General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 8 Rainham Shopping Centre, Rainham, GILLINGHAM, Kent, ME8 7HW

Pharmacy reference: 1032777

Type of pharmacy: Community

Date of inspection: 08/08/2019

Pharmacy context

The pharmacy is in a small shopping precinct near to the main high street in a residential area. The people who use the pharmacy are mainly older people. The pharmacy receives around 80% of its prescriptions electronically. The pharmacy provides a range of services, including Medicines Use Reviews, the New Medicine Service, influenza vaccinations, blood pressure and diabetes testing. It supplies medication in multi-compartment compliance packs to around 160 people who live in their own homes to help them manage their medicines. And supplies medicines to around 14 care homes with approximately 280 beds.

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	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 largely identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information and it keeps its records up to date. It regularly seeks feedback from people who use the pharmacy and uses this to help to improve its services. It keeps its records up to date 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 any patterns. Medicines in similar packaging or with similar names were separated where possible. Or caution stickers were used on the shelves where these medicines were stored. Dispensing incidents were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that head office would be informed about any incidents, but she was not aware of any recent dispensing incidents. Near misses and dispensing incidents were discussed during the patient safety review meeting which was held monthly. They were also reviewed weekly by the pharmacist.

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) said that the pharmacy would not open if the pharmacist had not turned up and a notice would be displayed to inform people. She knew that she should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. The dispenser said that she would not carry out any dispensing tasks until the pharmacist had turned up.

The pharmacy had current professional indemnity and public liability insurance. Records required for the safe provision of pharmacy services were available though not all elements required by law were complete. All necessary information was recorded when a supply of an unlicensed special was made and the private prescription record was complete. But the nature of the emergency was not always 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. Controlled drug (CD) running balances were checked weekly. The recorded quantity of one item checked at random was the same as the physical amount of stock available. The responsible pharmacist record was completed correctly and the correct RP notice was clearly displayed.

Patient confidentiality was protected using a range of measures. Confidential waste was removed by a specialist waste contractor and the people using the pharmacy could not see information on the computer screens. 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 2017 to 2018 survey were displayed in the shop area and the most recent results were available on the NHS website. The recent results were printed during the inspection and displayed in the shop area. Results were positive and around 85% of respondents were satisfied with the pharmacy overall. The pharmacist said that there had been a few recent complaints about the time taken to dispense people's prescriptions. She said that she had spoken with the surgeries about how the electronic prescription system worked and about how long was needed for repeat prescriptions to be processed. Team members gave estimated waiting times for people when they handed in their prescriptions and this had helped to manage people's expectations. The complaints procedure was available for team members to follow if needed and details about it were displayed in the shop area.

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 MCA could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said 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 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, three dispensers, one locum dispenser and two MCAs working during the inspection. The 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. There were three relief staff working at the pharmacy on the day of inspection. They had been brought in to help the pharmacy to catch up on tasks that had not been completed. The pharmacist said that five members of the team had recently left and the pharmacy was in the process of recruiting. The professional support manager was at the pharmacy to carry out a professional standards audit.

The MCA appeared confident when speaking with people. She was aware of the restrictions on sales of pseudoephedrine containing products. And she said 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.

Team members had completed accredited training courses. The MCAs were enrolled on an accredited dispenser course, so that they could provide cover in the dispensary when needed. The team had access to online training provided by the pharmacy. They were encouraged to complete monthly training modules and this was monitored by the pharmacist.

The pharmacy had meetings when needed to discuss any issues. The pharmacist said that there had been recent meetings held after the pharmacy closed to discuss the staffing issues and to create an action plan so that people who used the pharmacy were provided with a continued level of service. Team members said that they felt confident about discussing any issues with the pharmacist.

Targets were set for Medicines Use Reviews and the New Medicine Service. The pharmacist said that she did not feel under pressure to achieve the targets and would not let them affect her professional judgement. She confirmed that the pharmacy regularly met the targets and these were carried out for the benefit of people using the services.

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. 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 seven chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The 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 generally manages its services well and provides them safely. It 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. A variety of health information leaflets were available. Services and opening times were clearly advertised.

The pharmacist said that she checked monitoring record books for people taking high-risk medicines such as methotrexate and warfarin. And a record of blood test results was kept on the person's medication record. This made it easier for the pharmacy to check that the person was having relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were highlighted. So, there was an opportunity for the pharmacist to speak with these people when they collected their medicines. The 'date not to be handed out after' was recorded on the bag label for CDs. This helped to minimise the chance of them being handed out after 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 no people in the at-risk group taking valproate who needed to be on the Pregnancy Prevention Programme. She confirmed that she had ordered replacement warning cards and information leaflets from the manufacturer.

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 six months was marked. There were no date-expired items found in with dispensing stock. Medicines were kept in their original packaging.

Part-dispensed prescriptions were checked daily. '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 collected. The pharmacist said that uncollected prescriptions were usually checked weekly and items uncollected after six weeks would be returned to dispensing stock where possible. These had not been checked for around two months and there were some expired prescriptions for CDs found in the retrieval system. A member of the relief support team had been asked to deal with these. He said that the pharmacy was due to implement a text message reminder system to prompt people to collect their medicines.

Prescriptions for people receiving their medicines in multi-compartment compliance 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 people contacted the pharmacy when they needed them. The pharmacy kept a record for each person

which included any changes to their medication. They also kept 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 and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs. Care homes ordered prescriptions for their residents. Dispensing tokens were printed and sent to the care homes for them to check against what they had ordered. The dispenser said that the care homes were responsible for chasing up any missing items with the surgeries.

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 obtained people's signatures for deliveries where possible; these were recorded in a way so that another person's information was protected. 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.

The pharmacy had the equipment installed to comply with the EU Falsified Medicines Directive (FMD) and team members had received some training. The pharmacist said that the equipment was not yet being used.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Suitable equipment for measuring liquids was available but not for volumes less than 10ml. The pharmacist said that she would order a suitable measure. Triangle tablet counters were available and they were clean; a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for around six months. The weighing scales and the shredder were in good working order. And the phone in the dispensary was portable so it 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
✔ 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.