

Registered pharmacy inspection report

Pharmacy Name: Clover House Pharmacy, Clover House, Boston Road, SLEAFORD, Lincolnshire, NG34 7HD

Pharmacy reference: 1034331

Type of pharmacy: Community

Date of inspection: 08/06/2023

Pharmacy context

This community pharmacy is close to a medical practice in the town centre of Sleaford, Lincolnshire. Its main services include dispensing NHS prescriptions and selling over-the counter medicines. The pharmacy offers a medicine delivery service. And it supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. It also provides a private ear care service.

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	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	The pharmacy supports its team members through a structured appraisal process. And ongoing learning needs are tailored to support the safe delivery of the pharmacy's services.
3. Premises	Good practice	3.1	Good practice	The pharmacy's bespoke design supports a safe and efficient dispensing service. And it provides an ideal environment to support the pharmacy's growth in providing clinical services.
		3.2	Good practice	The pharmacy's consultation room is fitted out to a high standard and the team actively promote it to people using the pharmacy.
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 appropriately identifies and manages the risks associated with providing its services. It advertises how people can give feedback. And it uses the feedback it receives to inform the way it provides its services. The pharmacy mostly keeps the records it needs to by law. And it keeps people's confidential information secure. Pharmacy team members understand how to respond to concerns to protect potentially vulnerable people. And they act openly and honestly by recording and discussing the mistakes they make when dispensing.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) to support its safe and effective running. These covered responsible pharmacist (RP) requirements, pharmacy services and the management of controlled drugs (CDs). Training records associated with the SOPs confirmed its team members had read and signed those relevant to their roles. And team members had personal copies of SOPs available for reference if required. Pharmacy team members had a good understanding of their roles and responsibilities, and they were observed working in accordance with SOPs. The pharmacy employed several pharmacy technicians working in accuracy checking technician (ACT) roles. Pharmacists did not complete an audit trail of the clinical check completed by a pharmacist. The ACTs explained they generally checked repeat prescriptions only unless the RP provided direct authorisation to check a specific prescription. And team members routinely identified prescriptions as repeats with no changes.

The pharmacy premises had been extensively refitted, a dispensing robot was installed as part of this refit and the team members identified how the technology supported them in reducing the risk of a dispensing incident occurring. Pharmacy team members consistently recorded mistakes made and identified during the dispensing process, known as near misses. This prompted discussion amongst team members and action to help reduce the risk of error. These learning points were generally recorded shortly after the event occurred. And they were seen to be acted upon. The pharmacy had incident reporting procedures to support the team in recording a mistake that was identified following the supply of a medicine to a person, known as a dispensing error. And team members knew how to respond to these types of concerns. The frequency of formal patient safety reviews varied; team members recalled the last review taking place a few months ago.

The pharmacy had current indemnity insurance. The RP notice on display contained the correct details of the RP on duty. A sample of RP record identified that pharmacists did not routinely sign-out when ceasing the role. This meant it could be difficult to establish the period the RP had remained present in the pharmacy if a query were to arise. Details of prescribers within the private prescription record were not always recorded accurately. The pharmacy held its CD register electronically and records seen complied with legal requirements. It completed full, regular balance checks of physical stock against the register. A random physical balance check of a CD conducted during the inspection complied with the running balance in the register. The team recorded patient-returned CDs in a separate register at the point of receipt. And it kept complete records when supplying unlicensed medicines to people.

The pharmacy advertised how people could provide feedback and raise a concern. Pharmacy team

members understood how to manage feedback and how to escalate a concern when required. They demonstrated actions taken in response to feedback. For example, by having dedicated space to hold stock associated with brand specific prescriptions. Team members engaged in learning relating to confidentiality and data security. The pharmacy held all personal identifiable information in the staff area of the premises and confidential waste was segregated and securely disposed of via a secure shredding service. Team members had engaged in learning to support them in identifying and responding to safeguarding concerns. They were vigilant in monitoring collection and delivery of medicines to vulnerable people and reported concerns with medicine compliance to people's own GPs. Team members knew what action to take if people attended to seek help from the pharmacy using code words associated with offering a safe space for people experiencing domestic violence.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has suitably skilled and knowledgeable people working to provide its services safely and effectively. Its team members work together well. They receive regular opportunities to reflect on their learning and development needs. And they engage in ongoing learning to support the safe implementation of new services. Pharmacy team members understand how to raise concerns at work. And they regularly share information and ideas through team discussions.

Inspector's evidence

The RP was a locum pharmacist who was familiar with the pharmacy. Two ACTs, two dispensers who had completed level three accredited training, a medicine counter assistant and a delivery driver were working alongside the RP. The pharmacy also employed another ACT and two trainee team members, both enrolled on GPhC accredited learning courses relevant to their roles. The SI worked as one of the pharmacy's regular pharmacists with another regular pharmacist covering a couple of days each week. One of the ACTs worked in a supervisor role and supported with leadership responsibilities. Most team members worked part-time, and this provided some flexibility to increase hours during periods of annual leave.

The delivery driver was working through their induction period and as such had not started a GPhC accredited learning programme to date. Part of their learning had involved going out with the previous driver. And this had included being introduced to people receiving their medicines through the delivery service. Pharmacy team members demonstrated ongoing learning they completed to support them in their roles. This included learning associated with SOPs, competency-based learning associated with the dispensing robot, learning associated with the NHS Pharmacy Quality Scheme (PQS) and specialised learning associated with the pharmacy's services such as ear care. There was a clear vision to work steadily to increase the clinical services provided by the pharmacy and training was aligned with this vision. For example, a team member mentioned phlebotomy training had been offered. Registered team members discussed topics associated with their continual professional development with each other regularly. Pharmacy team members benefited from a structured appraisal process, including reviews during their induction period. And they felt able to feedback during their appraisal. The RP had provided assurances around their own ongoing learning prior to commencing work at the pharmacy. They were freely able to apply their professional judgement when delivering pharmacy services and worked well with team members.

Pharmacy team members understood how to raise a concern at work. And they knew how to escalate a concern if needed. Team members had been kept informed of the changes associated with the refit of the pharmacy and had been given the opportunity to highlight any specific concerns that could be addressed through the refit. Team members were observed working well together in a calm environment despite being exceptionally busy. Day-to-day discussions in the team focussed on managing patient safety, services, and workload. But the team did not regularly make formal notes of the outcomes of these discussions.

Principle 3 - Premises ✓ Good practice

Summary findings

The pharmacy is fitted out and maintained to a good standard. And it provides a professional environment tailored to the services it provides. Pharmacy team members actively promote the use of the private consultation room which is equipped to support the pharmacy's growth in offering more clinical services.

Inspector's evidence

The pharmacy was appropriately secure and maintained to a good standard with established processes for addressing any maintenance concerns. It had recently benefitted from a full refit and was bright, organised and was clean throughout. The pharmacy had appropriate heating arrangements and fans were available in summer months to increased ventilation. Robust plastic screening at both the medicine counter and partition wall between the dispensary and public area was clean. There were suitable gaps within the screening to support conversations with people. The pharmacy's consultation room was kept secure from unauthorised access with team members accessing it from the staff area and then inviting people in to use it. The room was advertised well, and team members promoted its availability to people. It was observed being used during the inspection. The room itself offered a large professional space to hold consultations. It was fitted out to a good standard with clinical services in mind. For example, flooring was easy to keep clean and a handwashing sink was available and equipped appropriately.

The pharmacy consisted of an open plan public area leading to the medicine counter. Access through to the dispensary was deterred through a gate next to the medicine counter. The layout of the dispensary was designed with efficiency and safety in mind. For example, team members completed higher-risk tasks such as those associated with the multi-compartment compliance pack service in a quiet area of the dispensary away from distractions. And there was specific shelving for holding medicines waiting to be delivered to people. The RP and ACTs had dedicated checking areas. And a separate work bench was used to hold assembled medicines waiting to be checked to minimise the need to stack baskets of medicines. Team members worked at individual workstations in the dispensary with the robot's output chutes supplying medicines directly to individual workstations. The pharmacy had appropriate staff facilities and a separate room with a sink provided space and suitable facilities for tasks such as reconstituting liquid medicines.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are fully accessible to people. Overall, the pharmacy manages its services well to ensure people receive appropriate care and support. The pharmacy has effective processes for managing its medicines. It stores its medicines safely and within the correct environment.

Inspector's evidence

The pharmacy was fully accessible through power-assisted doors from the private onsite carpark. The pharmacy advertised details of its opening times and services clearly. It provided seats in its public area for people waiting. Local signposting information was available, and the team understood the need to signpost people on to another healthcare provider should it be unable to supply a medicine or provide a service.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. The RP had good supervision of activity at the medicine counter and made themselves available to answer queries and provide advice to people when needed. Additional information at the medicine counter supported team members in providing appropriate counselling when handing out medicines. For example, advising people of whether to take antibiotics before, with or after eating. The RP was observed providing verbal counselling when handing out medicines to people. But the team did not regularly record counselling interventions on people's patient medication record (PMR) to help support continual care. The pharmacy had completed an audit associated with the safe supply of valproate to people within the at-risk group. And its team members were aware of the requirements of the valproate pregnancy prevention programme (PPP).

The pharmacy provided a private ear care service. Three team members, including the SI provided this service. Team members learning certificates were displayed in the consultation room for people using the pharmacy to see. This learning has included e-learning modules, face-to-face training, and competency assessments. The pharmacy had bespoke procedures related to the service provided by the private ear care company it was associated with. These procedures included obtaining signed consent from people accessing the service and completing a health screening to ensure micro-suction ear wax removal was suitable. Consultation notes included photographs of the ear before and after the treatment. And team members could escalate concerns onto a remote review panel and obtain specialist advice and support through the service. The team had followed the review pathway when a concern had been flagged during a consultation. Positive feedback about the service was observed twice during the inspection. And a team member took time to provide further details of the service to a person after receiving a recommendation from a friend.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels when dispensing medicines. The pharmacy had efficient systems for managing owed medicines and medicines it delivered to people's homes. The pharmacy used individual profile sheets to support the supply of medicines in multi-compartment compliance pack service. These record sheets contained information about a person's current medicine regimen. The sheets contained an 'authorised' signature, but they did not indicate the job role of the team member signing the sheet. And in the sample of sheets seen this signature did not belong to a pharmacist. As such it was unclear what the signature was

authorising. The team recorded details of medicine changes on the PMR and updated the record sheets appropriately. A sample of assembled compliance packs contained full dispensing audit trails and descriptions of the medicines inside. The pharmacy used large print labels for some people to support them in taking their medicines. But backing sheets on compliance packs did not contain details of adverse warning information to support people in taking their medicine safely. This was identified as a setting on the PMR and immediately rectified following the inspection. The pharmacy supplied patient information leaflets alongside compliance packs at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored its medicines safely and securely, with most medicines stored inside the robot. The team used the robot technology well to support it in dispensing medicines. Appropriate training was provided to support minor trouble shooting issues. And team members demonstrated safety checks associated with stock management, such as loading the robot correctly, manually entering stock and date checking. For example, team members physically counted the quantity of a medicine going back into the robot and they attached a special split pack sticker over the original barcode. This was then manually entered and reduced the risk of quantity errors occurring.

Medicines requiring safe custody were kept neat and secure. And the pharmacy had good arrangements for storing medicines requiring cold storage. This included maintaining temperature records to ensure medicines were kept within the correct temperature range and having designated fridges for different purposes. This reduced the amount of time a fridge door needed to be open for. The team kept date checking records and it identified medicines with short-expiry dates. It annotated bottles of liquid medicines with their date of opening. This supported the team in identifying if the medicine remained safe and fit to supply to people. A random check of stock on the dispensary shelves found no out- of-date medicines. And there was evidence of recent date checks for the stock held in the robot. The pharmacy had appropriate medicinal waste bins and CD denaturing kits available. The pharmacy received medicine alerts by email. And discussed how the checked and responded to these alerts.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. It monitors its equipment to ensure it remains in safe working order. And pharmacy team members use the pharmacy's facilities and equipment in a way which protects people's confidentiality.

Inspector's evidence

Information on computer monitors was suitably protected from unauthorised view. The pharmacy stored bags of assembled medicines within drawers and cupboards in the staff only area of the premises. It used barcode technology to assist its team members in checks associated with handing out of these medicines. Fridges below the medicine counter were used to store bags of assembled medicines requiring cold storage. These were protected from unauthorised access. Pharmacy team members used cordless telephone handsets. These allowed them to move out of earshot of the public area when discussing confidential information over the telephone. Team members had access to written reference resources as well as the internet.

The pharmacy had a range of equipment to support it in delivering its services and it maintained this equipment appropriately. For example, its robot was supported through a service contract. A spare picking arm was available within the pharmacy and telephone, or onsite engineer support was available when required. The equipment used for its ear care service was provided by the ear care company and checked regularly to ensure it remained in good working order. The pharmacy's electrical equipment was subject to portable appliance testing checks. The pharmacy had a range of clean counting and measuring equipment for liquids, tablets, and capsules. And single-use equipment for the supply of medicines in multi-compartment compliance packs.

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.