

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: 28/06/2024

Pharmacy context

This pharmacy is located on a busy road intersection in Lewisham. The pharmacy supplies medicines in multi-compartment compliance packs to people who need help managing their medicines. It also provides NHS Covid vaccinations and the NHS blood pressure service. The pharmacy offers a private travel clinic (including vaccinations) using patient group directions (PGDs). And it provides consultations via the Pharmacy First 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	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's working practices are largely safe and effective. The pharmacy keeps the records it needs to by law so that medicines are supplied safely and legally. Team members use the procedures in place to protect vulnerable people. And the pharmacy consistently records and reviews near misses which provides it with opportunities to learn and make the pharmacy's services safer.

Inspector's evidence

Standard operating procedures (SOPs) were available and were up to date. Team members signed the SOPs indicating they had read them. The SOPs outlined the roles and responsibilities of the team. They covered a range of pharmacy activities including handling complaints and managing safeguarding concerns. And the SOPs were recently reviewed.

The pharmacy had processes to record dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were recorded on paper as they occurred, and team members were given feedback by the pharmacist. And every three months a review was completed after which the team members were briefed on the findings. An example of action taken following review of the near miss record involved the whole team undertaking 'look alike, sound alike' training, which taught the team how to avoid making mistakes for similar sounding and similar looking medicines. Dispensing errors were reported online. The Responsible Pharmacist (RP) was able to describe the process they would follow if a dispensing error happened. In the event of harm or someone taking the wrong medicine, the incident was reported to the person's GP and all controlled drug (CD) related incidents were reported to the CD Accountable Officer.

The correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. It had a complaints procedure, and the pharmacy displayed a sign in the public area which explained how people could provide feedback. People could provide feedback or make complaints in person in the pharmacy, and online via the pharmacy's website.

Records for emergency supplies, unlicensed medicines, RP records and CD registers were well maintained. The private prescription records were largely well maintained except for a small portion of entries which incorrectly listed the pharmacist as the prescriber. The pharmacist confirmed he did not prescribe, and this was an error on making the entry. The need to ensure that the records accurately reflected the correct prescriber's details was discussed with the RP. CD registers were electronic, and the sample seen complied with requirements. The pharmacy still had the previous paper CD records, which had been 'closed' as they were no longer in use. CD balance checks were completed at regular intervals. A random check of one of the CDs showed that the recorded balance matched the quantity held in the CD cabinet.

Patient confidentiality was protected using a range of measures. Prescriptions awaiting collection were stored in a way to ensure people's private information was out of sight of the public. Team members who needed to access NHS systems had individual smartcards. Confidential waste was separated into

designated bags and collected by a specialist contractor for destruction. Computers and patient medication record (PMR) systems were all password protected. The superintendent (SI) pharmacist had completed level three safeguarding training, the RP had completed level two safeguarding training and other team members had completed level one safeguarding training. The RP had the NHS safeguarding app to refer any concerns. Team members would refer any safeguarding concerns to the RP.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy generally has enough team members for the services it provides. And they do the right training for their roles. The pharmacy supports its team members with ongoing training to help them keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection the team comprised of the RP, who worked full time, a trained dispenser, a trained medicines counter assistant (MCA) and a trainee MCA. The pharmacy team also included a part-time pharmacy technician, a part-time MCA and two part-time dispensers who were not in at the time of the inspection. One member of the team had recently left, and a foundation pharmacist was due to start in July, which left the pharmacy short staffed for a small period. However, the RP and the team felt that they could cope with the pharmacy workload and this was observed during the inspection. They were up to date with dispensing and appeared to work well together.

Staff performance was managed through appraisals with the superintendent pharmacist (SI). Team meetings were conducted weekly to discuss updates and workload, and quarterly to discuss the near miss record and learnings. Team members felt they were able to raise concerns or give feedback and the SI was easily contactable. The trainee MCA was aware of which medicines were liable to abuse and when to refer to the pharmacist. They were also aware of the maximum quantities of some medicines that could be sold over the counter.

The RP had completed training to deliver several services via PGDs. These services included a travel vaccination clinic, yellow fever vaccinations, flu vaccinations, COVID vaccinations and the NHS Pharmacy First service. To keep up to date, training linked to NHS schemes and some services was completed. Team members also attended training provided by a third party to upskill and keep their knowledge up to date. There were no targets set for services provided and the RP felt comfortable to make professional decisions.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy maintains its premises adequately and they are suitable for the services the pharmacy provides. The pharmacy has facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy had a large shop area and a small dispensary with limited spaces to work. There were designated areas for dispensing and checking prescriptions. A clean sink, with running water, was used for preparing medicines. The room temperature and lighting were suitable for providing pharmacy services. A storage room was located at the back of the pharmacy. The premises were secure. Pharmacy-only medicines were stored behind a medicines counter.

The pharmacy was accessible for wheelchair users and the pharmacy floor and passageways were generally free of clutter and obstruction. There were chairs available for people wanting to wait for a service or waiting whilst their medicines were being assembled. There was a row of temporary booths which had been set up for Covid vaccinations, but these were not used during the inspection. A consultation room was available for private conversations and services. This was only accessible from behind the medicines counter. It was cluttered and a little untidy.

The pharmacy had a website where it advertised its services and allowed people to order repeat prescriptions. Details about the superintendent and pharmacy registration were listed. The pharmacy contact details, and a contact form were available on the website.

Principle 4 - Services ✓ Standards met

Summary findings

Overall, the pharmacy provides its services safely and people with differing needs can access the pharmacy's services. It orders its medicines from reputable sources and largely manages 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. Some members of the team were multilingual and translated for people who did not speak English well.

Most prescriptions were received by the pharmacy electronically. Dispensed-by and checked-by boxes were available on the dispensing labels. These were seen to be used during the inspection and on prepared medicines that were checked, to help maintain an audit trail. Team members were aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. Sodium valproate medicines were dispensed in original packs. CD prescriptions were highlighted, which enabled team members to check the prescription was not expired when they were collected. However, prescriptions for other higher-risk medicines were not highlighted, so staff could not alert the pharmacist when they were collected. This could mean the pharmacy misses opportunities to provide additional advice to some people about their medicines.

Multi-compartment compliance packs were prepared in a designated area. The pharmacy used a folder with individual record sheets and recorded any changes. Assembled packs seen were labelled with product details but were missing mandatory warnings. The RP reviewed this during the inspection and updated the PMR system to enable warnings to be printed for multi-compartment compliance packs. Information leaflets were supplied monthly.

Medicines were obtained from licensed wholesalers. Medicines were stored on shelves and in drawers in a tidy manner. Some loose, cut strips of medicine blisters were found in the drawers and some medicines decanted into boxes were missing batch numbers. The loose strips were missing expiry dates. These were removed and placed in the pharmaceutical waste bin during the inspection. The importance of keeping information about batch numbers and expiry dates with medicines was discussed with the RP. The pharmacy struggled to obtain some medicines due to recent shortages. People who could not wait until the medicine became available were either signposted to other pharmacies or their GP was contacted to prescribe an alternative.

The pharmacy had two fridges that were in use for medicines. Fridge temperatures were monitored daily and recorded. Records seen showed that the temperatures were within the required range for storing temperature-sensitive medicines. CDs were held securely. Expiry-date checks were carried out by the team and the pharmacy had a date-checking matrix. A random check of medicines on the shelves found no date-expired medicine. Opened bottles of liquid medicines were annotated with date opened. Drug recalls were received via email and accessed via an online portal by the RP. The RP said they would

action alerts. But the team was behind on checking recent safety alerts. The importance of keeping up to date with the alerts to ensure the safety of the medicines was discussed with the RP. The RP gave assurances that he would make sure the remaining alerts were actioned as a priority.

The pharmacy used the National Protocol and national PGDs for the flu and Covid vaccinations services. For services such as travel vaccinations and the Pharmacy First service, the corresponding PGDs were in date and signed by the RP. Records of vaccinations were kept, which included batch numbers and expiry dates so treatment people had received could be traced if needed.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had calibrated glass measures, and tablet counting equipment. There was one plastic measure that was not crown-stamped. This was removed during the inspection. Equipment was mainly clean and ready for use. One counting triangle needed cleaning and the team said this would be done. A separate counter was available for cytotoxic medicines and a separate measure was available for CDs.

Two fridges of adequate size and a legally compliant CD cabinet were available. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. A cordless phone was available so staff could move to somewhere more private for confidential conversations.

The pharmacy had an in-date anaphylaxis kit available for when the pharmacist provided vaccinations. There was an otoscope that the RP used to deliver the Pharmacy First service. And the pharmacy had blood pressure machines for the blood pressure checking service. These did not have calibration dates on them, but the RP said they were replaced every two years.

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.