

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Churchfield Medical Centre, 322
Crawley Green Road, LUTON, Bedfordshire, LU2 9SB

Pharmacy reference: 1096601

Type of pharmacy: Community

Date of inspection: 20/02/2020

Pharmacy context

The pharmacy is located adjacent to a health centre in a residential area of Luton. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include prescription collection and delivery, substance misuse, emergency hormonal contraception and seasonal flu vaccination. The pharmacy has healthy living status.

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	1.1	Good practice	The pharmacy team identifies and manages the risks associated with providing its services in a variety of ways. Team members follow a daily and weekly checklist so tasks are completed effectively .
		1.2	Good practice	The pharmacy's team members record and review their mistakes and can give examples of actions taken to stop the same mistakes happening again.
2. Staff	Standards met	2.2	Good practice	The pharmacy's team members are supported in keeping their knowledge and skills up to date through ongoing training. And they complete a monthly knowledge test.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy team manages and delivers services safely and effectively. It takes extra care with high-risk medicines and makes sure people take their medicines the right way.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy team members follow up-to-date written procedures to help them provide services safely. So the pharmacy's working practices are safe and effective. The pharmacy keeps its records up to date to show that medicines are supplied safely and legally. The pharmacy team is good at managing the risks involved in providing its services. And they make sure that people have the information they need so that they can use their medicines in the right way. They understand their role in protecting the welfare of vulnerable people and keeping people's information secure.

Inspector's evidence

Near misses were recorded and reviewed and all fields of the near miss record were completed. Near misses were included in the monthly 'Safer Care' report. There were Safer Care weekly checklists which included environment such as clean and clear dispensary benches. A checklist detailed training completed by staff along with the Safer Care case study. Staff attended the Safer Care briefing which featured information on Coronavirus. The Safer Care notice boards and its current announcements were displayed in the dispensary. There were checklists of tasks to complete either daily or weekly in line with Safer Care on display. Daily tasks included ensuring interventions and near misses were recorded, the responsible pharmacist log was completed and fridge temperatures were monitored. Weekly tasks included controlled drug (CD) balance checks and tidying stock and consultation rooms.

Lookalike and soundalike 'LASA' medicines had been highlighted on the dispensary drawers with shelf-edge stickers which were also attached to prescriptions containing LASA medicines. The stickers comprised 'L A S A' overlaid on a red triangle. To alert staff and minimise picking errors amitriptyline and amlodipine were located in separate drawers. Staff had identified a near miss trend with hydralazine and hydroxyzine which were highlighted with the LASA stickers.

Workflow: colour-coded baskets were in use to separate different types of prescriptions and medicines during the dispensing process. The pharmacist performed the clinical check of all prescriptions. The final accuracy check of prescriptions was completed by the pharmacist unless the prescription was endorsed as being suitable for the final check by the accuracy checking technician (ACT). Interactions between medicines for the same person were shown to the pharmacist as part of the clinical check. Plain white dispensing cartons labelled and used to supply medicines were endorsed with their batch number and expiry date. The dispensing audit trail on the dispensing labels was completed identifying staff involved in dispensing and checking prescriptions. There was a procedure for dealing with outstanding medication. The original prescription was retained and an owing slip was issued to the patient. For 'manufacturer cannot supply' items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance aids were prepared on a rolling basis according to a matrix. There was a separate bench area to prepare compliance aids. The pharmacy managed prescription re-ordering on behalf of some patients and checked new prescriptions against the previous prescription and backing sheet for changes. There was a sheet to record and create an audit trail of any query regarding changes in medication. Each patient had their own polythene sleeve to retain information which included a backing sheet and any discharge summaries following a stay in hospital. The backing sheet was reprinted to reflect changes in medication. The pharmacy liaised with the doctor's surgery when new

patients were identified who would manage administration of medicines better if supplied in a compliance aid.

Backing sheets included a description identifying individual tablets and capsules. Patient information leaflets (PILs) were routinely supplied with each set of compliance aids. High-risk medicines such as sodium valproate or alendronate were generally supplied separately from the compliance aid. If CDs were included in a compliance aid, prescription dates were managed to ensure supply within the 28-day validity of the prescription. Levothyroxine and lansoprazole were supplied in the compliance aid and special instructions highlighted to ensure medicines were taken correctly.

There was a folder of recently reviewed standard operating procedures (SOPs) which included procedures for complaints, CD, responsible pharmacist and supplying high risk medicines. There were staff training records to show staff were up to date with training. The staff member who served at the medicines counter said she would not give out a prescription or sell a pharmacy only medicine if the pharmacist were not on the pharmacy premises. She said she would not sell three packs of Sudafed to the same person as it may make the congestion worse or be abused. Patient feedback was obtained via the community pharmacy patient questionnaire and results were displayed. The customer charter leaflet was displayed. To protect patients receiving services, there was professional indemnity insurance in place provided by the National Pharmacy Association (NPA) expiring 30 June 2020. The responsible pharmacist notice was on display and the responsible pharmacist log was completed.

The CD and methadone registers were complete and the balance of CDs and methadone was audited weekly. A random check of the actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. The invoice number and supplier name but not always address were recorded for receipt of CDs. Footnotes correcting entries were not always signed and dated. FP10MDA prescriptions were endorsed at the time of supply. Patient-returned CDs were recorded in the destruction register for patient returned CDs.

Records for supply of medicines for private prescriptions, emergency supplies and unlicensed 'specials' were complete. A small number of records included dispensing labels to record information. Avoiding this method of recording was discussed as it may not be a permanent record. A sample of patient group directions (PGDs) were in date.

The pharmacist and staff had undertaken General Data Protection Regulation (GDPR) training. A privacy notice was displayed. Staff were using their own NHS cards. Confidential waste paper was collected for shredding. The Data Security and Protection (DSP) toolkit was due to be completed. The pharmacy computer was password protected and backed up regularly. The pharmacist and ACT had completed Centre for Pharmacy Postgraduate Education (CPPE) level 2 safeguarding training. Staff had completed safeguarding and dementia friends training.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy's team members manage the workload within the pharmacy and work well together. They are supported in keeping their knowledge and skills up to date. Team members are comfortable about providing feedback to improve the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time and one part-time pharmacist, one full-time ACT, one full-time trainee pharmacy technician, two part-time dispensers, one full-time medicines counter assistant (MCA) and two part-time MCAs (one accredited and one enrolled on training) and two part-time delivery persons shared with another branch.

Staff were provided with ongoing training by their head office. Staff could study when it was quiet in the pharmacy. E-learning was completed on 'myLearn' which was a training platform on which staff had their own profile. There were training topics appropriate to staff roles such as dementia friends for the MCA. There was a monthly 'myKnowledge' check which staff had to complete. CPPE certificates of completed training could be uploaded to 'myLearn'. 'Learning Zone' was a company-wide paper-based training document sent to branches which included Safer Care topics such as sodium valproate, CDs, pregnancy and medicines and shared learnings from other branches such as errors. Staff were encouraged to discuss ways of avoiding a future similar incident.

In line with Pharmacy Quality Scheme (PQS) training had been completed in Community Pharmacist Consultation Service (CPCS), sepsis, safeguarding, reducing LASA errors and risk management. Understanding of sepsis symptoms and when to refer a member of the public to A&E was risk assessed. Staff performance was monitored through documented appraisals and reviews every six months. Team members set their own objectives and agreed them with their manager. Staff were able to provide feedback to improve services and had suggested reducing near misses by highlighting the less usual medicines with a marker pen. Examples given included highlighting omeprazole 10 where omeprazole 20 was the more commonly dispensed strength or Hypromellose preservative free eye drops which were less frequently dispensed than Hypromellose eye drops with preservative. There was a whistleblowing policy. The pharmacist said targets and incentives were not set in a way that affected patient safety.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are clean, secure and suitable for the services provided. The pharmacy prevents people accessing the premises when it is closed and keeps medicines and information safe.

Inspector's evidence

The pharmacy's premises were spacious and generally clean, tidy and well presented. Lavatory facilities were clean and handwashing equipment was provided. The consultation room was located to one side of the medicines counter and was not locked when not in use. It protected patient privacy. The computer screen was not visible to the public. The chaperone policy was displayed. There was sufficient lighting and air conditioning.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy makes it easy for people to access its healthcare services. It gets its medicines from reputable suppliers and makes sure they are stored securely at the correct temperature. The pharmacy team members know what to do if any medicines need to be returned to the suppliers. They highlight prescriptions for high-risk medicines and provide people with the information they need to take their medicines safely. And they give advice to people about where they can get other support.

Inspector's evidence

There was wide level access to the pharmacy premises including the consultation room to assist wheelchair users and a seating area for waiting patients. There was a hearing loop. Large font labels could be printed to assist visually impaired people. Patients were signposted to other local services such as urgent care and a walk-in centre in the local hospital. PGDs available included administration of emergency hormonal contraception and flu vaccination. People could obtain free condoms through the C Card scheme. Members of the public could access treatment for minor ailments and emergency supplies via the CPCS. The pharmacy was alerted to referrals via PharmOutcomes and email.

The pharmacist explained the procedure for supply of sodium valproate to people in the at-risk group. Information on the pregnancy prevention programme (PPP) would be explained. There was information to give to patients on PPP. The intervention was recorded on the PMR. The pharmacist was aware of the procedure for supplying isotretinoin following a negative pregnancy test result and within seven days of the date on the prescription. Information on the PPP would be explained. The treatment would be initiated by a consultant. The pharmacist said he would contact the prescriber and record the intervention regarding prescriptions for more than 30 days' supply of a CD. CD prescriptions were highlighted with CD stickers to ensure supply within the 28-day validity period.

Interventions were recorded on the patient medication record (PMR). Warning stickers were attached to prescriptions to prompt counselling to the patient. The pharmacist said when supplying warfarin, people were asked for their record of INR along with blood test due dates. INR was recorded on the PMR. Advice was given about side effects of bruising and bleeding along with advice about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were asked if they had regular blood tests and reminded about the weekly dose, when to take folic acid and care when handling methotrexate tablets. People were advised to seek medical advice if they developed an unexplained fever.

An audit had been conducted to identify people in the at-risk group taking sodium valproate and to explain the PPP. An audit had been completed to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking non-steroidal anti-inflammatory drugs (NSAID). Recent audits included monitoring dates of last foot checks and retinopathy screening for diabetic people and people taking lithium to ensure they understood signs of toxicity and attended regular blood tests. Use of inhalers in the treatment of asthma had been monitored in adults and children aged five to fifteen years. Referrals were recorded on the PMR and PharmOutcomes. Risk management training had been completed. The pharmacy had healthy living status. The healthy living display offered information to members of the public on type 2 diabetes including screening, diet and healthy feet. There was information to raise public awareness of children's oral health, stopping smoking, dry

January, winter health and a Coronavirus poster. There were health related leaflets displayed in the consultation room.

Medicines were delivered outside the pharmacy by two delivery persons. There was a drop sheet and patient signatures were obtained where possible indicating safe and effective delivery. Medicines and medical devices were obtained from Alliance and AAH. Floor areas were clear, and stock was neatly stored in the dispensary drawers and on the dispensary shelves. Stock was date-checked and recorded. Stickers were attached to short-dated stock. No date-expired medicines were found in a random check. Medicines were stored in original manufacturer's packaging and the date of opening was marked on liquid medicines. Cold chain items were stored appropriately between two and eight Celsius. Uncollected prescriptions were cleared from retrieval every month and the patient was contacted. Prescriptions containing high-risk medicines, CDs and fridge items were highlighted. Waste medicines were stored separate from other stock. Empty methadone instalment containers were placed in a red tote box for disposal. Falsified medicines directive (FMD) hardware and software was installed at the time of the visit. Drug alerts were received, printed, annotated and filed.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It uses these appropriately to keep people's private information safe.

Inspector's evidence

Current reference sources included BNF, C&D, Medicines online and NICE Clinical Knowledge Summaries. The dispensary sink was clean and there were stamped glass measures to measure liquids including separate marked measures for methadone. The medical fridge was in good working order. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinets were fixed with bolts. The blood pressure monitor was replaced regularly. The vaccination sharps bin was stored under lock and key and adrenaline ampoules for treatment of anaphylaxis were in date. Staff were using their own NHS cards. Confidential waste paper was collected for shredding. The Data Security and Protection (DSP) toolkit was due to be completed. The pharmacy computer was password protected and backed up regularly.

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.