General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Lakes Care Group LTD, Cavendish House, Ground Floor, 13 Lodge Road, London, NW4 4DD

Pharmacy reference: 9011325

Type of pharmacy: Internet / distance selling

Date of inspection: 06/10/2021

Pharmacy context

The pharmacy is situated on the ground floor of a commercial building. It dispenses mainly to care and nursing homes and offers a delivery service. It has a distance selling NHS contract and a web site www.lakespharmacy.co.uk which it does not promote at present. The pharmacy opened in February 2020.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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

Members of the pharmacy team usually work to professional standards and identify and manage risks effectively. They record mistakes they make during the dispensing process or discuss them with the regular pharmacist. And they try to learn from these events to avoid mistakes being repeated. The pharmacy keeps its records up to date and these show that it is providing safe services. Its team members understand how they can help to protect the welfare of vulnerable people. And the pharmacy team members keep people's private information safe.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were issued by the company. The SOPs covered the services that the pharmacy offered. These had been reviewed within the last year. The written procedures said the team members should log any mistakes the team made which were corrected during the dispensing process (known as near misses) in order to learn from these events. The team members logged some issues and discussed learning from these events, although the staff admitted that they did not always record these near misses. Mistakes which reached patients were recorded, learned from and the superintendent pharmacist (SI) was informed about these. Medicines with similar names or appearance were highlighted on the shelves to try to prevent picking errors. The SI regularly visited the pharmacy and undertook his own 'inspection' of the processes to ensure that he was happy with the processes in place. The pharmacy had employed an experienced pharmacist was to do a mock inspection to ensure that the pharmacy was complying with the standards required by the GPhC. This was due to happen in a few weeks' time.

The pharmacy displayed the responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice when they were unsure about the information to give to people. The owner discussed how it was difficult to get feedback from people who used the pharmacy's service. But feedback from one of the homes' managers had led to a change in the way the pharmacy dispensed some prescriptions. The homes needed to count the number of tablets or capsules on a regular basis and those medicines which were dispensed 'loose' in bottles were taking a long time to count and were being handled by staff regularly. The homes wanted to improve the way they did this. Prescriptions for loose capsules were now dispensed in weekly bottles so that the number of capsules counted was reduced and the handling of the medicines was also reduced.

The pharmacy had professional indemnity and public liability insurances in place. The pharmacy team recorded private prescriptions and emergency supplies on the computer. The controlled drugs registers were up to date. The team checked them regularly to ensure that there were no missing entries, that they were legally compliant and that the stock levels were as expected. The pharmacy had changed to using a computer for its controlled drugs registers and had been adding back returned medicines as 'quarantined stock' into the registers. It was documented when these returned medicines were destroyed. As this was not stock they should not be recorded in the legal register. After discussion it was decided that the pharmacy would go back to using paper records for these returned medicines.

The pharmacy had completed an information governance assessment and had a member of staff with

overall responsibility for compliance. Confidential waste was separated from general waste and disposed of securely by a licensed waste contractor. There was an electronic smartcard in the pharmacy which belonged to a member of the team who was on leave. The card was being used by staff to access the NHS spine. This was contrary to the conditions of use and may pose a risk to patient privacy. Computers and labelling printers were used in the pharmacy. Information produced by this equipment was not visible to people externally. Computers were password protected to prevent unauthorised access to confidential information. Other sensitive information was kept securely away from general view.

The pharmacist and senior staff had undertaken safeguarding training and were able to show who they would contact if they needed to escalate a concern. The pharmacist said that she spent a lot of time dealing with requests for covert administration of medicines. She reported that some of the homes had a lot of people who received their medicines covertly, but that she always tried to question the need, on every occasion. A request from the home was sent to the pharmacist. She assessed it and sent it on to the GP for their assessment. Once this was in place and a prescription issued the pharmacist would dispense the medicines accordingly. The medicines were put onto the MAR chart in the usual way, with no mention of covert administration, so that even of the medicine could be given covertly the patient would be given the opportunity to take them knowingly. There was a record in the home, showing that covert administration was allowed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services at present, and they work effectively together and are supportive of one another. They have the appropriate skills, qualifications and training to deliver services safely and effectively. Team members are given some ongoing training to help them keep their skills and knowledge current.

Inspector's evidence

During the inspection the manager, who was also a dispenser, and a person dealing with ordering and accounts were present. There was also a full-time pharmacist, two dispensers, a trainee who was a pharmacy apprentice, and two administration clerks. One of the clerks had a pharmacist qualification from another country but who was not registered to work as a pharmacist in the UK. One of the dispensers was fully qualified and the other was part-way through her course.

The team all knew their roles and were able to explain how they would ask for advice from more experienced colleagues, if needed. The pharmacy had found that the member of staff who had trained as a pharmacist overseas was able to add value by checking prescriptions prior to dispensing and chasing up missing items, because of her pharmaceutical knowledge. The team was expanding, and due to the training needs and restructuring, the business had put on hold any expansion to supply new care homes until the staff were able to fulfil the roles for which they were being employed.

Staff had all signed confidentiality agreements, and the delivery drivers had completed a delivery driver training package. The manager said that he was able to check on the progress through the training packages of the staff to ensure their timely completion. He used the support of the pharmacist to do so. After their formal training, the staff were encouraged to continue learning with training packages from suppliers and other sources.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services.

Inspector's evidence

The pharmacy was situated on the ground, and mezzanine floors of a commercial building. Entry was via a video door-bell entry system. The pharmacy was clean, tidy and bright. As the business increased, the pharmacy had introduced larger work surfaces to accommodate the increased numbers of items dispensed. There were staff welfare facilities provided. And the room was air-conditioned.

The workstations for the administration clerks were ergonomically positioned. The workbenches were clean and tidy. Work was designed to travel in a circle round the dispensary so that it was efficient. There were separate benches for picking orders, assembling administration cards, checking and despatch. There were also desk spaces for other administration work.

The pharmacy had a website as it was required by the NHS for all distance-selling contracts. It was reported that the pharmacy did not sell much through it. And it was not concentrating on that part of the business as it had enough work from the residential and nursing homes which it supplied. The website met the requirements set out in GPhC guidance about providing pharmacy services at a distance.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy delivers its services in a safe and effective manner and it gets its medicines from reputable sources. Pharmacy team members try to make sure that people have all the information they need so that they can use their medicines safely.

Inspector's evidence

The pharmacy service was mostly dispensing prescriptions for care home residents in both residential and nursing homes. The medicines were supplied in original packs except for a few people whose medicines were put into individual cards for administration.

The homes ordered their own medicines, and the pharmacy was sent copies of what had been ordered. The pharmacy checked that a prescription for each item ordered had been received. Missing items were flagged and then chased by the administrative team. A medicines administration chart (MAR chart) was then generated, showing at what time of day each medicine was to be administered. This also included warnings about the medicines. Any interim prescriptions which could not be supplied quickly by the pharmacy were sent to a pharmacy nearer the home to be dispensed. Where this happened, the pharmacy emailed a MAR chart to the home to facilitate administration.

The next step in the process was to produce the dispensing labels for each home. This step also created orders for the dispensing stock required for the prescriptions. The labels produced were placed into coloured baskets according to each home along with the prescriptions and the MAR charts. Once the ordered medicines were received, they were picked and assembled into the baskets. Each home was dealt with separately. The labels for dispensed medicines included relevant warnings and were initialled by the dispenser and checker which allowed an audit trail to be produced. The prescription was also initialled by the labeller and dispenser and the pharmacist who had checked the item.

For homes where medicines were supplied in individual administration cards, the medicines were picked and passed to another dispenser who assembled the cards and labelled them. Patient information leaflets were not routinely supplied with medicines on administration cards. But the pharmacy had provided a file containing the patient information leaflets for all the medicines supplied to each home. These might not be for the exact manufacturer but would give general information about the medicines, if required. Some commonly used medicines, such as furosemide, were de-blistered into large bulk pots ahead of dispensing. There was a comprehensive written process about how this was done. The pots were labelled with the manufacturer’s box, and there was an audit trail of who had de-blistered the tablets, when it was done, batch number, expiry date etc, which could be followed back to the removal from the manufacturer’s packaging. Each of the pots was only used for the same medicine on any occasion. When empty, the pots were cleaned with alcohol spray and allowed to dry. This process was covered by an SOP which was followed by the staff. Usually, 10 or more packs of 28 tablets were de-blistered at a time. The medicines remained in the pots for less than one week.

People taking medicines with a narrow therapeutic index were monitored. The pharmacy required that the homes supply them with the relevant blood test results and current dose of the medicines, to ensure that the medicines supplied matched the person’s requirements. There were no people

currently supplied sodium valproate who were in the at-risk group. But the pharmacy staff were aware that if someone in the at-risk group were to be supplied by them, they must ensure that counselling, a card and appropriate warning stickers should be supplied.

The pharmacy got its medicines from licensed wholesalers and stored them on shelves in a tidy way. Regular date checking was done, and no out-of-date medicines were found on the shelves. Liquid medicines with limited shelf-life once opened were marked with the date of opening. The fridge temperatures recorded showed that the medicines in the fridge had been consistently stored within the recommended range. Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. Electrical equipment was due to be tested. Stickers were affixed to various electronic equipment and displayed the next date of testing.

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.