General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloyds Pharmacy, New Windmill Health Centre Site, 83b Whinmoor Way, Leeds, West Yorkshire, LS14 5BD

Pharmacy reference: 9011649

Type of pharmacy: Community

Date of inspection: 29/03/2022

Pharmacy context

This community pharmacy is in a large medical centre in a suburb of Leeds. The pharmacy relocated in September 2021 to this site. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter (OTC) medicines. The pharmacy supplies some medicines in multi-compartment compliance packs to help several people take their medicines. And it delivers medication to people's homes. The pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 team members act competently when errors happen. They record all their errors and regularly review them. The team uses this information to take appropriate action to help prevent similar mistakes happening again.
2. Staff	Good practice	2.4	Good practice	The pharmacy promotes an open and honest culture within the team. The team members are enthusiastic in their roles and are good at supporting each other in their day-to-day work. They receive regular feedback on their performance and are encouraged to identify opportunities to further develop their knowledge and skills. The team members openly discuss and regularly review their errors. So, they can improve their performance and skills.
		2.5	Good practice	The pharmacy encourages the team members to share ideas on how to improve the delivery of services through regular meetings. And they actively engage in planning for changes the company introduces that may affect the team's workload. Team members have regular opportunities to raise concerns should they wish, during appraisals.
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 team members identify and manage the risks associated with providing pharmacy services well. They act competently when errors happen. The team regularly reviews the errors made. And it uses this information to take prompt and appropriate action to help prevent similar mistakes happening again. People using the pharmacy can raise concerns and the team appropriately responds. The team members have training, guidance and experience to correctly respond to safeguarding concerns. The pharmacy suitably protects people's private information. And it keeps the records it needs to by law.

Inspector's evidence

The pharmacy had systems in place to manage the risk from the COVID-19 pandemic. All team members wore Personal Protective Equipment (PPE) face masks. The pharmacy had bottles of hand sanitiser gel in the dispensary and on the pharmacy counter for the team and people presenting at the pharmacy to use. The pharmacy had installed a plastic screen on the pharmacy counter to provide the team with extra protection. The retail area was large enough to provide space for people to be socially distanced from each other. The size of the dispensary enabled team members to adhere to social distancing requirements.

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The team had read and signed the SOPs signature sheets to show they understood and would follow the SOPs. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

The pharmacist when checking dispensed prescriptions and spotting an error asked the team member involved to find and correct the error. The pharmacy kept records of these errors known as near misses. And it kept a separate near miss record for dispensing activity involving multi-compartment compliance packs. The team member involved completed the near miss record. The entries looked at showed a variety of reasons for the error and different actions identified by each team member to prevent future errors. This demonstrated that each team member had reflected on their own error. The team discussed common errors and how to prevent them from happening again. The team recently investigated why incorrect formulations of pregabalin had been picked in error on three occasions by different team members. The team had previously separated the different formulations and put warning notices on the storage drawers. However, further analysis of the errors revealed team members had misread the prescriptions. As a result, the team introduced a process of clearly marking the form, tablets or capsules, on the prescription. This meant everyone involved in the dispensing and checking of prescriptions could see this information. The pharmacy clearly displayed information about medication that looked alike and sounded alike (LASA) so the team was aware of this when dispensing prescriptions. The team also used a LASA stamp on prescriptions containing these products so every team member involved in dispensing and checking the prescription was alert to this.

The pharmacy had a procedure for managing errors that reached the person known as dispensing incidents. The procedure included the team completing a dispensing incident report and the completion of a reflective statement by the team members involved. All team members were informed of the

dispensing incident and the actions taken to prevent the same error happening again. Following an error when one person was handed another person's medication the team added a requirement to ask people for their date of birth when handing over their prescriptions. The team checked the response from the person against the information on the prescription. And initialled the prescription to show they'd asked this. The team had added a note to the person's patient medication record (PMR) to highlight there was someone else with a similar name. And had completed this task for other people who had similar names.

The pharmacy undertook weekly checks of the team's compliance with the SOPs and other aspects such as completion of training modules. The outcome from the weekly checks fed into a monthly team briefing that included a review of the near miss errors and dispensing incidents. The team used the briefings to discuss case studies sent from the head office team. The pharmacy manager kept notes from the briefings that detailed the discussions held and who in the team had attended. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And a leaflet provided people with information on how to raise a concern with the pharmacy team. Some people had raised concerns after the pharmacy implemented the process of asking people for their date of birth when handing over prescriptions. The team members explained the reason why this was introduced and found most people were happy with the explanation.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. It also displayed a separate privacy notice. The team members had completed training about the General Data Protection Regulations (GDPR). And they separated confidential waste for shredding offsite. The confidential waste bin was located next to the general waste bin and occasionally confidential waste was found in the general waste bin. So, the team introduced a system of placing confidential waste generated throughout the day in clearly marked baskets. A team member sorted through the baskets before putting the waste into the confidential bin. The team also marked each bin to indicate which type of waste it held.

The pharmacy had safeguarding procedures and guidance for the team to follow. And team members had guidance on the Ask for ANI (action needed immediately) initiative. The pharmacist and pharmacy technician had recently completed level two training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team members had access to contact numbers for local safeguarding teams and they responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has an experienced team with the qualifications and skills to support its services. The pharmacy encourages an open and honest culture. Team members work very well together. And they support each other in their day-to-day work, especially at times of increased workload and as the pharmacy introduces new services. The team members discuss ideas to enhance the delivery of the pharmacy's services and they benefit from identifying areas of their own practice they wish to develop. They take opportunities to enrol on to training courses and they receive feedback on their performance. So, they can develop their skills and knowledge.

Inspector's evidence

A full-time employee pharmacist and a regular locum pharmacist covered the opening hours. The pharmacy team consisted of a full-time dispenser who was the pharmacy manager, a full-time pharmacy technician who was the pharmacy supervisor and a trainee accuracy checking technician (ACT), three part-time dispensers and a part-time new member of the team. The pharmacy had advertised for another team member. At the time of the inspection the regular pharmacist, the pharmacy technician and two part-time dispensers were on duty.

The four team members on duty at the time of the inspection worked very well together and supported each other with the completion of tasks. The pharmacy technician as pharmacy supervisor was aware of the pressure the team was under especially when colleagues were absent due to the pandemic or annual leave. And the risk of errors if they felt under pressure. So, she asked all team members to slow down when dispensing and to concentrate on completing one prescription at a time. To support this the team member working on the pharmacy counter informed people how long the prescription would take so the person could decide to wait or come back. The team members had agreed an action plan for tasks they had fallen behind with, such as recording when date checking of stock had taken place. The pharmacy was training more team members for certain roles to ensure tasks were completed especially at times of workforce pressures such as team absences. To support this the pharmacy manager had written a step-by-step guide clearly explaining how to complete key tasks such as cashing up and ordering OTC stock.

The team members used company online training modules to keep their knowledge up to date. They had protected time to complete the training. And were advised by the pharmacy manager when new training modules appeared. The pharmacy provided formal performance reviews for the team and gave team members regular informal feedback. So, they could discuss their development needs. The pharmacy technician identified that as the pharmacy increased the services offered to people it would benefit from having an ACT to support the pharmacist. And had used the opportunity of the performance review to discuss enrolling on to the training course.

The team held regular meetings and team members could suggest changes to processes or new ideas of working. For example, the team members had suggested relocating large packs of creams from higher shelves to lower storage areas to reduce the risk of harm. The pharmacist had rearranged the shelves holding completed prescriptions so the team could easily locate them. The team members regularly discussed the preparations they were putting in place to support them during the planned IT upgrade and when the pharmacy began using the company's offsite dispensary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were hygienic and tidy. The pharmacy had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and the team had access to alcohol gel for cleansing their hands. The pharmacy had enough storage space for stock, assembled medicines and medical devices and the team kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy was secure and it had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related. The pharmacy had a good-sized soundproof consultation room which the team used for private conversations with people.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible for people. And it manages its services well to help people receive appropriate care. The pharmacy supports the team to suitably plan for the introduction of changes to the delivery of its services. This helps ensure people continue to receive safe and effective care. The pharmacy gets its medicines from reputable sources and it stores them properly. The team generally carries out checks to make sure medicines are in good condition and appropriate to supply.

Inspector's evidence

People accessed the pharmacy via an automatic door. The pharmacy had an information leaflet providing people with details of the services it offered and the contact details of the pharmacy. The team wore name badges detailing their role so people using the pharmacy knew who they were speaking to. The team was planning for its use of the company's offsite dispensary. The team identified the processing of prescriptions may be slightly longer than it currently was. So, they were advising people to allow a few days from ordering their prescriptions to collecting it from the pharmacy. This meant when the team started to use the offsite dispensary most people would be regularly ordering their prescriptions this way. The team members provided people with clear advice on how to use their medicines. And they highlighted prescriptions containing high-risk medicines to the pharmacist who provided the person with appropriate counselling. The pharmacist used the PMR to capture details of the conversation with the person. The team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and had information to provide people when required.

The pharmacy provided multi-compartment compliance packs to help around 90 people take their medicines. The team managed the workload by dividing the preparation of the packs across the month. Most prescriptions were sent as electronic repeat dispensing which helped the team prepare the packs in advance. The team members kept a record of each person's current medication which they referred to when checking received prescriptions. The team used a room off the main dispensary to dispense the prescriptions as it was away from the distractions of the retail area. The team used the same room to store completed packs on shelves clearly marked with the person's name. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. So, people could identify the medicines in the packs and had information about their medicines. The pharmacy received copies of hospital discharge summaries which the team checked for changes or new items. Team members were concerned they were not receiving up-to-date information about people's medication from the team at the medical centre. And as they had a good working relationship with the team at the medical centre, they'd arranged a meeting to discuss this. The pharmacist, after checking the packs, bagged them and attached the prescriptions. If the packs were supplied weekly the pharmacist bagged them separately with each weekly prescription attached. The pharmacist marked the bags to clearly show which week of supply it was.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses securely as required with the prescription attached. This helped to ensure the correct dose was selected when the person presented.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels to record who in the team had dispensed and checked the prescription. A sample found the team completed both boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And the team kept the original prescription to refer to when dispensing and checking the remaining quantity.

The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. And it had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The team provided a text messaging service informing people when their prescriptions were ready to collect. The team advised people to not always wait for the text if they needed their medication urgently or it was for an acute prescription such as antibiotics. The pharmacy kept a record of the delivery of medicines to people and it kept separate records for deliveries of CDs. The record of CD deliveries captured the name of the person receiving the CD and that confirmation of the address had been obtained. The record also indicated if the person wanted to speak to the pharmacist.

The pharmacy obtained medication from several reputable sources. The team kept the shelves holding stock tidy and in preparation for using the offsite dispensary was controlling the volume of stock ordered. The team checked the expiry dates on stock and usually kept a record of this. However, over the last few months only one record had been made. The team members checked the expiry date when dispensing and checking prescriptions. And they checked the expiry dates when putting away stock. The team had recently found some oral contraceptive medication sent from the wholesaler with a short expiry date and ensured every team member was aware of this. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. And when supplying medication to people advised them which box to use first. No out-of-date stock was found. The team members recorded the dates of opening for medicines with altered shelf-lives after opening. This meant they could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day. A sample of these records found most were within the correct range. Some days, whilst the reading at the time it was taken was correct, the maximum temperature for that day was slightly outside the range. The inspector discussed taking a second reading later in the day and recording it to show the maximum temperature was in range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned CDs separate from in-date stock in a CD cabinet that met legal requirements. The team used baskets to separate different CDs and it kept the CD stock tidy. The team had ordered an additional cabinet to provide space for storing stock separately from completed prescription waiting to be supplied. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email and the company communication portal which the team accessed twice a day. The team usually printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided which included a range of CE equipment to accurately measure liquid medication. The pharmacy had a large fridge with a glass door that enabled the team to check the stock without prolong opening of the door.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view and it held private information in the dispensary and rear areas, which had restricted access.

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.