

# Registered pharmacy inspection report

**Pharmacy Name:** Lloydspharmacy, Willesborough Health Centre,  
Bentley Road, Willesborough, ASHFORD, Kent, TN24 0HZ

**Pharmacy reference:** 1032565

**Type of pharmacy:** Community

**Date of inspection:** 19/06/2019

## Pharmacy context

The pharmacy is in a surgery surrounded by residential premises. The nearest large town centre is around one mile away. It receives around 96% of its prescriptions electronically. The people who use the pharmacy are mainly older people. The pharmacy provides a range of services including, Medicine Use Reviews, the New Medicine Service, and health checks (blood pressure, cholesterol and diabetes testing). It provides multi-compartment compliance packs to around 70 people who live in their own homes to help them take their medicines safely.

## 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 generally identifies and manages the risks associated with its services. It protects people's personal information. And it largely keeps its records up to date. It actively seeks feedback from the public. And team members understand their role in protecting vulnerable people.

### Inspector's evidence

The pharmacy adopted some measures for identifying and managing risks associated with pharmacy activities. These included; documented, up-to-date standard operating procedures (SOPs), near miss and dispensing incident reporting and review processes. Near misses were highlighted with the team member involved at the time of the incident; they identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for trends and patterns. Items in similar packaging or with similar names were separated where possible. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. A recent incident had occurred where the wrong strength of medicine had been supplied to a person. The pharmacist had carried out an investigation and reported it to head office and the manufacturer. The remaining stock of those medicines had been checked and no further affected medicines were found. The pharmacy held monthly safety meetings to discuss near misses and dispensing incidents. This helped to identify areas of improvement to help minimise the chance of errors.

Workspace in the dispensary was limited. It was free from clutter and there was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members roles and responsibilities were specified in the SOPs. The dispenser said that pharmacy would remain closed if the pharmacist had not turned up. She confirmed that a notice would be displayed and people would be signposted to other local pharmacies. The trainee dispenser said that she would not hand out bagged items or sell pharmacy-only medicines if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance in place. Records required for the safe provision of pharmacy services were available and most elements required by law were complete. All necessary information was recorded when a supply of an unlicensed special was made. And the private prescription records were completed. The nature of the emergency was not routinely recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The address of the supplier was not always recorded in the CD register. The pharmacist said that he would ensure that this was recorded. Controlled drug (CD) running balances were checked around once a month. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The correct RP notice was clearly displayed and the RP log was completed correctly.

Patient confidentiality was protected using a range of measures. Confidential waste was removed by a specialist for disposal. People using the pharmacy could not see information on the computer screens.

And computers were password protected. Smart cards used to access the NHS spine were stored securely and team members used their own smart cards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed General Data Protection Regulation training.

The pharmacy carried out yearly patient satisfaction surveys; results from the 2019 survey were displayed in the shop area. Results from the 2018 survey were available on the NHS website. Results from the 2019 survey showed that 60% of respondents were satisfied with the pharmacy overall. Around 25% of respondents were dissatisfied with the comfort and convenience of the waiting area. Due to the small size of the shop and the current layout, there was no room for additional seating. There was additional seating available in the surgery. Around 20% of respondents were dissatisfied with the time taken to be served. The pharmacist said that this had been due to staffing issues around the time the survey was completed. He said that the pharmacy had received support from head office. And additional work had been carried out over the weekends when the pharmacy was closed. He confirmed that the issue had been resolved and the waiting time had reduced.

The pharmacist said that he had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist said that there been a safeguarding concern at the pharmacy. He had reported the concern to the surgery and they had visited the person.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough trained team members to provide its services safely. They are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

### Inspector's evidence

There was one pharmacist, two dispensers and one trainee dispenser working during the inspection. The team wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed.

The trainee dispenser appeared confident when speaking with people. She was not aware of the restrictions on sales of pseudoephedrine containing products. But she said that she would refer to the pharmacist if a person requested to purchase more than one box of any medicine. She confirmed that she would refer to the pharmacist if a person regularly requested to purchase any medicines. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The dispensers had completed an accredited pharmacy course. And the trainee dispenser was enrolled on one. She had worked at the pharmacy for around three months and said that she carried out most of her training at home. She confirmed that she felt confident to ask any of the team members if she was unsure about anything. Team members completed regular online training. This was monitored by the pharmacist. The pharmacist said that he had completed a declaration of competence and consultation skills training for the provision of the influenza vaccination service.

The pharmacist said that there were regular meetings to discuss any issues. He said that many of the team members worked part time, so the communication board was used to pass on important information. He confirmed that team members had yearly performance reviews and appraisals. And they had had them carried out in March 2019.

Targets were set for Medicine Use Reviews (MUR) and the New Medicine Service. The pharmacist said that the pharmacy achieved the MUR target for the last year. And he confirmed that he carried out these services for the benefit of people who used the pharmacy. He did not feel under pressure to achieve the targets and said that he would not let them affect his professional judgement.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services.

### Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter and in glass fronted cabinets. The cabinet displayed a sign 'Please ask for assistance with these medicines'. The pharmacist had a clear view of the medicines counter from the dispensary. He could listen to conversations at the counter and intervene where needed. Air-conditioning was available; the room temperature was suitable for storing medicines.

Some bagged items were kept on the floor in the dispensary. These potentially presented a tripping hazard for team members. The pharmacist said that he would place these items in boxes so that they were tidier and this would reduce the chance of them being kicked and damaged.

There was a chair and a stool in the shop area. The shop area was small so the chairs could not be positioned away from the medicines counter. This may mean that conversations at the counter and in the dispensary may potentially be overheard by people in the pharmacy. The pharmacist said that people were offered the use of the consultation room if they wished to have a private conversation. He confirmed that team members went to the back area of the dispensary if they needed to discuss someone's medication.

The consultation room was accessible from the shop area. Low-level conversations in the consultation room could not be heard from the shop area. The windows in the doors were not see-through. There were two chairs and a desk available. The room was accessible to wheelchair users. The room was suitable for the services offered. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

## Principle 4 - Services ✓ Standards met

### Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy generally manages its services well and provides them safely. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe to use.

### Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. A variety of patient information leaflets were available. Services and opening times were clearly advertised. The pharmacist said that the induction hearing loop was in good working order. Several members of the team had been trained to carry out the testing services. The pharmacist said that he checked the results following the tests and spoke with people when needed. He said that he had referred a person to their doctor following a high blood pressure reading.

The pharmacist said that he checked monitoring record books for people taking high-risk medicines such as methotrexate and warfarin. And a record of the results was kept. Prescriptions for these medicines were highlighted so that the pharmacist could speak with these people about their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. And the sticker included the date these were not to be handed out after. The pharmacist said they checked CDs and fridge items with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few female patients. But it did not have the up-to-date patient information leaflets or warning cards available. He confirmed that he would contact the manufacturer to request further supplies of these. There were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next three months was marked. There were no date-expired items found in with dispensing stock. Medicines were kept in suitably labelled containers.

The dispenser said that part-dispensed prescriptions were checked around once a day. 'Owings' notes were provided and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until items were collected. The dispenser said that uncollected prescriptions were checked weekly using a colour coded retrieval system. The pharmacist said that people were contacted to ask if they needed their medicines. If the items remained uncollected for a further two weeks these were then returned to dispensing stock. And the prescriptions were returned to the NHS spine or the prescriber.

Prescriptions for people receiving their medicines in compliance packs were ordered in advance so that any issues could be addressed before they needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that people ordered these if they needed them. The pharmacy kept a record for each patient which included any changes to their medication. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each tray. Medication descriptions were not always put on the packs. This could make it harder for people to

identify the medicines in the packs. Patient information leaflets were routinely supplied. There was currently one member of the team who managed the packs. The pharmacist said that another team member who used to do this task had been working at another pharmacy within the organisation. He planned to train another member of the team in case there was any unplanned absence.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness; two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible on a hand-held electronic device. The pharmacist said that the deliveries were all within the local area. He confirmed that the driver was provided with a cool box for transporting medicines requiring refrigeration.

Licensed wholesalers were used for the supply of medicines and medical devices. Drug alerts and recalls were received from the head office. A record of any action taken was kept at the pharmacy. This provided assurance that these had been actioned appropriately and in a timely manner.

The pharmacy had the equipment installed ready for the implementation of the EU Falsified Medicines Directive. The pharmacist said that team members had not received any training and the equipment was not being used.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy generally has the equipment it needs to provide its services safely.

### Inspector's evidence

Up-to-date reference sources were available in the pharmacy and online. Suitable equipment for measuring medicines was available but not for volumes less than 5ml. The dispenser said that an oral syringe was used to measure smaller amounts. The pharmacist said that he would order a suitable measure. Triangle tablet counters were available and clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

The pharmacist said that the blood pressure monitor had been in use for less than two years and he had attempted to order a new monitor but it was out of stock. He said that he would order an alternative brand. Other testing equipment was calibrated regularly and this was recorded. The weighing scales were in good working order. The phone in the dispensary was portable so could be taken to a more private area where needed.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

### What do the summary findings for each principle mean?

Finding	Meaning
<span style="color: green;">✓</span> <b>Excellent practice</b>	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.
<span style="color: green;">✓</span> <b>Good practice</b>	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
<span style="color: green;">✓</span> <b>Standards met</b>	The pharmacy meets all the standards.
<b>Standards not all met</b>	The pharmacy has not met one or more standards.