General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, 108 High Street, WEST WICKHAM, Kent, BR4 OND

Pharmacy reference: 1091063

Type of pharmacy: Community

Date of inspection: 24/11/2022

Pharmacy context

This is a community pharmacy on a busy high street. It primarily offers NHS services, including dispensing prescriptions and it provides the New Medicine Service. And it does a flu vaccination service. It supplies medication in multi-compartment compliance packs to some people who need help with taking their medicines.

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 appropriately identifies and manages the risks associated with its services. Team members record any dispensing mistakes that happen and take action to reduce future risk. People can provide feedback or raise concerns about the pharmacy's services. The pharmacy keeps its records up to date and accurate. And it protects people's personal information well. Team members know how to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had previously used paper-based standard operating procedure (SOPs), and had moved to electronic versions earlier in the year. A record was kept to show that team members had read through the SOPs relevant to their roles. Team members could access the SOPs through the pharmacy's computer system if they needed to refer to them.

Staff recorded any near misses, where a dispensing mistake happened and was identified before the medicine was handed out. The responsible pharmacist (RP) described how she had previously done monthly reviews of the near misses to identify any patterns or trends. But due to the level of business, the reviews were a month or two behind. Dispensing errors, where a dispensing mistake happened and the medicine was handed to a person, were recorded on the computer system. The RP gave an example of an error where the wrong strength had been dispensed for a person. As a result, she had discussed this with the team to highlight that the medicine was available in two different strengths. Stickers had been placed on the shelves to highlight medicines which sounded similar or looked alike.

The dispenser could describe her own role and responsibilities and what she could and could not do if the pharmacist had not turned up in the morning. Team members' roles were also described in the pharmacy's SOPs.

There was a leaflet in the public area which explained to people how they could make a complaint or provide feedback, and the pharmacy had a complaint procedure. Team members were not aware of any recent complaints.

The pharmacy had current indemnity insurance. Records seen for private prescriptions and unlicensed medicines dispensed complied with requirements. And the right information was recorded when an emergency supply of a prescription-only medicine was made. The right RP notice was displayed in the public area, and the RP record had been filled in correctly. Controlled drug (CD) records seen had been filled in correctly, and the CD running balances were checked regularly. A random check of a CD showed that the physical quantity of stock matched the recorded balance.

No confidential information was visible from the public area. Staff were seen using their own smartcards to access the NHS electronic systems. There was a separate bag for confidential waste, and this was collected by a specialist waste company. Team members had read through the pharmacy's confidentiality SOP.

The RP confirmed she had completed the level 2 safeguarding training and could describe what she would do if she had any concerns about a vulnerable person. Team members said that they would refer

any concerns to the pharmacist. And they had completed the company's safeguarding training.

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 roles. They are comfortable about making suggestions or raising concerns. And they do some ongoing training to help keep their knowledge and skills up to date. Staff are able to take professional decisions to help make sure people are kept safe.

Inspector's evidence

During the inspection there was the RP, a dispenser, and a part-time trainee dispenser. Team members were up to date with their workload and appeared to be well organised during the inspection. The trainee dispenser received time during work to complete her training course.

Staff had access to ongoing training on the pharmacy computer system, and the RP was able to monitor their progress. Team members sometimes got time to do this training at work, but explained that it was often difficult to get time to do so. The trainee dispenser was confident when describing the questions she would ask when people wanted to buy a medicine over the counter. And how she referred requests for medicines that could be abused to the pharmacist. Team members felt comfortable about raising any concerns or making suggestions. They had previously received annual appraisals, but these had been put on hold as the pharmacy was in the process of being sold. Staff were set some targets to achieve, but the RP said that she still felt fully able to make professional decisions.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, tidy, and secure. They are suitable for the services the pharmacy provides. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean, tidy, and with good lighting. There was a large amount of workspace available. Some of the workspace had baskets of dispensed items on it, but there was still enough clear space to allow for safe dispensing. There were some areas which required repainting, but the fixtures and fittings were generally in a good state of repair. The pharmacy had clearly marked fire exits which were kept clear. And the premises could be secured from unauthorised access.

The pharmacy had a decent-sized consultation room which was clean and tidy. The room allowed people to have a conversation at a normal level of volume which would not be overheard.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. People with a range of needs can access its services. It gets its medicines from reputable sources and stores them properly. And it takes the right action in response to safety alerts, so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy had step-free access from the street via an automatic door. Staff could describe the other local health services available to people, and how they signposted people. They had access to online translation services, but said that this was rarely needed.

Baskets were used to isolate individual people's medicines, to help prevent them becoming mixed up. There was a clear workflow through the dispensary, and a designated area for checking dispensed items. Prescriptions for higher-risk medicines such as warfarin and methotrexate, were routinely highlighted. And there were SOPs detailing the additional advice that staff should provide with these medicines. The RP said that prescriptions for Schedule 5 CDs were highlighted, but not Schedule 3 or 4 CDs. This could make it harder for the staff handing these medicines out to know if the prescription was still valid. Team members were aware of the guidance about pregnancy prevention for people in the at-risk group who were taking medicines containing valproate. The original packs of these medicines had the warning cards attached, and the pharmacy had spare warning stickers and cards for use with split packs. The RP was not aware of any people currently in the at-risk group.

The pharmacy dispensed medications into multi-compartment compliance packs for some people who needed additional help taking their medicines. People were assessed to see if they needed the packs by the local Medicines Optimisation Service. 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. The dispenser showed how she kept a clear record when there were any changes in a person's medicines. And she was seen wearing gloves when dispensing the packs and handling the medicines. Staff initialled the packs when they had dispensed and checked them to provide an audit trail.

There was an in-date patient group direction for providing the flu vaccination service. And the RP described the training she had done to know how to provide it safely. Deliveries of medicines to people's homes was done by a driver, who also did the delivery for a few other local branches. The pharmacy kept an audit trail to show when medicines had been delivered.

Medicines were obtained from licensed wholesale dealers and specials suppliers, and were stored tidily in the dispensary. Date-checking was done regularly, and this activity was recorded. Medicines approaching their expiry date were marked so that staff were aware when they were dispensing them. No date-expired medicines were found during a random check of the stock. The fridge temperatures were recorded daily, and the previous records were within the appropriate range. CDs were stored securely. Medicines people had returned were kept separate from stock and then sent offsite for safe destruction. Drug alerts and recalls were received electronically, and the dispenser explained how she acted on them and showed how she recorded the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had suitable clean glass measures, and some measures were marked for use with certain liquids only to prevent cross-contamination. The blood pressure meter was marked with the date of first use and was replaced every two years. There was an in-date anaphylaxis kit in the consultation room for use with vaccinations. The phone was cordless and could be moved to a more private place in the dispensary to help protect people's personal information.

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.