

Registered pharmacy inspection report

Pharmacy Name: Lewis Grove Pharmacy, 1 Lewis Grove, Lewisham,
LONDON, SE13 6BG

Pharmacy reference: 1040849

Type of pharmacy: Community

Date of inspection: 23/01/2020

Pharmacy context

This is a large pharmacy near the centre of Lewisham, close to a large shopping centre. It mainly dispenses NHS prescriptions and offers a range of services including travel vaccinations. It supplies medication in multi-compartment compliance packs to some people who need help taking their medicines. It offers people Medicines Use Reviews and the New Medicine Service. And provides medicines for a substance misuse service to a small number of people.

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	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 manages the risks associated with its services. When a mistake happens, the team responds well. The pharmacy largely keeps the records it needs to by law to show that medicines are supplied safely and legally. Team members know how to protect vulnerable people. People using the pharmacy can provide feedback and raise concerns. And team members are aware of their own role and responsibilities. They generally protect people's personal information well.

Inspector's evidence

Initially, no standard operating procedures (SOPs) were found, and the dispenser said that the superintendent pharmacist (SI) had taken them home to update. A folder of SOPs was then found in the pharmacy but there was no evidence that the staff had read them, and these were understood to be not in use. Following the inspection, the SI confirmed that he had updated the SOPs and they were now at the pharmacy. He said that in the future he would keep an electronic version at the pharmacy as well as the printed copy. He said that the folder of SOPs found in the pharmacy during the inspection had been received by the pharmacy but were not being used. He confirmed that the team members had been familiar with the pharmacy's previous set of SOPs before he had started reviewing them.

A near miss log was available for recording dispensing mistakes that occurred but had not been handed out. The most recent record found was from May 2019, and team members were not aware of any recent near misses. During the inspection, a near miss occurred where the wrong quantity had been dispensed and staff were observed to record this on the log. They said that they would record any near misses that occurred in the future. Dispensing errors, where a mistake occurred and was handed out to someone, were recorded on standardised forms. An error had occurred where the wrong dose of a medicine had been handed out, and staff had been reminded to check the dose with the patient when handing the medicines out in future.

The medicines counter assistant (MCA) was clear about her own role and responsibilities and could describe what the pharmacy could not and couldn't do if the pharmacist had not turned up. Team members were observed communicating well with each other during the inspection and referring queries to the pharmacist as appropriate.

The pharmacy undertook an annual patient survey. The results from the 2018 to 2019 one were on the NHS website and they were largely positive. People could find details of how to make a complaint or provide feedback in the pharmacy's practice leaflet. The dispenser was aware of a recent complaint the pharmacy had received about a dispensing error, but this was being dealt with by the SI who was not present during the inspection.

The pharmacy had a current indemnity insurance certificate displayed. The right responsible pharmacist (RP) notice was displayed, and the RP record had largely been completed correctly. Controlled drug (CD) registers examined complied with requirements. The CD running balances had been checked recently and were checked on a regular basis. A random check of a CD item showed the recorded balance matched the quantity of stock kept. A few private prescription records had the name of the prescriber missing, and some records of emergency supplies did not clearly state the nature of the emergency. This could make it harder for the pharmacy to find out these details if there was a query. Records for

supplies of unlicensed medicines seen had the right information recorded.

People using the pharmacy generally couldn't see other people's personal information. A shredder was used to destroy confidential waste. There was a small amount of confidential information in the consultation room; the dispenser said that the room was rarely used, and the information was removed before the room was used. She said that they had gone through the information governance requirements but was unable to find the folder during the inspection. Following the inspection, the SI confirmed that the pharmacy now had a confidentiality declaration for team members to sign, and a safeguarding SOP for them to follow. The pharmacist present during the inspection confirmed that he had completed the level 2 safeguarding training and could describe what he would do if he had any concerns about a vulnerable person. Team members could also explain what they would do if they had any concerns and said that they would refer them to the pharmacist. They are not aware of any safeguarding concerns that had occurred at the pharmacy.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to provide its services safely and they do the right training for their role. They can raise concerns or make suggestions to improve the pharmacy's services. They do some ongoing training to help keep their knowledge and skills up to date. They can take professional decisions to make sure that people are kept safe.

Inspector's evidence

The pharmacy was currently running on locum pharmacists, who worked usually worked there for a few weeks at a time. On the day of inspection there was a locum pharmacist who had been there just over a week, a trained dispenser, a trained locum dispenser, and two trained MCAs. Team members were up-to-date with the workload. Some team members had worked at the pharmacy for many years.

The dispenser explained that all staff had been enrolled on an e-learning system to help them keep their knowledge and skills up to date. Team members usually completed this training in their own time. The training they completed was not routinely monitored. The MCA was able to describe the ongoing training she had done, which had included a package about children's oral health. And she said that she was currently going through the training on coughs and colds. Team members said that they also kept up to date by reading pharmacy magazines which were left in the staff area.

Staff felt comfortable about raising any concerns or making suggestions. They said that the SI was receptive to any suggestions and took action in response. A team member had raised an issue about the broken chairs in the waiting area and these had been replaced. And the carpet had been replaced with hard flooring when this had been suggested by staff. Regular formal meetings did not take place, but there was a small team in the pharmacy and staff said that they discussed any issues as they arose. Team members were not set any formal targets for the pharmacy's services. The pharmacist felt able to take any professional decisions as they arose.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are suitable for the pharmacy's services and they are kept secure from unauthorised access. People can have a conversation with a team member in a private area. But the pharmacy could do more to keep all areas tidy and free from unnecessary clutter.

Inspector's evidence

The premises were large, but the dispensary was relatively small compared to the shop area. However, there was a sufficient amount of clear workspace to help team members dispense safely and manage the workload. There were stacks of baskets containing part-dispensed items on some areas of the worksurface, but these were kept in an orderly manner. Most areas were clean and tidy, but the area used to store the multi-compartment compliance packs was untidy and the dispenser said she would address this. Part of the back-shop area was cluttered but there was still an adequate amount of storage space. Lighting was good throughout the pharmacy. The room temperature was suitable for the storage of medicines and was maintained with air conditioning.

The consultation room was away from the shop floor and offered a good level of soundproofing. The room was a little untidy in placed and contained some unnecessary items; the dispenser said that they rarely used the room and she would ensure it was tidied before anyone used it again. The premises were secured from unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. It gets its stock from reputable sources and stores it properly. People with a range of needs can access the pharmacy's services. It doesn't always highlight prescriptions for higher-risk medicines. And this could mean that an opportunity to speak with people who collect these medicines is missed.

Inspector's evidence

The pharmacy had step-free access from the street and had wide open spaces to help people with pushchairs or wheelchairs manoeuvre. A seating area was available for people who were waiting for their prescriptions to be dispensed, and this was away from the counter to help protect other people's personal conversations. A list of the pharmacy's services was displayed in the window. The pharmacy offered a remote GP consultation service called 'Medicspot' where people could talk with a GP via video messaging. The dispenser said that if a person was given a prescription as a result of the consultation, they could have it dispensed at the pharmacy or they were free to take it elsewhere.

Baskets were used during the dispensing process to help isolate individual people's medicines. There was a clear workflow through the pharmacy, with the pharmacist checking dispensed items in a set area.

Team members explained how prescriptions for higher-risk medicines such as warfarin, methotrexate, and lithium were highlighted. Only one example of a prescription for one of these medicines (lithium) was found on the shelf and it had not been highlighted. This could mean that the pharmacy could miss an opportunity to speak with the person when they collected this medicine. The dispenser said that she would discuss this with the SI and make sure that prescriptions for higher-risk medicines were highlighted in the future. A range of stamps was available for highlighting prescriptions with additional information such as fridge medicines or CDs. Dispensed prescriptions for CDs were found to have been highlighted with a stamp. Prescriptions were kept with dispensed items, which made it easier for staff to respond to any queries when handing the medicines out. They were aware of the additional guidance around pregnancy prevention to be given to some people taking valproate medicines. They were unsure if they had any patients currently in the at-risk group, but the pharmacy had the associated information such as cards and stickers.

People were assessed to see if they would benefit from multi-compartment compliance packs by the local medicines optimisation service (LIMOS). LIMOS also undertook some degree of ongoing monitoring to see how people were managing their medicines. Patient information leaflets were routinely supplied with the packs, and the packs were labelled with the required warning information for the medicines inside. Packs were not generally labelled with descriptions of the medicines inside, and this could make it harder for the person or their carer to identify the medication. The dispenser showed how she was trying to get the computer system to include the description of the medicines on the labels. When a medicine was changed or stopped, a record was made. Some records did not indicate when the change had been made and who made it, which could make it harder for the pharmacy to find this information if there was a query.

A range of patient group directions (PGDs) was found, but the ones seen had expired. The SI supplied medicines under the PGDs and he was not present during the inspection. The dispenser said that she would discuss this with the SI. Following the inspection, the SI confirmed that he had in-date PGDs to cover the travel service.

Medicines were obtained from licensed wholesale dealers and specials suppliers, and they were generally stored in an orderly manner. Bulk liquids were marked with the date of opening to help staff know if the medicine was still suitable to use. The pharmacy did regular date-checking of its stock but was recording a list of medicines that had gone out of date rather than when each section of the pharmacy was checked. This could make it harder for the pharmacy to show when a particular section had been checked. No date-expired medicines were found on the shelves sampled. Medicines for destruction were separated into designated bins and sacks and sent offsite for secure disposal. The pharmacy had the equipment to comply with the Falsified Medicines Directive, but staff were awaiting further instructions and training before using it routinely.

CDs were stored securely. Medicines requiring cold storage were kept in a suitable fridge and the temperatures were monitored and recorded daily. Records examined showed that the temperatures had kept within the required range. The pharmacy received drug alerts and recalls, and the dispenser explained the action they took in response. A record of previous alerts and recalls was kept, but ones issued within the previous month were not found, although the dispenser was aware to some extent about them. She said that she would discuss this with the SI and ensure that the records were kept up to date.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. It uses its equipment in a way which helps protect people's personal information.

Inspector's evidence

The pharmacy had calibrated glass measures for use with liquids. One required descaling, and the dispenser said that she would do this. A separate marked cylinder was used for certain liquids and a separate tablet triangle was used with cytotoxic medicines to help avoid cross-contamination. The pharmacy had a Cobas machine for testing blood, but this was no longer used due to the service no longer being provided. There was a blood pressure machine on the shop floor, and this was regularly checked and calibrated by an external agency. Team members had access to up-to-date reference sources including the internet. The fax machine was away from the public area, and the cordless phone could be moved somewhere more private to help protect people's private information. An in-date anaphylaxis kit was available for when vaccinations were done.

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.