General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Dronfield Medical Centre, High Street, DRONFIELD, Derbyshire, S18 1PY

Pharmacy reference: 1093205

Type of pharmacy: Community

Date of inspection: 05/02/2020

Pharmacy context

This busy community pharmacy is located within a medical centre and most people who use the pharmacy are from the local area. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. It dispenses a small number of private prescriptions, some of which are from the company's online prescribing service. It supplies medicines in multi-compartment compliance aid packs to help people take their medicines at the right time.

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	1.2	Good practice	The pharmacy records and analyses adverse dispensing incidents to identify learning points which it incorporates into day to day practice to help manage future risks.
2. Staff	Good practice	2.2	Good practice	The team members have the appropriate skills, qualifications and competence for their role and the pharmacy supports them to address their ongoing learning and development needs.
		2.4	Good practice	The pharmacy team work well together. Team members communicate effectively, and openness, honesty and learning are encouraged.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy proactively manages its services to ensure effective care and improved outcomes for people.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy effectively manages the risks associated with its services to ensure it keeps people safe. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. They record their mistakes so that they can learn from them and they act to help stop the same sort of mistakes from happening again. The team members complete all the records that it needs to by law and ask its customers for their views. They complete training so they know how to protect children and vulnerable adults and keep peoples' private information safe.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided, with signatures showing that all members of the pharmacy team had read and accepted them. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their role. They were wearing uniforms and name badges showing their role. The name of the responsible pharmacist (RP) was displayed as per the RP regulations.

Dispensing incidents were reported to the pharmacist superintendent (SI) via Lloyds incident reporting system on the intranet, and a copy of the patient safety incident form was retained in the pharmacy. A root cause analysis and reflective statement had been completed for the most recent error which had been the supply of a date expired medicine. The foil strip inside the pack had a different expiry date to the one on the outside of the box, indicating that the procedure for dispensing a quantity less than the original pack size had not been followed and the remaining part of the foil strip was placed in a different box to the one it came from. As a result of the incident the team had re-read the dispensing and checking SOPs and were reminded to date check the foil strip inside the box, and not just the outer packaging when dispensing from a split box. The incident had also highlighted that the team had fallen behind with their routine date checking procedure due to the heavy workload over Christmas. So, this was prioritised, and all top 100 medicines had been date checked. Near misses were reported, reviewed and discussed with the pharmacy team as part of the safer care monthly briefing meetings. Learning was included such as 'remember to check against prescription' when selecting medicines for dispensing. A 'safer care checklist' was completed weekly which involved checking the dispensary environment, people and processes and patient safety review meetings took place as part of this. There was a safer care notice board and the similar packaging of Clinitas and chloramphenicol had been highlighted on this. Staff said they felt comfortable reporting errors and could give examples of actions they had taken to prevent re-occurrences. For example, alert stickers were in front of look-alike and sound-alike drugs (LASAs) so extra care would be taken when selecting these. Amitriptyline had been moved to a new location to avoid confusion with amlodipine. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out. There were regular communications from head office with shared learning, such as highlighting the LASAs cyclizine and colchicine, and labetalol and lamotrigine.

A customer complaint SOP was in place. The trainee medicine counter assistant (MCA) described how she would deal with a customer complaint which would include referring to the pharmacist or pharmacy manager. The pharmacy manager explained she would try to resolve the complaint and assist

head office if the complaint had been made directly to them. 'Customer Charter Standards of service' leaflets were available in the consultation room with details of who to complain to, so these might not be accessible to all.

A customer satisfaction survey was carried out annually. The results of the most recent survey were available on www.NHS.uk website. Areas of strength (100%) included offering a clear and well organised layout, staff overall, being polite and taking time to listen and answering any queries. An area identified which required improvement was the comfort and convenience of the waiting areas (12.5% of respondents were dissatisfied). The pharmacy's published response was 'pharmacy will review waiting areas within 28 days of the report'. There were two chairs available for patients waiting for prescriptions, but there were several occasions when more than two people were waiting for prescriptions during the inspection and had to stand up.

Professional indemnity insurance was in place. Private prescription and emergency supply records, the RP record, and the controlled drug (CD) register were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Three CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately.

All staff had completed training on data protection and confidentiality. Confidential waste was placed in designated bags which were collected by an appropriate company for disposal. A dispenser correctly described the difference between confidential and general waste. There was a risk that some assembled prescriptions awaiting collection might be visible from the medicines counter and the RP agreed to take some action to resolve this, such as turning the prescriptions, so patients' details could not be seen.

The RP and accuracy checking technician (ACT) had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding. Other staff had completed level 1. An MCA said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time and said she would also liaise with the safeguarding lead in the medical centre if the concern was about a patient there. There was a safeguarding policy and procedure folder and a notice showing the contact numbers of who to report concerns to in the area. The pharmacy had a chaperone policy, and this was highlighted to patients. All members of the pharmacy team, including the delivery driver had completed Dementia Friends training, so had a better understanding of patients living with this condition. Two members of the team had attending training on Dementia at the town hall, as they were working towards becoming a dementia friendly town.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough staff to manage its workload safely. Team members work well together and communicate effectively. They are well trained, and the pharmacy encourages them to keep their skills up to date and supports their development. They are comfortable providing feedback to their manager and receive feedback about their own performance.

Inspector's evidence

There was a pharmacist, a pharmacy manager who was a NVQ2 qualified dispenser, two other NVQ2 qualified dispensers, an MCA and a trainee MCA on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection. The RP felt staffing levels were adequate and explained that the opening hours had been reduced, as they no longer opened on Saturdays, but the staff hours had not changed, so there were now more staff working in the core hours. A holiday planning chart was on display and planned absences were organised so that not more than one person was away at a time. Absences were covered by re-arranging the staff rota or transferring staff from neighbouring branches. There was also a delivery driver, an ACT, a dispenser and a new member of staff, who were part of the pharmacy team, although not present at the inspection. There was also a cluster relief dispenser and ACT who could be requested if necessary.

Staff carrying out services had completed appropriate training and the team used the Lloyds online training system 'My Learn' to ensure their training was up to date and recorded. All members of staff completed a monthly knowledge assessment which they were required to pass. Packages were on new products such as CBD and also topics such as data protection and safeguarding. Learning zone bulletins were received highlighting additional training that was required, such as sepsis. The pharmacy manager confirmed this had been completed sometime ago. Staff had regular protected training time. There was a notice on display showing each members of the teams allotted training time. The pharmacy manager gave team members positive and negative feedback regularly and had an 'Annual Contribution Discussion' with them to formally manage their performance, training and development.

Communication within the company was mainly through the intranet on 'One Portal'. The pharmacy manager was part of a WhatsApp messenger group with other managers in the region and patient safety learning was shared within this group as well as in weekly conference calls. Informal staff huddles were held at least weekly when a variety of issues were discussed with the team, and concerns could be raised. A dispenser said she felt there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the pharmacist or her line manager about any concerns she might have. She said the team could make suggestions or criticisms informally.

The RP said he felt comfortable reporting errors and was able to describe the last error and what learning had arisen from it, despite not being involved in the error himself. He felt empowered to exercise his professional judgement and could comply with his own professional and legal obligations. For example, refusing to sell a pharmacy medicine because he felt it was inappropriate. He said targets were set for Medicines Use Reviews (MUR) but he didn't feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a professional environment for people to receive healthcare. The pharmacy has a private consultation room that enables it to provide members of the public with the opportunity to receive services in private and have confidential conversations.

Inspector's evidence

The pharmacy premises including the shop front and facia were clean, well maintained and in a good state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with two chairs. The temperature and lighting were adequately controlled. The pharmacy was fitted out to a good standard, and the fixtures and fittings were in good order. Maintenance problems were reported to maintenance department via a ‘one call’ number and the response time was appropriate to the nature of the issue.

There was a stockroom, an office and a second dispensary in the basement, which was used to assemble and store compliance aid packs. Staff facilities included a tearoom and a WC with a wash hand basin and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. The consultation room was equipped with a sink. A hand washing notice was displayed above the sink and hand sanitizer gel was available. The consultation room was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign and was used when carrying out services such as MURs, and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are well managed and easy for people to access. People receive their medicines safely and the pharmacy gives people taking high-risk medicines extra advice. The pharmacy gets its medicines from reputable sources and carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchair users. There was an automatic door at the entrance. There was a hearing loop in the pharmacy and a sign indicating this.

Services provided by the pharmacy were advertised inside the pharmacy on a hanging banner. A large number of flu vaccinations had been carried out during the previous season. Team members were clear what services were offered and where to signpost people to a service not offered such as needle exchange. A folder was available containing relevant signposting information which could be used to inform patients of services and support available elsewhere. Signposting was not usually recorded so it was difficult for staff to remember examples of improved patient outcomes. Five people had been referred for foot checks as part of an audit of patients with diabetes. There was a healthy living notice board with some 'stay well this winter' leaflets but the only other health promotion leaflets were in the consultation room, so not accessible to all.

Patients ordered their repeat prescriptions directly through their medical centre, in line with area policy to reduce stockpiling and medicine wastage. There was a home delivery service with associated audit trail. Each delivery was recorded, and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was adequate in the dispensary, and the work flow was organised into separate areas with a designated checking area. The dispensary shelves and drawers were well organised, neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. 'Pharmacist' stickers were used to highlight when counselling was required and high-risk medicines such as warfarin, lithium and methotrexate were targeted for extra checks and counselling. INR levels were checked to see if they were in range when dispensing warfarin prescriptions, but they were not usually recorded. The team were aware of the valproate pregnancy prevention programme. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling. An audit had been carried out which found there were no patients in the at-risk group. Three patients had been counselled as part of a lithium audit and a note made on their patient medication record (PMR) confirming this. The RP described an intervention he had made during an MUR when a patient told him she was having headaches which he thought might be a side effect of the indapamide, which was in an immediate release form. He suggested a prolonged release formula to help reduce this side effect. After liaising with the patient's

GP, the change was made, and the patient informed him there had been an improvement. Records of referrals to GPs and interventions were maintained and recorded on the PMR system.

Around eighty community patients received their medication in multi-compartment compliance aid packs. These were assembled and stored in a separate dedicated room. They were well managed with an audit trail for communication and changes to medication. There was a designated member of the medical practice team who managed the ordering of the prescriptions for the compliance aid packs and liaised with the pharmacy if there were any changes. A dispensing audit trail was completed, and medicine descriptions were usually included on the packaging to enable identification of the individual medicines. Staff confirmed packaging leaflets were included so patients and their carers could easily access all the required information about their medicines. Disposable equipment was used. People only received their medication in compliance aid packs if their GP had recommended this. An assessment was assumed to have been completed by the GP as to the appropriateness of a pack before recommending it.

The trainee MCA explained what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product. CDs were stored in CD cabinets which were securely fixed to the floor. The keys were under the control of the responsible pharmacist during the day and stored securely overnight. Patient returned CDs were recorded and destroyed using denaturing kits.

There was a sharps bin in an unlocked cupboard in the consultation room, which was accessible from the retail area. The RP said the cupboard was usually secured, and he would lock it to prevent potential harm. Pharmacy (P) medicines were stored behind glass doors in the retail area. They were easy to open, and a member of the team said people did help themselves to the P medicines at times. But the cabinets were positioned close to the medicines counter so members of the pharmacy team were usually in a position to intervene.

Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from ‘Specials’. No extemporaneous dispensing was carried out. Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented and short dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired medicines were segregated and placed in designated bins.

The pharmacy was not compliant with the Falsified Medicines Directive (FMD). It had the software and hardware needed to comply and the team had competed the relevant training but had not been advised by head office to start scanning to verify or decommission medicines. They had been told that a couple of pharmacies in the company were trialling the system first.

Alerts and recalls were received via e-mail messages from head office and a confirmation response was usually required. They were read and acted on by the pharmacist or a member of the pharmacy team and then filed, with a record of what action had been taken, in case of query.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe and use it in a way that protects privacy.

Inspector's evidence

Current versions of the British National Formulary (BNF) and BNF for children were available and the pharmacist also used the 'One Portal' system to access approved websites for the most up-to-date information.

There was a clean medical fridge. The minimum and maximum temperatures were being recorded daily and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested. There was a selection of clean glass liquid measures with accuracy stamps. The pharmacy also had a range of equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination. The blood pressure machine was replaced every two years and the blood glucose machine calibrated every 13 weeks to ensure accuracy.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. Individual electronic prescriptions service (EPS) smart cards were used appropriately. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.