General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Raj Medical Centre, Laceby Road, GRIMSBY, South Humberside, DN34 5LP

Pharmacy reference: 1123326

Type of pharmacy: Community

Date of inspection: 27/02/2020

Pharmacy context

This community pharmacy is within a medical centre on a main road leading into Grimsby, an industrial port town in North East Lincolnshire. The pharmacy sells over-the-counter medicines and it dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions through its NHS services. And it offers some private health-check services. It supplies some people with their medicines in multi-compartment compliance packs, designed to help them remember to take their medicines. And it delivers medicines to people's homes.

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	Pharmacy team members act openly and honestly by sharing information when mistakes happen. They contribute to regular safety reviews to share their learning. And they reflect on their mistakes and demonstrate how they act to reduce risk.
2. Staff	Standards met	2.2	Good practice	Pharmacy team members complete regular learning relevant to their role. And they show how they apply this learning when delivering the pharmacy's services
		2.4	Good practice	Pharmacy team members demonstrate enthusiasm for their roles. And they work together well. They understand the importance of sharing learning following mistakes. And identify how engagement in regular learning opportunities supports the pharmacy in managing the risks associated with its services.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy works well to address the specific needs of the local community by working with local businesses to provide the flu vaccination service in schools and people's places of work.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies the risks associated with its services. It has some robust review processes which help demonstrate how it manages these risks. The pharmacy keeps people's private information secure. It keeps its records required by law up to date. And it has appropriate arrangements for managing feedback and concerns. Pharmacy team members have the knowledge and skills required to support them in recognising and reporting safeguarding concerns. So, they are able to act to help protect the safety and wellbeing of vulnerable people. Team members act openly and honestly by sharing information when mistakes happen. They contribute to regular safety reviews to share their learning. And they reflect on their mistakes and demonstrate how they act to reduce risk.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). The company was in the process of moving from a static review of its SOPs every two-years to a two-year rolling review cycle. This meant the pharmacy was receiving updated SOPs in small batches. And team members were reading and signing the SOPs relevant to their roles as they were received. SOPs included the roles and responsibilities of pharmacy team members. And pharmacy team members had signed training records associated with the SOPs. The manager was in the process of signing off training records to confirm team members were competent in working in accordance with the updated SOPs. A member of the team explained what tasks could and couldn't be completed if the RP took absence from the premises. And dispensary team members were observed working in accordance with SOPs during the inspection.

Workflow in the dispensary was efficient despite available work space being limited. The team prioritised acute prescriptions. And there was designated areas for completing labelling, assembly and accuracy checks. A work bench to the side of the dispensary was utilised for tasks associated with the multi-compartment compliance pack service. The pharmacy engaged in the company's 'Safer Care' processes. This included weekly rolling checks across the pharmacy environment, staffing and procedures. And team members explained how these checks helped support them in managing their working environment.

Pharmacy team members took ownership of their mistakes by discussing them with the pharmacist and recording them in a near-miss error log. A team member explained how recording her own mistakes helped prompt reflection. The quality of recording in the near-miss error log was good with pharmacy team members clearly reflecting on contributory factors and learning following a mistake being made. A team member reflected on a recent mistake following a picking error. She explained that it could be easy to assume the right medicine was picked when picking from the correct stock location. But the mistake had identified a similar looking medicine had been stored away in the wrong stock location in error. This had prompted shared learning about the mistake. And the team member explained how it had helped her reflect on the importance of checking each medicine individually against the prescription when picking medicines. The pharmacy reported dispensing incidents to its superintendent pharmacist's team through an electronic reporting system. The RP provided evidence of incident reporting. This included sharing learning with team members and completion of a route cause analysis. Team members directly involved in an incident were also asked to complete a reflective account to support them in minimising the risk of a similar event occurring again.

Every four weeks the pharmacy team held a formal meeting to review the findings from weekly Safer Care checks and the near-miss error log. The RP led these meetings. And team members were encouraged to provide feedback and contribute ideas during the meetings. The RP demonstrated notes of the team discussions and these were supported by thorough monthly trend analysis of near misses. The trend analysis process looked at why the near miss had occurred and the type of mistake made. Pharmacy team members demonstrated how they applied risk reduction actions to reduce the risk of mistakes occurring during the dispensing process. For example, they had separated 'look-alike and sound-alike' (LASA) medicines on the dispensary shelves and in the dispensary drawers. And they had also separated different strengths of some medicines to reduce the risk of a picking error occurring. For example, omeprazole. Team members also demonstrated how wider learning from their superintendent pharmacist's team had influenced practice in the pharmacy. For example, the pharmacy had implemented two labelled baskets for amitriptyline and amlodipine when putting the stock order away. And pharmacy team members explained stock of the two medicines being received was put into the baskets. A second member of the team then checked the contents of the basket to ensure the two medicines were not put away incorrectly.

The pharmacy had a complaints procedure. And it provided details of how people could leave feedback or raise a concern about the pharmacy through a customer charter leaflet. A member of the team explained how she would manage a complaint by escalating details of the concern to the pharmacy manager or pharmacist in the first instance. Pharmacy team members explained they received mostly positive feedback about the pharmacy and the services provided. And they received some tokens of gratitude from people who visited the pharmacy. The pharmacy also promoted feedback through their annual 'Community Pharmacy Patient Questionnaire'. It published the results of this questionnaire for people using the pharmacy to see.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice contained the correct details of the RP on duty. Entries in the RP record complied with requirements. A sample of the pharmacy's prescription only medicine (POM) register, specials records and controlled drug (CD) register complied with legal and regulatory requirements. The pharmacy maintained running balances in its CD register. And it completed weekly stock checks of the register against physical stock. Physical balance checks of Medikinet 5mg tablets and Longtec prolonged release 30mg tablets complied with the balances recorded in the register. The register was maintained in accordance with legal requirements. The pharmacy also maintained a patient returned CD register. And team members entered returns upon receipt.

The pharmacy displayed a privacy notice. It stored people's personal information in staff only areas of the pharmacy. And pharmacy team members responded appropriately when posed with a hypothetical scenario relating to protecting people's personal information. They had completed learning associated with the General Data Protection Regulation (GDPR) and the NHS Data Security and Protection requirements. The pharmacy disposed of confidential waste through transferring it to designated bags which were sealed when full, and the contents securely disposed of via a waste management contractor.

The pharmacy had procedures and information relating to safeguarding vulnerable people. Pharmacy team members had completed e-learning on the subject. The RP had completed level two safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE) . A pharmacy team member confidently explained how she would recognise and report a concern. Team members were able to provide some examples of how they signposted people to organisations which could offer further support. And the pharmacy shared concerns relating to medicine compliance with surgery teams when

necessary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and knowledgeable people working to provide its services safely and effectively. Pharmacy team members feel confident raising any professional concerns they may have. And the pharmacy responds to feedback from its team members appropriately. Pharmacy team members complete regular learning relevant to their role. And they show how they apply this learning when delivering the pharmacy's services. They demonstrate enthusiasm for their roles. And they work together well. They understand the importance of sharing learning following mistakes. And identify how engagement in regular learning opportunities supports the pharmacy in managing risks associated with its services.

Inspector's evidence

On duty during the inspection was the RP, four qualified dispensers (including the pharmacy manager) and a healthcare assistant. The pharmacy also employed another two qualified dispensers and another healthcare assistant. It had suffered from some acute staffing issues over the past few months. The staffing issues had led to one of the dispensers transferring to the pharmacy from another local branch permanently. But the pharmacy was still 16 hours down on regular staffing hours. This had increased pressure on the pharmacy team. And pharmacy team members explained they had had a difficult few months. But some support had been provided by other teams and through team members taking on extra shifts.

Some certificates relating to team members pharmacy qualifications were displayed in the consultation room. Pharmacy team members were encouraged to engage in continual learning relevant to their role. One team member discussed recent topics covered by e-learning, regular 'knowledge checks' relating to medicines and Safer Care. Pharmacy team members could take time during their working day to engage in this learning. And had worked hard to keep their learning up to date during the acute staffing situation. A pharmacy team member explained how she applied learning to her practice. This included an unprompted discussion about the requirements of the valproate pregnancy prevention programme (PPP). Pharmacy team members were also supported through structured appraisals with their line manager. And confirmed they could feedback during their appraisals.

The pharmacy had some targets related to sales, services, training and customer experiences. Pharmacy team members were motivated to work towards meeting targets through an incentive scheme. The scheme rewarded all team members for achieving targets, with the exception of managers and pharmacists. And pharmacy team members supported pharmacists in managing services through identifying eligible people who may benefit from a service such as a Medicines Use Review (MUR) or New Medicine Service (NMS) consultation throughout the dispensing process. The RP on duty was the regular pharmacist. She discussed her approach to completing services. And she demonstrated a robust approach to managing the NMS to ensure follow up consultations were not missed.

Pharmacy team members shared learning through regular Safer Care briefings. Details of these meetings were recorded. This helped to ensure learning could be shared with team members not on duty on the day a meeting took place. Pharmacy team members also completed Safer Care case studies to help them reflect on how they managed their services.

The pharmacy had a whistleblowing policy. And details of how its team members could provide feedback or raise concerns was advertised in the staff room. Pharmacy team members explained they could provide feedback in an open environment in the first instance. And were aware of how to escalate a concern through their manager and area manager if required. Pharmacy team members explained how they implemented their ideas to support workflow. For example, the team had streamlined the management of Electronic Prescription Service (EPS) prescriptions in the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitably maintained. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was modern and professional in appearance. And it was secure. The public area was fitted with wide spaced aisles and was accessible to people using a wheelchair or pushchair. There was seating provided for people waiting for prescriptions or services. The pharmacy had a sign-posted consultation room to the side of the public area. The room was free of clutter. But seating in the room was stained. And this distracted from the otherwise professional appearance of the room.

The pharmacy was air conditioned and lighting throughout the premises was bright. The pharmacy was clean. Designated handwashing sinks were equipped with antibacterial hand wash and paper towels. Pharmacy team members reported maintenance concerns to their head office. There were two unactioned maintenance requests outstanding on the day of inspection. The requests related to portable appliance testing and fitting a security mirror.

The dispensary had limited space. And pharmacy team members explained how the volume of items being dispensed had increased significantly since the pharmacy had relocated some six years ago. Pharmacy team members were observed managing the available space effectively. And they explained how Safer Care processes had drew their attention to the need to manage dispensing space effectively. For example, keeping baskets off the dispensary floor. Work benches were free from non-work-related clutter and floor spaces were free of trip hazards. A door leading off the back of the dispensary provided access to a staff room. This room was also used to store items such as dispensary sundries and some paperwork. A desk and computer in the room provided a small amount of space for completing administration tasks.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services easily accessible to people. It reaches out to the community to promote the benefits of following a healthy lifestyle. And it works well to address the specific needs of the local community by working with local businesses to provide the flu vaccination service in schools and people's places of work. The pharmacy identifies high-risk medicines and makes interventions when necessary. This helps make sure people have the support they need to take their medicines safely. It obtains its medicines from reputable sources. And it generally manages them appropriately to help make sure they are safe to use and fit to supply.

Inspector's evidence

The pharmacy was visible from the main road. It had onsite carparking. And it was accessed through either an automatic door at street level. Or an open plan doorway leading from the medical centre. It advertised its opening times and details of its services in window displays. And leaflets providing further details of its services were readily available for people to take. Pharmacy team members were aware of signposting requirements. And explained how they could signpost a person to another healthcare provider or pharmacy should they be unable to provide a service or supply a medicine.

The pharmacy had an area dedicated to promoting healthy living. Pharmacy team members were keen to engage people in conversation about their health and wellbeing. The pharmacy promoted a number of national health awareness days. And raised money for charity through some of these events. The pharmacy's services were accessible to people. The RP reflected on beneficial outcomes from services such as NMS and the Community Pharmacist Consultation Service (CPCS). The RP provided an example of how she had managed a complex referral through the CPCS service.

The pharmacy had up-to-date patient group directions (PGDs) and procedures readily available to support the supply of medicines through its services. Team members also had access to the most up-to-date version of the minor ailments protocol. The pharmacy had attended three local businesses, including a school to provide the 2019/2020 flu vaccination service remotely. Two members of the team had attended each visit and had set up a suitable room for administering the vaccinations. Appropriate risk assessments were carried out prior to the visits. The pharmacy had received positive feedback from the businesses for providing this service remotely to meet their needs.

The pharmacy had processes to help identify high-risk medicines. And to provide counselling to people to support them in taking these medicines. Pharmacists provided verbal counselling associated with monitoring required for medicines such as lithium, methotrexate and warfarin. They did not record details of these conversations on people's medication records. But the RP demonstrated how she routinely completed paper-based intervention records when required. These records were kept up to date. And they clearly highlighted how the pharmacy shared information with prescribers. A sample of interventions looked at included doses being written in error as millilitres rather than milligrams on prescriptions. A prescription with the wrong dose and regimen of an antibiotic for H-pylori eradication treatment. And interventions on paediatric doses.

The pharmacy engaged in ongoing audits associated with its services and the supply of medicines. In

addition to Safer Care audits the pharmacy completed audits relating to the NHS Pharmacy Quality Scheme (PQS). Pharmacy team members were knowledgeable about the outcomes of these audits. And they demonstrated how they strengthened the pharmacy's processes, particularly in relation to managing some high-risk medicines. A PPP toolkit was available to support the dispensing of valproate to females. And team members understood the requirement to supply safety information and warning cards when dispensing valproate.

A dispenser demonstrated audit trails in place for the pharmacy's managed repeat prescription service. The service was due to change in Spring 2020. This change would see restrictions on pharmacies ordering prescriptions on behalf of people. The local NHS Clinical Commissioning Group were introducing the changes. And the pharmacy was promoting the changes through posters, leaflets and verbal guidance provided when people attended to collect their medicines. The pharmacy was ensuring people were provided with their repeat prescription slip to support them in ordering their own medication moving forward. And the team had begun exploring how they could support vulnerable people by working with surgery teams to ensure appropriate arrangements for supporting people with ordering their prescriptions was in place.

The team had completed training and competency tests prior to sending prescriptions to the company's hub as part of its off-site dispensing service. And it engaged in quarterly 'Safer Scripts' process to ensure these competencies were kept up to date. The pharmacy did not rely heavily on the hub dispensary. And the manager explained this was mainly due to the upcoming change to the repeat prescription service. This change would mean the pharmacy had less control over managing its workflow associated with repeat prescriptions. The pharmacy had appropriate processes in place to manage the dispensing of part-prescriptions (when some of the medicines on a prescription were dispensed locally and others by the hub). And pharmacy team members could physically see what the hub had supplied through a large clear window on each assembled bag of medication. The bags supplied by the hub were transferred to a paper bag at the point of handout to help protect people's confidentiality. Consent for the service was included within the pharmacy's Electronic Prescription Service (EPS) nomination.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. And it used the prescription throughout the dispensing process when the medicine was later supplied. The delivery driver provided an oversight of his role. People were asked to sign for receipt of their medicines through the delivery service. Signatures were obtained using an electronic point of delivery (EPOD) device.

The pharmacy managed the supply of medicines in multi-compartment compliance packs through its patient medication record (PMR) system. Each person on the service had a profile sheet. But profile sheets were updated every few months against the electronic record. And not routinely each time a change to a person's medication regimen took place. A discussion took place about the risks associated with not updating the profile sheet as this sheet was designed to support a safe dispensing process. A sample of assembled packs contained descriptions of the medicines inside to help people identify them. And full dispensing audit trails were provided on each pack. The pharmacy provided patient information leaflets at the beginning of each four-week cycle of packs. Pharmacy team members understood that supplying medicines in multi-compartment compliance packs did not always help to improve people's compliance with taking their medicines. And they explained how they support people in using other measures such as setting reminders on their mobile phones to help them remember to take their medicines.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored Pharmacy (P) medicines behind the Perspex screens throughout the public area of the pharmacy. Signage on the screens explained that staff assistance was required if people wished to purchase a medicine. Medicine sales took place at the healthcare counter which was close to the entrance of the dispensary. And the RP could supervise sales taking place and was able to intervene if necessary.

The pharmacy stored medicines in the dispensary in an organised manner and within their original packaging. Drawers and shelves in the dispensary were kept orderly. The pharmacy held CDs in secure cabinets. Medicine storage inside the cabinets was orderly. There was designated space for storing patient returns, and out-of-date CDs. Assembled CDs were held in clear bags. And prescriptions for both CDs and cold chain medicines were highlighted. The pharmacy's fridge was clean and stock inside was stored in an organised manner. Assembled cold chain medicines were held in clear bags. The pharmacy team monitored and recorded fridge temperatures daily (Monday-Friday). A sample of the diary confirmed the fridge was operating between two and eight degrees Celsius as required.

The pharmacy had a date checking rota to help manage stock and it recorded details of the date checks it completed. But checks of dispensary stock were running behind schedule. The rota identified some areas of the dispensary had last been checked in October 2019. Pharmacy team members were aware of the increased lengths between stock checks. And this had been addressed in Safer Care briefings. And the manager explained there was a plan to bring the checks back up to date. They explained they were taking extra steps during the dispensing process to ensure medicines were checked for their suitability to supply. No out-of-date medicines were found during random checks of dispensary stock. But not all short-dated medicines were identifiable through stickers. The team did annotate details of opening dates on bottles of liquid medicines which had shortened expiry dates once opened. Medical waste bins, sharps bins and CD denaturing kits were available to support the team in managing pharmaceutical waste.

Pharmacy team members were aware of changes to medicine packaging associated with the requirements of the Falsified Medicine Directive (FMD). They had completed some e-learning relating to FMD requirements. And the pharmacy had scanners fitted. But team members had yet to begin scanning medicines. And they explained no details relating to when scanning would begin had been received. The pharmacy team received safety alerts and drug recalls electronically. It acted upon these alerts in a timely manner. And it kept an audit trail of the alerts it had actioned along with copies of the alerts for reference purposes.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And pharmacy team members act with care by using the pharmacy's facilities and equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for children. Pharmacy team members could access additional resources through the intranet and internet. The pharmacy's computer system was password protected. And information on computer screens was protected from unauthorised view through the layout of the premises. Pharmacy team members on duty had working NHS smart cards. The pharmacy stored assembled bags of medicines on designated shelves to the side of the dispensary. Information on bag labels and prescription forms held in a retrieval file was not visible from the public area of the pharmacy. Pharmacy team members used cordless telephone handsets. And two members of the pharmacy team were observed moving into the staff room when having telephone conversations with people.

The pharmacy had a range of clean, crown stamped measuring cylinders for measuring liquid medicines, including separate cylinders for use solely with methadone. It also had a range of counting equipment for counting tablets and capsules. This included a separate triangle for counting cytotoxic medicines. The pharmacy team had annotated the pharmacy's blood pressure machine with a date of replacement which read January 2020. The replacement sticker on its glucometer read February 2019. But the team had not calibrated the glucometer since June 2019. The manager identified the machine should be calibrated every three months in accordance with the pharmacy's SOPs. And acted to complete a calibration check with new control solution during the inspection. Stickers on the pharmacy's electrical equipment indicated portable appliance checks had not been completed since November 2016. The manager confirmed she had raised this as a maintenance issue. Electrical plugs and cables were visibly free from wear and tear.

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.