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: 14/07/2022

Pharmacy context

The pharmacy is located on a busy shopping precinct in a largely residential area. It receives most of its prescriptions electronically. And it provides a range of services, including the New Medicine Service, blood pressure checks, diabetes checks and fit to fly certificates. It also 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. And it provides medicines to several care homes. It also provides substance misuse medications to a small number of people.

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

Overall, 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. And people can provide feedback about the pharmacy's services. Team members understand their role in protecting vulnerable people. The pharmacy largely keeps its records up to date and accurate. But it doesn't always record private prescriptions within the required timeframe.

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. 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. And items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. 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. 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 type of medicine had been supplied to a person.

The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. 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.

Team members' roles and responsibilities were specified in the SOPs. A team member said that the pharmacy would remain closed if the pharmacist had not turned up. They said that the pharmacist from the hub had recently signed into this pharmacy's RP log to allow them to carry out tasks which require a RP to be signed in. The pharmacy manager explained which tasks should not be carried out if the RP was not in the pharmacy. The inspector reminded the pharmacy manager and the pharmacists about the RP requirements and that a pharmacist could not be signed in to more than one RP record at a time. The pharmacy manager confirmed that this practice would not happen in future.

The pharmacy had current professional indemnity and public liability insurance. The private prescription records were mostly completed correctly, but the pharmacy was around one year behind with entering some of the prescriptions. The pharmacy manager was aware and said that it was due to recent staffing issues. She confirmed that the prescription details would be recorded in the private prescription book as soon as possible. The pharmacy's new computer system had the facility to record the details of the prescription at the time the medicines were dispensed. Not recording the prescriptions in a timely manner could make it harder for the pharmacy to find these details if there was a future query.

Following the inspection, the pharmacy manager confirmed that the private prescription book was now up to date. And she had reminded team members to ensure that all private prescriptions were recorded within the required timeframe. 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. The pharmacy manager said that this would be entered in future. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Any liquid overage was recorded in the relevant register. 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. The pharmacist had completed the RP record on the day of the inspection. Previous records could not be viewed during the inspection as these were on the pharmacy's old computer system.

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. Team members had completed training about the protecting people's personal information.

The pharmacy had not carried out a recent patient satisfaction survey due to the pandemic. Team members explained that they handed out feedback forms to people who used the pharmacy and encouraged them to provide feedback about the pharmacy's services. The complaints procedure was available for team members to follow if needed and details about it were available online. Team members said that they were not aware of any recent complaints.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some safeguarding training provided by the pharmacy's head office. One of the dispensers described some 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 had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. Team members 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 can raise any concerns or make suggestions. 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 regular locum pharmacist, four trained dispensers, one trainee dispenser and one medicines counter assistant (MCA) working during the inspection. There were three support staff who were qualified dispensers. They were at the pharmacy to help with the roll out of the pharmacy's new computer system. Most team members had completed an accredited course for their role and the rest were undertaking training. 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.

Team members appeared confident when speaking with people. When asked, one of the team confirmed that they were aware of the restrictions on sales of medicines containing pseudoephedrine. And they would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Team members discussed when a person had frequently requested to buy any of these medicines. Effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacy manager said that team members received regular training from the pharmacy's head office. One of the team members said that training had to be completed at home as there was no time to do it during the working day. They explained that the pharmacy manager monitored their training and would prompt them to complete the modules if needed.

The pharmacist said that he could take professional decisions. And he was aware of the continuing professional development requirement for the professional revalidation process. He explained about some recent learning he had done about an antiviral medicine. He had undertaken this training due to a person asking for information about the medicine. He learned about it so that he would be able to help in future if asked.

Team members said that there were informal huddles in the morning to discuss any issues and allocate tasks. They also had regular reviews of any dispensing mistakes and discussed these openly in the team. Team members explained that they had regular ongoing informal appraisals and performance reviews. And they felt comfortable about discussing any issues with the pharmacist or making any suggestions during the working day.

Targets were set for the New Medicine Service. Team members did not feel under pressure to achieve the targets and carried out the service for the benefit of the people. The pharmacist said that he would not let the targets affect his professional judgement. And he explained that the pharmacy often exceeded the target.

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 which presented a professional image. Pharmacy-only medicines were kept behind clear screens in the shop area. ‘Please ask for assistance’ was displayed on the front of the screens. 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 two chairs in the shop area and both had arms to aid standing. The 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

Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. And it responds appropriately 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.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance with power-assisted doors. 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. And there was a lowered counter to the side of the medicines counter which could be used by wheelchair users if needed.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. And he explained that a record of blood test results was kept. But this was not able to be checked by the inspector during the inspection due to the pharmacy's new computer system being installed. 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. Team members said that 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 (PPP). The pharmacist said that it would be recorded on the person's medication record if they were on the PPP. And the pharmacy had the relevant patient information leaflets and warning cards available.

Stock was stored in an organised manner in the dispensary. The pharmacy manager explained that the pharmacy was behind with its date-checking routine and this was due to some staffing issues. Team members had recently started date checking the stock again and this activity had been recorded. The pharmacy manager explained that any short-dated items found with dispensing stock would be highlighted and these would be removed from dispensing stock around one month before they were due to expire.

Part-dispensed prescriptions were checked frequently and 'owings' notes were provided when prescriptions could not be dispensed in full. People were kept informed about supply issues and 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 regularly. But there were some bagged items waiting collection and the prescriptions for the items was no longer valid. The pharmacy manager said that the retrieval system would be checked again and items which had not been collected for around two months would be returned to dispensing

stock where possible. And the prescriptions would be returned to the NHS electronic system or to the prescriber.

Team members assembled multi-compartment compliance packs in a room to the rear of the pharmacy. And this helped to minimise distractions. The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in these packs. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. And prescriptions for 'when required' medicines were not routinely requested. The pharmacy manager said that people either contacted their GP or the pharmacy to request these items when their packs were due. 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. But the delivery driver had a hand-held electronic device which was used to scan the bag labels prior to the items being delivered. This enabled the pharmacy to keep an audit trail of its deliveries. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. And 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. And it uses its equipment to help protect people's personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available but not for volumes less than five millilitres. The pharmacist said that he would order a suitable measure. Separate liquid measures were used to measure marked for use with certain liquids. 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 in use since July 2022 and this was noted on the machine. It was due to be replaced one year from first use. The weighing scales 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 with maximum and minimum temperatures 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.