General Pharmaceutical Council

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: 22/11/2023

Pharmacy context

This is a large community pharmacy on a busy road intersection in Lewisham. It mainly provides NHS services such as dispensing and offers the NHS blood pressure service. It provides NHS Covid vaccinations from the consultation room and from a series of booths which have been set up in the shop area. It provides a supervised administration service. And offers a private travel clinic (including vaccinations) using patient group directions (PGDs).

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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Standards not all met	4.2	Standard not met	The pharmacy makes supplies under patient group directions which are no longer valid.
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. It largely keeps the records it needs to by law. And people can provide feedback or raise concerns about the pharmacy. The pharmacy generally protects people's personal information well. And staff know how to protect the wellbeing of a vulnerable person. Team members record any dispensing mistakes to help them learn and make the pharmacy's services safer.

Inspector's evidence

Team members initially had some difficultly in locating the standard operating procedures (SOPs) but were eventually able to locate them. The SOPs were in date and covered a range of the pharmacy's activities. Team members had signed individual SOPs to indicate that they had read and understood them. Their roles and responsibilities were outlined in the procedures.

Dispensing mistakes which had been identified before the medicine had been handed to a person (known as near misses) were recorded on a sheet in the dispensary. Near misses were discussed with team members at the time if they occurred. The responsible pharmacist (RP) said that they were reviewed each year to identify any patterns or trends. It was discussed with the RP that a more frequent review may help in identifying any patterns or trends more promptly. The RP described how he would report any dispensing errors, where a mistake happened, and the medicine had been handed to a person. He was not aware of any recent dispensing errors which had occurred.

The dispenser could explain what they could and could not do if the pharmacist had not turned up in the morning. They said that codeine linctus and promethazine elixir were not sold over the counter and were only supplied against prescriptions.

People could provide feedback or make complaints in person in the pharmacy, and online via the pharmacy's website. There was a sign in the public area which explained how people could provide feedback, but the sign was set away from the counter and not that easy to read. The pharmacy had a complaints procedure for staff to follow.

The indemnity insurance certificate on display had expired, but the pharmacy's indemnity insurer confirmed that there was current cover. The right RP notice was displayed. The RP record had largely been filled in correctly, but there were occasional gaps where the RP had not signed out. Many of the records about private prescriptions dispensed had the pharmacy's name as the prescriber. When examined more closely, the ones seen had the pharmacy's name and then the name of the external prescriber after it. The RP confirmed that the pharmacy did not offer a prescribing service. The need to ensure that the records accurately reflected the correct prescriber's details was discussed with the RP. Some records about emergency supplies had the reason for the supply as 'script to follow' rather than stating the nature of the emergency. Controlled drug (CD) registers were electronic, and the sample seen complied with requirements. The pharmacy still had the previous paper CD records, and they had not been 'closed' when the electronic ones had been started. The RP confirmed that the paper ones were no longer used and said that he would close them. He was signposted to the pharmacy's indemnity insurer to ask for advice about how to do this. CD running balances were checked regularly, and a check of a random CD balance showed that the physical quantity in stock matched the recorded

balance.

As detailed in Principle 3, there was some confidential information which could potentially be seen on the way to the consultation room, but this was removed. Otherwise, there was no confidential information visible from the public area. Confidential waste was placed into a separate bag, and computer terminals were password protected. Team members confirmed that they had individual NHS smartcards. But the superintendent pharmacist's smartcard was still in one terminal even though he was not present; this was immediately removed.

Team members confirmed that they had completed safeguarding training and said they would raise any safeguarding concerns with the RP. There was a safeguarding SOP for staff to refer to. The RP confirmed he had done safeguarding concerns. He was familiar with the NHS safeguarding app and could explain what he would do if he had any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

Overall, the pharmacy has enough trained staff to help provide its services safely and effectively. Staff do some ongoing training to help keep their knowledge and skills up to date. And they feel comfortable about raising any concerns. Registrants are able to take professional decisions to help keep people using the pharmacy safe.

Inspector's evidence

There was the RP, two trained dispensers, and a trained counter assistant working during the inspection. A trainee counter assistant came in part-way through the visit. Two team members were away on unplanned leave. This increased the pressure on the team members, but they were seen managing their work and the queue of people effectively. They were up to date with dispensing. They did some ongoing training, which included mandatory e-learning packages and reading information from manufacturers and in pharmacy magazines. Staff felt comfortable about raising any concerns and the superintendent pharmacist was easily contactable. The RP felt able to take any professional decisions, and no numerical targets were set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

On the whole, the premises are suitable for the pharmacy's services. People can have a conversation with a team member in a private area. The premises are mostly clean and tidy, but the pharmacy could do more to ensure that all areas are kept clear from clutter and unnecessary items.

Inspector's evidence

The pharmacy had a large shop area, and a smaller dispensary. There was a row of temporary booths which had been set up for Covid vaccinations, but these were not seen being used during the inspection. The premises were generally clean and tidy, but some areas were a little cluttered and some of the booths were untidy. This was discussed with the RP during the inspection. There were some baskets piled on the dispensary benches but there was enough clear space for dispensing.

The consultation room was set away from the shop floor and allowed for people to have a conversation in a private area. People entering the consultation room passed by the end of the dispensary. There were a few bags of dispensed medicines which could be seen on the way, and these were immediately removed. The RP was reminded to ensure that people's personal information was protected in the future. He said that people were escorted to and from the room, and this was largely seen to be the case during the inspection. The premises were secure from unauthorised access when closed.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy generally provides its services in a safe way. But it makes supplies under patient group directions which are no longer valid. The pharmacy gets its medicines from reputable sources and generally stores them properly. It takes the right action in response to safety alerts, but it could do more to ensure that it reacts to these in a timely way.

Inspector's evidence

There was step-free access into the pharmacy through a manual door. The shop area was large and there was space for people with wheelchairs or pushchairs to manoeuvre. The pharmacy computer could generate large-print labels for people who needed them, and the pharmacy did deliveries for a small number of people who were housebound.

Baskets were used to keep different people's medicines separate during the dispensing process. The team was aware about the guidance about pregnancy prevention for people taking valproate. And about the recent guidance for dispensing the medicine in the original manufacturer's pack, and the need to undertake a risk assessment if someone needed the medicine in a different container.

The RP confirmed that the pharmacy used the National Protocol and national PGDs for the flu and Covid vaccinations services. For other vaccination services such as travel vaccinations, the PGDs in the pharmacy had expired, and there was evidence that travel vaccinations had been administered since they had expired. The RP explained that the PGDs had been purchased, but he had not yet completed the required training for the new PGDs. So, the pharmacy did not have valid PGDs for these other vaccination services.

Prescriptions for CDs were not always highlighted, which made it harder for team members handing out medicines to know if the prescriptions were still valid. Two prescriptions for CDs found awaiting collection had expired, and this was discussed with the RP. The RP was unsure if prescriptions for higher-risk medicines were routinely highlighted. No examples of prescriptions for these medicines were found awaiting collection.

Dispensed multi-compartment compliance packs examined were labelled with the descriptions of some of the medicines inside, but not all of them. This could make it harder for a person or their carer to identify the medicines inside. Patient information leaflets were not routinely supplied with the packs, but the RP said this would be done in the future. The dispenser showed how the pharmacy kept a record of any changes to people's medicines in a folder. Some of the records did not have dates or details of who initiated a change, which may make them less useful if there was a query.

Medicines were obtained from licensed wholesale dealers and generally stored in a tidy manner in the dispensary. The RP said that there were still issues with obtaining medicines, with some going in and out of stock at the suppliers. Bulk liquids were marked with the date of opening to help staff know if they were still suitable to use. Staff date-checked stock regularly and recorded this. No date-expired medicines were found in stock when a random sample of stock was examined. Medicines for destruction were kept separate from current stock. There were three fridges for medicines which required cold storage, and the temperatures were monitored and recorded regularly. Temperature

records seen were within the appropriate range. The fridge in one of the vaccination booths was unlocked and so the small quantity of medicines inside were not secure, but the fridge was locked, and the key removed when this was highlighted with the RP. CDs were kept in a secure locked cabinet.

The pharmacy received drug alerts and recalls were received electronically. The team was behind on checking the more recent safety alerts. Several of them were checked, but then the internet connection failed, and the system was no longer accessible. For the alerts checked, it was found the pharmacy had no affected stock. The RP gave assurances that he would make sure the remaining alerts were actioned as a priority.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And it uses its equipment to help protect people’s personal information. It largely keeps its equipment clean and fit to use.

Inspector's evidence

There was an in-date anaphylaxis kit available. Computer terminal screens were turned away from people, and the phone was cordless and so could be moved into a more private area if needed. Glass calibrated measures were available for use with liquids, but some required cleaning, and team members said this would be done. Tablet and capsule counting equipment was clean, and a separate counter was used for methotrexate to help avoid cross-contamination.

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.