

# Registered pharmacy inspection report

**Pharmacy Name:** Lockwood Pharmacy, 227 Lockwood Road,  
HUDDERSFIELD, West Yorkshire, HD1 3TG

**Pharmacy reference:** 1106439

**Type of pharmacy:** Community

**Date of inspection:** 23/05/2019

## Pharmacy context

The pharmacy is in a row of shops in the suburbs of Huddersfield. And, it is open seven days a week. The pharmacy mainly dispenses NHS prescriptions and sells a range of over-the-counter medicines. It provides a substance misuse service, including supervised consumption and needle exchange. And, it supplies and multi-compartmental compliance packs to nursing homes and people living in their own homes. Pharmacy team members provide a stop smoking service, a minor ailments service and head lice detection and treatment. They provide emergency supplies of medicines via the NHS Urgent Medicines Supply Advanced Service (NUMSAS).

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy has procedures to identify and manage risks to its services. It has systems in place to manage complaints. And it listens to people's feedback and makes changes to help improve pharmacy services. It maintains the pharmacy records it must by law. Pharmacy team members read and follow the procedures. They know how to keep people's information secure. And, they are clear about what to do if there is a concern about a vulnerable child or adult. But, they are not receiving regular training to help keep their knowledge up to date. They record and discuss mistakes that happen. And they use this information to learn and make changes to help prevent similar mistakes happening again. But they don't always discuss or record every mistake or enough detail about why mistakes happen. So, they may miss opportunities to improve.

### Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The superintendent pharmacist (SI) and owner had reviewed the procedures in February 2017. And had scheduled the next review of the procedures for December 2018. The SI said he was still in the process of reviewing and implementing new style SOPs. Pharmacy team members had read and signed the SOPs after the last review in 2017. The pharmacy defined the roles of the pharmacy team members in each procedure.

The pharmacist highlighted and recorded near miss errors made by the pharmacy team when dispensing. The pharmacy team discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. And, the pharmacist said that not all near miss errors were recorded. A dispenser explained that when they were told they had made a mistake, they would try and identify what could be changed. But, they usually attributed the mistake to not concentrating. So, their learning would be to concentrate more next time. They also said that if they noticed the mistake themselves and fixed it before it reached the pharmacist, it would not be recorded. The owner said he analysed the data collected about mistakes every month. But, records of analysis were not available during the inspection. He explained that a change after recent near miss errors was for pharmacy team members to dispense multi-compartmental compliance packs using the prescriptions rather than the backing sheet. This was to help them spot if a medication had been stopped or changed since the last one was dispensed. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents on a template reporting form. And, records were available. Pharmacy team members captured comprehensive information about what had happened, and the steps taken to prevent a mistake happening again. But, there was little exploration to establish the root cause of an error. In one example seen, the owner explained the steps that had been taken to prevent it happening again. The mistake had involved the incorrect information being printed on documentation that accompanied a compliance pack. The mistake had caused staff at the nursing home to give the patient more medication than prescribed. The pharmacy team had made changes to the SOP for dispensing packs and generating documentation. And, pharmacy team members had read the revised SOP.

The pharmacy provided supervised consumption. It had not carried out a risk assessment of the substance misuse services being provided. But pharmacy team members asked people collecting supervised doses to confirm their name and date of birth when handing out doses and checked against the prescription. The pharmacist said that sometimes, he also asked people to confirm their current

dose, particularly if he knew there were other people with a similar name. Substance misuse service prescriptions were prepared in advance for the duration of the prescription, which was usually 14 days. Each patient had an individual named box in the controlled drug (CD) cabinet to separate their bottles from others. The prescription was laid in front of the box and the days dose was removed from the box and placed on top of the prescription until it was collected. The pharmacists said this was an easy way to see any uncollected doses at the end of the day.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. And the latest analysis of questionnaires was available. One improvement point was for the pharmacy to provide more advice about stopping smoking. Since they feedback, two members of the pharmacy team had become accredited as NHS stop smoking advisors. They booked appointments with people to assess their needs and then prescribed the relevant nicotine replacement therapy over an 18-week course. The accredited team members re-accredited their training every two years. And the NHS required them to achieve three people who had become smoke-free each year. The advisor said they had achieved six people smoke-free since the service had started less than a year ago.

The pharmacy had up to date professional indemnity insurance in place.

The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity after each entry in the register. But, it did not regularly audit registers of CDs used infrequently. So, they might find it difficult to spot any mistakes or losses. It audited methadone registers weekly. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines electronically. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy team members had been trained to protect privacy and confidentiality. The SI and owner had delivered the training verbally. And, they had read an information governance booklet. But the booklet was from 2010 and had not been updated considering the General Data Protection Regulations (GDPR). Pharmacy team members were clear about how important it was to protect confidentiality.

When asked about safeguarding, a dispenser some examples of symptoms that would raise their concerns in both children and adults. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to local safeguarding contacts for advice. The pharmacy had contact details available for the local safeguarding service. Pharmacists had trained via The Centre for Pharmacy Postgraduate Education in the last two years. But, other staff had not received formal training. But, they had a good understanding of how to protect vulnerable people and who to refer to for advice. All pharmacy team members had completed Dementia Friends training in 2017.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete training ad-hoc and discuss learning with the pharmacist. They reflect on their own performance informally. But, they don't have a formal process to discuss their performance or individual training needs. So, they may not effectively tailor learning to their individual needs to make sure their knowledge and skills are up to date. The pharmacy team members can discuss issues and act on ideas to support the delivery of services.

### Inspector's evidence

At the time of the inspection, the pharmacy team members present were three pharmacists, one pharmacy technician and three dispensers. The pharmacist said there was always one pharmacist and at least one other member of staff on duty. Pharmacy team members completed training ad-hoc by reading various trade press materials. And by having regular discussions with the pharmacists about current topics. The pharmacy did not have an appraisal or performance review process. A dispenser said that any needs she had would be discussed with the pharmacists informally and they would support her to achieve her goals by providing training and signposting to resources.

A dispenser explained that she would raise professional concerns with the owners or superintendent pharmacist (SI). She said she felt comfortable raising concerns. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. But, pharmacy team members were not aware of the policy. A dispenser said that if they had any professional concerns they felt they couldn't raise, they would contact the GPhC.

The pharmacy team communicated with an open working dialogue during the inspection. A dispenser said she was told by the pharmacist when she had made a mistake. The discussion that followed did not fully explore why she had made the mistake. But, she said she would always try and change something to prevent the mistake happening again.

Pharmacy team members explained a change they had made after they had identified areas for improvement. They had changed the prescription retrieval system so that prescription bags were stored alphabetically in totes. They explained this made prescriptions easier and quicker to find for people.

The pharmacy owners and SI did not ask the team to achieve any targets.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak to pharmacy team members privately.

### Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy also had a cellar which was used and suitable for preparation and storage of compliance packs.

The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy is accessible to people. And it generally provides its services safely and effectively. It sources its medicines from licensed suppliers. And it generally stores and manages its medicines effectively. But, it doesn't have a robust process to remove short-dated stock. So, there is a risk some medicines may not be fit for purpose.

Pharmacy team members monitor the services they provide to make sure they are safe. And, they make changes to help make services safer when necessary. They dispense medicines into devices to help people remember to take them correctly. But, they do not always provide people with medicines information leaflets. The team takes some steps to identify people taking high-risk medicines. And it provides them with some advice. But the team don't have any written information for people to take away. So, people may not have correct information they need to help them take their medicines safely.

### Inspector's evidence

The pharmacy had level access from the street. Pharmacy team members explained they could provide large print labels for people with a visual impairment. And, they would communicate in writing with someone with a hearing impairment.

The pharmacy supplied medicines in multi-compartmental compliance packs when requested. And it provided medicines in packs to nursing homes. It included descriptions of the medicines supplied on the packaging so people could identify the medicines inside. But, it did not regularly provide people with patient information leaflets about their medicines. The pharmacy team documented any changes to medicines provided in packs on the patient's master record. But, they did not capture which prescriber had asked for the change, when, or who had implemented the change in the pharmacy. When pharmacy team members were notified of a change of medication, they segregated any packs for the patient waiting in the pharmacy on to a quarantine shelf. They said this helped to prevent any more packs being dispensed until the queries had been resolved. They received hospital discharge summaries via the NHS PharmOutcomes online system. The pharmacist reconciled the summary against the latest pharmacy records and resolved any discrepancies before the packs were assembled.

The pharmacy team had decided to stop selling codeine linctus over-the-counter. They explained they had made the decision after they had noticed a trend in people requesting product more than once in a day and trying to time their requests when there was a different pharmacist on duty. They said they had tried measures to restrict the sales in addition to the usual safety questions, such as raising the price of the product, but this had not deterred people. So, they decided it was safer to withdraw the product to prevent misuse. They also said there were other, more effective, safer products available to treat a cough.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent people's prescriptions being mixed up. The pharmacist said that he would provide the necessary information to someone presenting a prescription for valproate that was at-risk during pregnancy. He said he would also check whether they were taking adequate pregnancy prevention. The pharmacy did not have a supply of information

material to provide to people or the necessary warning labels to attach to valproate dispensed outside its original container.

Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to three months in advance of its expiry. But, they relied on noticing a sticker to remove the item before it's expiry. No out-of-date stock was found on shelves. The pharmacy responded to drug alerts and recalls immediately. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed.

The pharmacy obtained medicines from eight licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). The pharmacy team kept the CD cabinets tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. The pharmacy team kept the contents of two pharmacy fridges tidy and well organised. They monitored minimum and maximum temperatures in one fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits. But, it had a second fridge in the stock room where temperatures were not monitored or recorded. The fridge contained a small amount of stock. This was discussed with the superintendent pharmacist during the inspection. And, a thermometer was installed, and temperatures monitored quickly after the inspection.

Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). But, they had not received training. And, procedures had not been updated to accommodate the process. They explained some of the features of compliant products, such as the 2D barcode and the tamper evident seal on packs. The pharmacy had installed new product scanners and software. But, they were not currently incorporating the requirements of FMD in to the dispensing process. So, the pharmacy was not legally compliant.

The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for deliveries of CDs. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy to arrange a re-delivery. The team highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect confidentiality.

### Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The equipment available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone. And they used a pump to dispense large quantities of methadone. They calibrated the pump weekly and cleaned it after each use. They did not keep record of calibration. But, they had attached a procedure for using the pump at the workstation.

The pharmacy kept sensitive information and materials in restricted areas. It positioned computer terminals away from public view. And they were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. And, it shredded confidential waste. The dispensary fridges were in good working order. And the team used them to store medicines only. Access to all equipment was restricted and all items were stored securely.

### 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.