General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lockyer's Pharmacy, 252 Evelyn Street, Deptford, LONDON, SE8 5BZ

Pharmacy reference: 1040798

Type of pharmacy: Community

Date of inspection: 28/11/2019

Pharmacy context

This is a community pharmacy on a parade of shops in Deptford. It dispenses NHS prescriptions and supplies medications in multi-compartment compliance packs to people who need help managing their medicines. People can ask to have their blood pressure, HBA1c, and cholesterol levels checked. And the pharmacy offers a minor ailments service for people who need medicines for minor conditions without a prescription.

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	Team members are good at recording any mistakes that happen during the dispensing process. And the pharmacy regularly reviews the records for any patterns so that team members can learn and make the services safer.
2. Staff	Standards met	2.5	Good practice	The pharmacy actively asks team members for suggestions to help improve its services.
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 identifies and manages the risks associated with its services so that it can provide them safely. Team members are good at recording any mistakes that happen during the dispensing process. And the records are regularly reviewed for any patterns so that team members can learn and make the services safer. Staff work in accordance with written procedures and protect people's personal information well. The pharmacy keeps the records it needs to by law to show that medicines are supplied safely and legally. Team members understand their role in protecting vulnerable people.

Inspector's evidence

Near misses were recorded on an ongoing basis and reviewed monthly for any patterns. A pattern had been identified which involved medicines which sounded or looked alike, such as amlodipine and atorvastatin. To help prevent a repetition, the medicines had been separated on the shelves and the shelves themselves highlighted. Team members were involved in the review of dispensing incidents and discussed any mistakes that had occurred. They also signed the review document to show they had read it.

Dispensing errors were recorded and investigated. The pharmacist gave an example of an error that had occurred and the action that had been taken to avoid a repetition. She explained that any dispensing errors were routinely reported to the National Reporting and Learning System.

Dispensing baskets were used to isolate individual people's medicines when dispensing, which helped reduce the risk of the medicines becoming mixed up. There was a clear workflow through the dispensary.

A range of standard operating procedures (SOPs) was available and they included areas such as safeguarding, dispending, and confidentiality. The SOPs were reviewed annually by the supervisor and the pharmacist. Team members had signed to indicate that they had read and understood the SOPs. Staff were able to describe clearly what they could and couldn't do if the pharmacist wasn't present. And staff who worked on the counter said that they would check with the pharmacist if someone requested multiple packs of a medicine. The pharmacist confirmed that she had done a training package on risk management and had discussed her learnings with the team.

The pharmacy undertook an annual patient survey, and the results from the most recent one were positive, with around 95% of respondents rating the pharmacy as very good or excellent overall. People had given feedback about the quality of the seating area, and to address this the seats had been replaced. The pharmacist said that they had removed a glass cabinet on the shop floor to give more space for people with pushchairs or wheelchairs, and this had been done as a result of feedback. Team members were aware of the pharmacy's complaint procedure and said that they would refer any complaints to the pharmacist. People could find out how to make a complaint or provide feedback from the leaflets in the public area.

The pharmacy had a current indemnity insurance certificate. The right responsible pharmacist (RP) notice was displayed and the RP log had been completed correctly. Other records examined, such as private prescription records, emergency supplies, and supplies of unlicensed medicines had been

completed in accordance with requirements. The entries in the controlled drug (CD) registers examined had been made correctly, and the CD running balances were checked regularly.

No confidential information was visible from the public area. The consultation room downstairs was accessed by going through the dispensary, and no people's personal information was visible on the way. Staff said that people using the consultation room were always escorted to and from the room. Team members who used the NHS electronic services had individual smartcards. And they had completed training on information governance and the General Data Protection Regulation (GDPR). A shredder was used to destroy confidential waste.

Team members had read and signed the safeguarding policy and said that they would refer any concerns to the pharmacist. The pharmacist confirmed she had completed the level 2 training and was able to describe what she would do if she had any concerns. She was not aware of any safeguarding concerns that had come up.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely, and they do the right training for their role. They receive ongoing training to help keep their knowledge and skills up to date. And they are comfortable about raising any concerns and are actively asked for suggestions to help improve the pharmacy's services. Staff are able to take professional decisions, and this is not affected by the pharmacy's targets.

Inspector's evidence

At the time of the inspection there was one pharmacist (who was the superintendent and regular pharmacist), one trained dispenser, one trainee dispenser, and a new team member who had worked there for around six weeks. The dispenser had completed the NVQ 3 course and was waiting to be registered as a pharmacy technician. The team was up-to-date with the workload and other tasks. The pharmacist said that a new medicines counter assistant had started earlier in the week and she had seen evidence that they had completed an accredited training course.

The pharmacist felt able to take professional decisions to help make sure that people were kept safe. Team members undertook ongoing training as topics came up. They showed the training folders they maintained which showed the previous training they had completed. They were given time set aside at work to complete accredited training, but for ongoing training they had some time at work and did the rest at home. They explained how they discussed any dispensing mistakes in the team and tried to identify any changes that could be made to make the services safer. They felt comfortable about raising any concerns or making suggestions. One suggestion that they had made was to dispense all repeat items before 5:30pm and only dispense walk-in items after that. They said that this had helped them manage the workload better at the end of the day and reduced the amount of time that people had to wait. Team members had regular staff meetings and said that they were actively asked for any suggestions they could make both in the meetings and throughout the day.

Team members had some targets such as number of Medicines Use Reviews and flu vaccinations. But these were an aim rather than a requirement and they did not feel under any undue pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe, secure, and suitable for the pharmacy's services. People can have a conversation with a team member in a private area, although this area is less accessible to people with wheelchairs or pushchairs.

Inspector's evidence

The premises were generally clean and tidy. There was a sufficient amount of clear workspace available to dispense safely, and lighting was good throughout. Multi-compartment compliance packs were prepared in the dispensary, but there was enough work space to allow this to be done safely.

The room temperature was suitable for the storage of medicines and was maintained with air conditioning. The consultation room was in the basement and was accessed through the dispensary and down a flight of stairs. As the room was well away from the public area, it offered a good level of privacy. Team members had acted to ensure that confidential information was not visible to people passing through the dispensary or using the room, and staff said that each person using the room was always escorted. No confidential material was readable on the way from the public area to the consultation room, but one of the computer terminal screens could be seen on the way back up. It was far enough away that the text was not easily readable, and the pharmacist said that she would look at obtaining a privacy screen for it. People using the room passed through the dispensary, but not very close to shelves of dispensary stock. The pharmacist had made enquiries about installing a dedicated consultation room in the shop area and would make a decision in 2020. The premises were secure from unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services in a safe and effective way. Team members dispense medicines into multi-compartment compliance packs in a safe manner. The pharmacy gets its medicines from reputable sources and generally stores them properly. It takes the right action in response to safety alerts to make sure that people get medicines and medical devices that are safe to use. People with a range of needs can access most of the pharmacy's services. But the consultation room is downstairs and is less accessible to people with additional mobility needs.

Inspector's evidence

The pharmacy had step-free access from the street, and a list of the services provided was in the window. There was a range of health information leaflets that people could take. The pharmacist said that they had leaflets at local surgeries which made people aware of the travel vaccination service. And the trainee dispenser said that he had visited the local fire brigade and a community centre to promote the flu vaccination service. He explained that the current health promotion was on 'Help us help you', which made people aware they could visit the pharmacy in the winter period for help with minor ailments. He showed the area of the pharmacy they used for health promotion displays and said that the display was changed every month or two. A folder was maintained which contained information about past and future health promotions. The trainee dispenser had been trained as a Healthy Living Champion, and he explained that health promotion activities were a regular point of discussion at team meetings. The pharmacist described how they had tried to tailor the health promotion around alcohol to make it easier for people to understand by having a 'guess the units' competition instore. She said that they had also posted information on social media and had done this for an information campaign which made people aware of the amount of sugar in soft drinks. All team members had been trained as Dementia Friends. The consultation room was downstairs.

Multi-compartment compliance packs were provided to some people. People were assessed for the service by the local Lewisham Medicines Optimisation Service, and this service also monitored people on an ongoing basis. Packs were labelled with a description of the medicines inside to help people and their carers identify them, and patient information leaflets were routinely supplied. Team members showed that they kept hospital discharge notes and demonstrated how they made records when a person's medicine was stopped or changed. But not all the records included the date on which the change had happened, which could make it harder to find out this information if there was a future query.

The pharmacy had the equipment to be able to comply with the Falsified Medicines Directive (FMD). The pharmacist explained that staff had been using the FMD equipment to decommission medicines, but they had experience previous problems with doing this. She said that the system was now working, and they were using it routinely.

The pharmacist described an example of when she had supplied emergency hormonal contraception and had also been able to give a supply of contraceptive pills. Both supplies had been made under patient group directions. The person had said that this had made it easier for them to access contraception as they had not needed to book an appointment with their GP, and later came back for a repeat supply.

The pharmacist described how she sent a copy of the person's record book when requesting prescriptions for medicines which were higher-risk and required ongoing monitoring, such as warfarin and lithium. Prescriptions for higher-risk medicines were not highlighted, but the pharmacist said that she asked people for their books each time and gave people the additional advice they needed. However, not highlighting the prescriptions may make it harder for the team member handing out the medicine to know they needed to check with the pharmacist. Prescriptions for CDs were routinely highlighted, which made it easier to prevent these being handed out after the prescription was no longer valid. The pharmacist was aware of the advice around pregnancy prevention to be given to people taking valproate. She said that the pharmacy had no people in the at-risk group. The pharmacy did not have the stickers for use with split packs of valproate, and team members said that they would order these in. Prescriptions were kept with dispensed items which made it easier for staff to refer to them if there was a query.

A selection of patient group directions (PGDs) was examined and signed in-date copies were available. The pharmacist described the training she had undertaken in order to be able to provide the PGD service safely. The pharmacy used an electronic audit trail to show that medicines had been safely delivered to people. People signed on a handheld device to confirm safe receipt and the signatures could be viewed by the pharmacy.

Medicines were obtained from licensed wholesale dealers and specials suppliers, and they were stored in a tidy and orderly manner in the dispensary. But five boxes of medicines were found to contain mixed batches, which could make checks for expiry date or safety recalls less effective. The pharmacist said that she would discuss this issue with the team. Most bulk liquids had been marked with the date of opening, but one had not; this could make it harder for staff to know if the medicine was still suitable to use in the future. The bottle of liquid was removed for destruction during the inspection. Stock was regularly date checked and this activity was recorded. Medicines for destruction had been appropriately separated from stock and placed into designated destruction bins.

Suitable fridges were used to store medicines which were temperature sensitive. The fridge temperature ranges were monitored and recorded daily. The current temperature on one of the fridges was a little high on the day of inspection. The trainee dispenser said that he had discussed this with the pharmacist, and they were going to monitor it throughout the day and take action if it did not come within the appropriate range. CDs were kept securely.

The pharmacy received drug alerts and recalls and team members explained the action they took in response. The action taken was recorded, which made it easier to refer to in the future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services and it maintains it appropriately. It uses its equipment to protect people's personal information.

Inspector's evidence

There were clean glass calibrated measures for use with liquids. The anaphylaxis kit was in date and easily accessible when providing vaccinations. Team members had access to up-to-date reference sources including the internet. There were records to show that the Cobas machine (HBA1c and cholesterol testing) had received regular calibration checks. The blood pressure meter was replaced annually by the local NHS organisation.

The phone was cordless and could be moved somewhere more private to help protect people's personal information. The fax machine was away from the public area.

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.