General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lotus Pharmacy, 119 Croydon Road, Elmers End, BECKENHAM, Kent, BR3 3RA

Pharmacy reference: 1032587

Type of pharmacy: Community

Date of inspection: 24/05/2023

Pharmacy context

This is a community pharmacy in South East London, in a largely residential area. It mainly provides NHS dispensing services, and some additional services such as the New Medicine Service and deliveries of medicines to people's homes. It previously supplied multi-compartment compliance packs, but these are now dispensed at the company's dispensing hub and supplied from another nearby branch.

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	1.8	Good practice	The pharmacy responds proactively to concerns about the wellbeing of vulnerable people, and team members can give examples of when they have done this.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy is good at providing its services safely and effectively. It takes extra steps to make sure that people receive services that are safe, and that people taking higher-risk medicines receive the additional information they need.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy appropriately identifies and manages the risks associated with its services. Team members know about their own roles and responsibilities, and they keep the records that they need to. They protect people's personal information well. And they respond proactively to concerns about the wellbeing of vulnerable people and can give examples of when they have done this.

Inspector's evidence

There was a range of standard operating procedures (SOPs) available on the pharmacy's computer system. The responsible pharmacist (RP) showed how a record was kept of when individual team members had read and signed the ones relevant to their roles. The SOPs were issued by the pharmacy's head office and were in the process of being updated.

Dispensing mistakes which were identified as part of the dispensing process were recorded on the pharmacy's computer system. Dispensing mistakes where the mistake had reached a person were recorded separately on the computer system, and a copy sent to head office. A monthly review was done of any dispensing mistakes, and previous learning points had included separating items which looked similar or sounded alike. An annual review was also done, and the review from 2022 included actions such as re-reading the SOPs, and moving the multi-compartment compliance pack service to another branch. In this review there were also learnings recorded from an incident that had occurred at the branch, and the RP described the changes that had been put in place to help prevent a recurrence.

The trainee dispenser was clear about what she could and could not do if the pharmacist had not turned up in the morning. She explained how she referred requests for any abusable medicines to the pharmacist on duty.

There were signs in the public area to explain to people how they could make a complaint or provide feedback about the pharmacy's services. Team members confirmed that they had read the pharmacy's complaint SOP and the safeguarding SOP. There was a suggestions box on the pharmacy counter.

The pharmacy had current indemnity insurance. The RP notice was wrong, but it was changed immediately when this was highlighted, and the RP record had been filled in properly. Records seen about private prescriptions dispensed and emergency supplies made contained the required information. Controlled drug (CD) registers examined complied with requirements, and records about unlicensed medicines supplied had the necessary information recorded.

No confidential information was visible from the public area. Confidential waste was sent off site for secure disposal. Staff had signed confidentiality training, and the RP confirmed that team members had done confidentiality training but was unable to locate the records for this. Team members had individual smartcards to access the NHS electronic systems. The RP confirmed she had done level 2 safeguarding training and gave detailed examples of what the pharmacy had previously done in response to safeguarding concerns. She explained that team members who had worked at the pharmacy for over three months had completed safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide its services, and they do the right training for their roles. They get ongoing training to help keep their knowledge and skills up to date. They feel comfortable about raising any concerns or making suggestions. And they can take professional decisions to help keep people safe.

Inspector's evidence

During the inspection there was the RP (who was the regular pharmacist), two trainee dispensers, and a team member who had only started a few weeks ago. The pharmacy also employed another team member who had worked at the pharmacy for around five weeks. The RP was aware of the training requirements for support staff working in the pharmacy. Staff were observed being supportive of each other and communicating effectively.

Team members described how they undertook ongoing training by completing packages sent through from head office. These could be completed on the portable electronic tablet. The RP did not think that she could see team member's progress with these training packages. But explained that head office could monitor team member's progress with this training and contacted the pharmacy if training was missed. Team members got protected training time at work to complete the ongoing training. The pharmacy had a whistleblowing policy, and team members felt very comfortable about raising any concerns or making suggestions. They had weekly meetings, and notes from the meetings were kept on a board in the dispensary for them to refer to. Team members were not set formal targets to achieve. The RP felt able to take professional decisions when necessary.

Principle 3 - Premises ✔ Standards met

Summary findings

Although storage space is limited, the pharmacy largely keeps its premises clean and tidy. People can have a conversation with a team member in a private area. And the premises are secure from unauthorised access when they are closed.

Inspector's evidence

The premises were clean and largely tidy. Storage space was limited, and although it was used well, there were some delivery boxes on the floor. The boxes had been moved to the side to help prevent staff tripping on them, and most boxes were put away during the inspection.

There was a consultation room which was clean and tidy. It was set off the shop floor, and allowed a conversation to take place inside at a normal level of volume and not be overheard. The premises were secure from unauthorised access when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is good at providing its services safely and effectively. It takes extra steps to make sure that people receive services that are safe, and that people taking higher-risk medicines receive the additional information they need. The pharmacy's services are accessible to a range of people. It gets its stock from reputable sources and on the whole it stores its medicines properly. Team members take the right action in response to any safety alerts, which helps people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy had a small step from the street and a manual door. There was a doorbell, and team members described how they would go and assist people who needed help. The door stayed open once pushed, and team members said that people with mobility scooters were able to come in directly. There was an adequate space inside the pharmacy for manoeuvring wheelchairs or pushchairs, but space was limited. The pharmacy could produce large-print labels for people who needed them. And the RP said that the pharmacy had occasionally provided medicine administration sheets to help people remember if they had taken their medicines.

Dispensing baskets were used to help isolate different people's medicines, and there was a clear workflow through the dispensary. No dispensed prescriptions for higher-risk medicines were seen during the inspection, but the RP was able to demonstrate how she printed out additional information to highlight prescriptions for these medicines. For example, she showed how she would print out a list of points to go through with when a person collected a prescription for lithium. Theses point included checking about regular blood tests, and advising about signs that the blood levels were too high. Following an incident at another branch, she described how the company had changed the way that methotrexate was dispensed, and the labels now indicated a particular day of the week to take the medicine on. She said that people taking this medicine had been contacted to find out which day of the week they usually took the medicine, and their computer records were updated accordingly. The RP explained how she contacted people taking higher-risk medicines who had their medicines delivered, to make sure that they got the information they needed to take their medicines safely. She showed how this contact was recorded on the person's individual computer record.

Dispensary staff were aware of the guidance about pregnancy prevention for people taking valproate-containing medicines, and the pharmacy had spare leaflets, cards, and warning stickers. The RP described how a person taking the medicine and who was in the at-risk group had been spoken with. And a note put on the computer system confirming that the person was on a Pregnancy Prevention Programme.

The RP described how she had identified a potential issue with the size of blood pressure machine cuff. A person who did not quite fit the larger or smaller cuff had a difference of 15% in the blood pressure readings between the two size cuffs. The RP was concerned the readings may not accurately indicate whether or not the person had high blood pressure. She had contacted the Royal Hypertensive Society and discussed the issue with a consultant who helped her with her query; this included taking the cuffs apart and measuring the inflating bladders inside. Following this, the RP felt able to go back to the person's GP with an accurate blood pressure reading and advised that the person did not require

treatment for high blood pressure. She said that she also sent details of the interaction to head office, who prepared a booklet about it for the other branches in the group.

The RP described how people having their medicines in multi-compartment compliance packs now had them sent to the company's hub for dispensing and they were then supplied by a nearby branch. She said that as people could only nominate one pharmacy, this had caused issues when people needed urgent medicines such as antibiotics. She had discussed this with the local surgery who now provided these people with printed prescriptions for any urgent medicines so that they could receive them without delay.

The pharmacy got its medicines from licensed suppliers and generally stored them tidily. Stock was date checked regularly, and no date-expired medicines were found in stock. Bulk liquids were marked with the date of opening to help staff know if they were still suitable to use. Medicines for destruction were clearly separated from stock and send offsite for destruction. Fridge temperatures were monitored and recorded regularly, and records seen were within the appropriate range.

The pharmacy received drug alerts and recalls via email from a range of sources. The RP showed how the pharmacy maintained a spreadsheet to show what action had been taken in response to each one.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely, and it keeps it clean. It uses its equipment to help protect people's private information.

Inspector's evidence

The pharmacy had a large range of clean glass measures for use when measuring liquid medicines. The blood pressure meter was less than a year old, and had a date on the box of when it had started being used. There was a range of cuffs of different sizes for use with the meter. The phone was cordless and could be moved to a more private area to help protect people's personal information. Tablet and capsules counting equipment was clean.

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.