about the changes. The team were struggling with the work load. Because people had left and were not being replaced. Locums were covering who were unfamiliar with the branch. Additional cover was provided on an ad hoc basis. And this made it difficult for the team to plan ahead. The team thought that they needed regular planned cover.

The inspector observed the team working. Everyone was busy but there didn't appear to be a co-ordinated approach to the workload. Customers were not always acknowledged. Some team members found the manager unapproachable. And they felt undervalued. They were aware of the whistle blowing policy on one portal. And there had been communication to the previous cluster manager to share the teams concerns that the safer care process was not always robust.

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. The pharmacy had employed some members of staff who were unfamiliar with the company way of working. And the team were promised that the manager would provide training to newer members of the team to get them up to speed with company processes and procedures. But this had not happened. The inspire wheel indicated that three members of the pharmacy team were behind with their training. And they were amber for training. Some members of the pharmacy team had never received an appraisal. The ACT told the inspector she had been in post for fifteen months and had never received an appraisal. Other team members said that morale was low.

The team was set various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The RP thought targets did not impact on the ability of the team to make professional judgements. And the team strive to provide services to meet people's needs.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The dispensary was a good size. It was a little untidy, and there was some clutter on the benches. The team used the bench space to organise the workflow. The retrieval area was overflowing and there were a lot of bulky prescriptions obstructing the floor. There was a clean sink in the dispensary for medicines preparation and staff use. There was a toilet with a sink with hot and cold running water for hand washing. The pharmacy had two sound-proofed consultation room with seats where people could sit down for private conversations with the team member. There was a desk and computer in each. The rooms were smart and professional in appearance and was signposted by a sign on the doors. The temperature was cold throughout the inspection. The team said that the pharmacy was constantly cold. They had some portable heaters. But these weren't very effective. 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. 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 automatic doors to the front. 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.

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. 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 two hundred people living in their own homes. They kept all documents related to each person in separate polypockets. 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 checker attached the "pharmacist" sticker 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. The RP said that he doesn't usually make records of these conversations on the patient record. 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 patients were prescribed valproate. And met the requirements of the programme. Two people had been identified as eligible under PPP. Both had been counselled and received the supporting literature.

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 RP 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. 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. No out of date stock was found on the shelves. The pharmacy had a 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 some out of date and patient returned CDs. These were in marked bags but were stored together in the CD cabinet.

The team were scanning products when they arrived in the pharmacy from the supplier. If the medicine was not collected it was returned to stock. The team had received some information on how to follow the directive and had completed a training unit. 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 fridges 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 fridges used to store medicines were 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.