

Registered pharmacy inspection report

Pharmacy Name: Lloyds pharmacy, 4a Singleton Centre, Singleton Village, ASHFORD, Kent, TN23 5GR

Pharmacy reference: 1032580

Type of pharmacy: Community

Date of inspection: 15/09/2020

Pharmacy context

The pharmacy is located in a small shopping precinct in a village setting. The people who use the pharmacy are mainly older people. The pharmacy receives around 80% of its prescriptions electronically. It provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations, a stop smoking service and blood pressure checks. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a small number of people who live in their own homes to help them manage their medicines. The inspection was carried out 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	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	The pharmacy encourages its team members to undertake ongoing training. And it gives them time set aside to do it. This helps them keep their knowledge and skills up to date.
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 adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. It protects people's personal information and people can provide feedback about the pharmacy's services. The pharmacy keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs), and reporting and reviewing of dispensing mistakes. The pharmacy had carried out workplace risk assessments in relation to Covid-19. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes and these were recorded and reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. Warning stickers were used on shelf edges to highlight where these medicines were kept. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong strength of medicine had been supplied to a person. The person had realised the error while still in the shop area and returned the incorrect medicine to a member of the team. The team dispensed the correct medicine and the incident was reported to the pharmacy's head office.

Workspace in the dispensary was free from clutter. 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 pharmacy manager said that the pharmacy would remain closed if the pharmacist had not arrived in the morning. She knew that team members should not carry out any dispensing tasks until the pharmacist had turned up. And she confirmed that she would inform people about any delays and she would inform the pharmacy's head office if she was not able to contact the pharmacist. The healthcare assistant knew that she should not hand out dispensed items or sell pharmacy-only medicines if the pharmacist was not on the premises.

Risk assessments relating to Covid-19 had been carried out for the services provided. Team members wore protective equipment while in the consultation room and asked that people using the services also wore it. The pharmacist said that people were asked to complete any paperwork prior to entering the consultation room to help minimise the time in a confined space. They were asked to wait in the shop area after their consultation if needed. These measures helped to minimise the spread of infection. The inspector discussed with the pharmacist about the reporting process in the event that a team member tested positive for the coronavirus. He said that he would inform the pharmacy's head office and team members would have to arrange for personal tests to be carried out.

The pharmacy had current professional indemnity and public liability insurance. All necessary information was recorded when a supply of an unlicensed medicine was made. The private prescription records and emergency supply records were completed correctly. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly.

Confidential waste was removed by a specialist waste contractor, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy. The pharmacy team members had completed training about the General Data Protection Regulation.

The pharmacy had carried out patient satisfaction surveys and the most recent results were displayed in the shop area. And these were positive overall. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The pharmacy manager said that there had been a complaint recently received and that it was referred to the pharmacy's head office. A report had been completed and it was kept for future reference.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed safeguarding training provided by the pharmacy's head office. The pharmacy manager could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. She confirmed that there had not been any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with ongoing and structured training to support their learning needs and maintain their knowledge and skills. And they get time set aside in work to complete it. They can raise any concerns or make suggestions and have regular meetings. 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 trained dispensers (one was also the pharmacy manager) and one trained healthcare assistant working on the day of the inspection. The pharmacy manager said that the pharmacy had recently recruited a part-time healthcare assistant and who was due to start working at the pharmacy soon. The team members wore 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 healthcare assistant appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she confirmed that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. Team members were provided with ongoing training by the pharmacy's head office. The pharmacy manager explained that each person was allocated set time each week to complete any training. She said that the team were able to carry out the ongoing training during the pandemic and she had monitored this. Team members could also access the online training at home if they wanted to. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The pharmacy manager said that the team had regular meetings to discuss any issues, dispensing mistakes and training. Information from the pharmacy's head office was passed on when it was received and this was also discussed during the meetings. The pharmacy manager carried out appraisals and performance reviews for team members every six months and these were documented. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And the pharmacist said that he felt able to take professional decisions.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that he did not feel under pressure to achieve the targets and he carried out the services for the benefit of the people using the pharmacy. The pharmacy manager said that the pharmacy was on course to achieve the targets this year.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area. But the pharmacy could do more to make sure that the room temperature in the warmer months remains at a suitable level.

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 in cabinets in the shop area and notices were displayed requesting that people ask for assistance if they wanted these medicines. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed.

The weather outside on the day of the inspection was warm. Air conditioning was not available in the pharmacy and the room temperature on the day of the inspection was 28 degrees Celsius. There were two large fans available in the dispensary, but one of these had been brought in by the pharmacist on the day of the inspection. The pharmacy manager said that the temperature had been regularly reaching up to 30 degrees Celsius on hotter days. Room temperatures had not been regularly recorded, but the pharmacy manager said that she had occasionally taken a photograph of the thermometer. She said that she would keep records of the room temperature in the future. She explained that she had informed the pharmacy's head office about the room temperatures as team members were finding it difficult to work in the heat. And she was concerned about the medicines being stored at higher temperatures than recommended. The pharmacy manager said that she would follow this up again with the pharmacy's head office again. The inspection was undertaken in September, as the months were starting to get cooler.

A small clear screen had been installed at the medicines counter to help minimise the spread of the coronavirus. Notices were displayed at the entrance to the pharmacy asking people to cover their face. And a one-way system had been implemented in the shop area to help people to maintain a suitable distance from each other. There were two stools in the shop area for people to use while they waited. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The pharmacy's consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened. Low-level conversations in the consultation room could not be heard from the shop area. 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

The pharmacy provides its services safely and manages them well. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. And it dispenses medicines into multi-compartment compliance packs safely. The pharmacy gets its medicines from reputable suppliers and largely stores them properly.

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. Services and opening times were clearly advertised and a variety of health information leaflets was available.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. 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 people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant patient information leaflets and warning cards available.

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 few months were marked. There were no date-expired items found in with dispensing stock. But there were a few boxes which contained mixed batches. And this could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately. The pharmacist said that he would ensure that medicines were kept in their original packaging in the future.

Part-dispensed prescriptions were checked regularly. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were checked weekly. The pharmacy manager said that people were contacted if they had not collected their items after around four weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that people were referred to the local community support team for assessments if they might benefit from having their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not

routinely requested; the dispenser said that the pharmacy usually contacted people to see if they needed them when their packs were due each month. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that 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 did not currently obtain people's signatures to help minimise the spread of infection. The pharmacist confirmed that the driver had been instructed to leave the bagged items on the doorstep and confirm the person's details before leaving the address. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response. The pharmacy had the equipment to be able to comply with the EU Falsified Medicines Directive but it was not yet being fully used. The pharmacist said that he and other team members had undertaken some training on how the system worked. He was not sure when the pharmacy would be fully using the equipment.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available and clean. Triangle tablet counters were available and clean; and a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for around one year. The pharmacy manager said that it would be replaced in line with the manufacturer's guidance. The carbon monoxide testing machine was calibrated by an outside agency and the weighing scales were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

The pharmacy had protective equipment for team members to wear, including, gloves, masks, aprons and visors. The pharmacy manager said that the equipment was uncomfortable to wear due to the warm temperature in the pharmacy. But team members wore it to help minimise the spread of infection.

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
✓ 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.