General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, White Lion House, High Street, CRANBROOK, Kent, TN17 3DF

Pharmacy reference: 1032687

Type of pharmacy: Community

Date of inspection: 25/05/2021

Pharmacy context

The pharmacy is located on a busy high street in a town centre in a largely residential area. It is the only pharmacy in Cranbrook and it serves a mixed population. The pharmacy receives around 80% of its prescriptions electronically. The pharmacy provides a range of services, including the New Medicine Service, diabetes checks, blood pressure checks and seasonal flu vaccinations. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a large 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

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	The pharmacy is good at recording and reviewing any mistakes that happen during the dispensing process. It uses this information to help make its services safer.
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	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 well. It properly keeps the records it needs to by law, to show that its medicines are supplied safely and legally. Team members understand their role in protecting vulnerable people. And the people who use the pharmacy are able to provide feedback about its services.

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. Team members had signed to show that they had read, understood and agreed to follow the SOPs. 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. Near misses were recorded and reviewed regularly for any patterns as part of the weekly 'Safer Care' processes. The outcomes from the reviews were discussed openly during the regular team meetings. And learning points were also shared with other pharmacies in the group. As a result of the reviews, team members were reminded to double check before putting stock away to ensure that it was put in the right place. And items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And amlodipine and amitriptyline were kept in separate areas to help minimise the chance of a mistake. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that any dispensing errors would be reported to the pharmacy's head office and recorded on the pharmacy's computer system. A recent error had occurred where the wrong type of medicine had been supplied to a person. And a root cause analysis had been carried out for this.

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 medicines counter assistant (MCA) knew that she should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. The team had access to the pharmacy if the pharmacist had not turned up, but the pharmacy would remain closed. The dispenser knew that which tasks she could carry out if there was no responsible pharmacist (RP).

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 were completed correctly and in a timely manner. The nature of the emergency was routinely

recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. 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 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 team members had completed training about how to manage people's personal information.

The pharmacy had carried out yearly patient satisfaction surveys, but because of the pandemic it had not carried one out for 2020 to 2021. Results from the 2019 survey were displayed in the shop area and results from the 2017 to 2018 survey were available on the NHS website. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The dispenser said that there had not been any recent complaints. And she would refer any complaints to the pharmacist so that they could try and resolve it in the pharmacy. If the team were not able to resolve it, then it would be passed to the pharmacy's head office if needed.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (level 2) training about protecting vulnerable people. Other team members had undertaken training provided by the pharmacy's head office. The dispensers could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. And 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 some ongoing training to support their learning needs and maintain their knowledge and skills. They feel comfortable about raising concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. The team discusses adverse incidents and uses these to learn and improve. And 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 locum pharmacist, four trained dispensers (one held the NVQ level 3 qualification) and one trained MCA. Team members had completed an accredited course for their role and the NVQ level 3 dispenser had applied to be on the GPhC pharmacy technician register. Team members 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 pharmacy had been without a pharmacist manager for several months and had been relying on locum pharmacists to provide cover. The team had managed to keep up to date with the workload and continued to provide the services well.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine-containing products. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She used effective questioning techniques to establish whether the medicines were suitable for the person.

The pharmacist explained to one of the dispensers about how to properly endorse a handwritten prescription to ensure that the correct payment was applied for. And he reminded the dispenser to check that the correct brand was being claimed for. The pharmacist and NVQ level 3 dispenser were aware of the continuing professional development requirement for the professional revalidation process. And the pharmacist felt able to take professional decisions.

The team had managed to keep up to date with the online training provided by the pharmacy's head office. The dispenser showed that most of the team had completed all the necessary training and she monitored this. Recent training included the NHS data and security toolkit. The team had also carried out training about how to take payments over the phone as the pharmacy had been carrying out an increased number of deliveries to people during the pandemic who needed to pay for their medicines.

The inspector discussed with the dispenser about the reporting process in the event that a team member tested positive for the coronavirus. She was clear on the action to take and said that she would refer to the SOPs where needed. Team members had received at least one dose of the Covid-19 vaccination and some had received two doses.

The dispenser said that she could contact the regional manager to discuss any issues or make suggestions. And that the regional manager regularly visited the pharmacy to check on the team and discuss any issues face to face. The dispenser said that the team underwent formal appraisals and

performance reviews every six months. But these had not been done recently due to the pharmacy not having a manager. The pharmacy held Safer Care meetings each month where the team would discuss the near misses and dispensing errors. The team would also discuss the case studies received from the pharmacy's head office. The team were offered the chance to ask any questions during the meetings.

Targets were set for the New Medicine Service (NMS). The target had recently increased from one NMS a week to five a week. The dispenser said that the service was provided for the benefit of people using the pharmacy and the team did not feel under pressure to achieve the targets.

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.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout. And this presented a professional image. Pharmacy-only medicines were kept behind clear cases in the shop area. People were directed to seek assistance from a member of the pharmacy team if they wanted to purchase these medicines. There was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available and the room temperature was suitable for storing medicines.

There were three chairs available in the shop area for people to use. These were positioned away from each other to help people keep a suitable distance. And were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. There was a screen at the medicines counter and notices on the floor to help people keep a suitable distance from other people while in the pharmacy. The dispenser said that the pharmacy had limited the number of people allowed in the shop area at the start of the pandemic. But the shop area was large and people maintained a suitable distance without needing to be prompted by pharmacy staff.

The pharmacy's consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened. Conversations at a normal level of volume 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 has a robust system for dispensing medicines into multi-compartment compliance packs to ensure that these are done safely. The pharmacy gets its medicines from reputable suppliers and stores them properly. 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.

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 induction hearing loop appeared to be in good working order. The pharmacy was in the process of training the team before starting to provide the minor ailments scheme.

Dispensed fridge items were kept in clear plastic bags to aid identification. The dispenser said team members checked CDs and fridge items with people when handing them out. The pharmacy supplied valproate medicines to a few people. And the dispenser confirmed that a pharmacist had spoken to any people in the at-risk group about the Pregnancy Prevention Programme and notes were made on their medication record to show this. Prescriptions for Schedule 3 and 4 CDs were highlighted and the date 'not to be handed out' after was recorded on the sticker. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Prescriptions for higher-risk medicines were routinely highlighted, so there was the opportunity to speak with these people when they collected their medicines. The dispenser said that the locum pharmacists usually checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not always kept. She explained that some pharmacists made a note on the person's medication record to show that they had spoken with them, but this was not consistently done. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals.

Expiry dates were checked every three months and this activity was recorded. Items due to expire before the end of the current year were clearly marked. There were a few boxes of medicines found with dispensing stock found which had expired in January 2021. The dispenser checked the record, and the area they were found in was still due to be checked. She said that items were usually removed from dispensing stock around three months before they were due to expire. And she would remind team members to ensure that this was carried out. Medicines were kept in their original packaging and were stored in an organised manner.

Part-dispensed prescriptions were checked frequently. '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. And there were very few part-dispensed prescriptions at the pharmacy. The dispenser called a person during the inspection to inform them about a manufacturing supply issue with their medicines. She explained the options available to the person and offered to request another prescription for different strengths of the medicine. Prescriptions were kept at the pharmacy until the remainder was dispensed and

collected. Uncollected prescriptions were checked monthly and people were sent a text message reminder if they had not collected their items after around one month. People were also given a follow-up call to remind them about their medicines before the items were returned to dispensing stock. The person's medication record was updated to show that they had not received the medicines and the prescriptions were returned to the NHS electronic system or to the prescriber.

The system for managing people who had their medicines in multi-compartment compliance packs was well organised and the packs were supplied safely. People had assessments carried out by their GP to show that they needed the packs. Several team members could provide cover where needed and there was a clear audit trail to show when the packs were needed for. Prescriptions for people receiving their medicines in the 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 by the pharmacy. The dispenser said that the pharmacy contacted a few people to ask if they needed them when their packs were due. And others were responsible for contacting the pharmacy when they needed these medicines. 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.

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, and 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 driver was supplied with personal protective equipment (PPE) and maintained distance while checking people's details. 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 pharmacy's head office. 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.

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. Triangle tablet counters were available and clean. 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 was first used fewer than six months ago and the date of use was on the monitor. The weighing scales and the shredder were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed. PPE such as masks was available and hand sanitiser was available throughout the pharmacy.

Fridge temperatures were checked daily, and 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.