General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 143 Avon Road, Cranham, UPMINSTER, Essex, RM14 1RQ

Pharmacy reference: 1031436

Type of pharmacy: Community

Date of inspection: 03/12/2019

Pharmacy context

The pharmacy is located in a parade of shops. People who use the pharmacy are mainly from the local area. A surgery is situated across the road from the pharmacy and another two surgeries are five and ten minutes away. The pharmacy supplies medicines in multi-compartment compliance packs to people who need help managing their medicines. It provides Medicines Use Reviews, the New Medicine Service and provides flu vaccinations. The pharmacy also provides an INR service as part of which people are supplied with warfarin.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services. The pharmacy asks its customers for their views. It largely keeps the records it needs to so that medicines are supplied safely and legally. Team members know how to safeguard vulnerable people. They work to written procedures to help provide the pharmacy's services safely. The team members generally respond appropriately when mistakes happen during the dispensing process. This helps them prevent similar mistakes from happening in the future and make the services safer.

Inspector's evidence

Standard Operating Procedures (SOPs) were up to date. However, core dispensing SOPs had not been updated to include additional information following the introduction of the Falsified Medicine Directive (FMD). Team members had read and signed SOPs relevant to their roles. Team roles were defined within the SOPs.

Near misses were discussed with the person who had made the mistake when it was discovered by the responsible pharmacist (RP). A record was then made on the near miss log which was then transferred to the PharmOutcomes system. The last recorded near miss had been in August 2019. The RP said that there were probably some near misses after then which had not been recorded. At the end of each month a patient safety review was usually completed which was discussed at the team meeting. The review looked for trends and patterns also included a discussion about how a reoccurrence of errors could be prevented. However, the review had not been done for the past few months. As a result of past reviews co-amilofruse and co-amilozide were separated on the shelves as were amlodipine and amiloride.

Dispensing incidents were reported on the intranet which also sent a copy of the report to head office. A printed copy was retained in store. The head office team and superintendent pharmacist (SI) reviewed the incident report form. The pharmacy had not had any reported dispensing incidents in a while. An incident had occurred in the past which involved eye drops which had been prescribed generically. As a result, the team had separated all branded eyedrops from the basket and stored them separately.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure in place with a notice displayed which explained to people how they could make a complaint. Annual patient satisfaction surveys were also carried out. As a result of past feedback on the seating area, when needed chairs were brought out from the consultation room as there was not much space available to leave them there at all times.

The correct RP notice was displayed. Team members were aware of the tasks that could and could not be carried out in the absence of the RP.

Records for private prescription, emergency supplies, unlicensed medicines supplied, RP and CD registers were well maintained. CD balances were checked regularly. A random check of a CD medicine complied with the balance recorded in the register. CDs that people had returned were recorded in a register before they were destroyed.

The pharmacy had an information governance policy in place. Relevant team members who accessed NHS systems had smartcards. The RP had access to Summary Care Records (SCR); consent to access these was gained verbally. Confidential waste was either shredded or collected in a segregated bag and collected by a contractor for destruction. All team members had also completed training on confidentiality on the'Day Lewis Academy' (the internal online training system).

Team members had completed safeguarding training on the Day Lewis Academy. The RP had also completed level 2 safeguarding training. Details were available for the local safeguarding boards along with the safeguarding policy. Team members would refer any concerns to the RP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They have completed or are doing the required accredited training for their roles. They do ongoing training to help keep their knowledge and skills up to date. And they feel comfortable about raising any concerns.

Inspector's evidence

At the time of the inspection the pharmacy team comprised of the RP, a dispenser (declared competent under the grandparenting clause), an apprentice and a trained medicines counter assistant (MCA).

The RP felt that there were an adequate number of staff for the services provided. Team members covered leave and absences. Anticoagulant services were provided on a Friday by an allocated pharmacist who also supplied medicines as part of the services.

Staff performance was reviewed annually. Progress, achievements, targets and training needs and further training were discussed during the reviews. Team members felt they were able to raise concerns or give feedback.

Team members counselled people on the use of over-the-counter medicines and asked appropriate questions before recommending treatment. The MCA was aware of the maximum quantities of some medicines that could be sold over-the counter and would refer to the RP for any other multiple sale requests. Team members had personal access to a training suite which helped them keep up to date. Online eLearning was also completed on the 'Day Lewis Academy' which had a range of mandatory modules (for example safeguarding, risk management) and other optional ones which team members received points for completing. Points were also received for attending seminars and training sessions. Earning a certain number of points enabled them to reach the next level (gold, silver, bronze). Team members said there was a monthly module to complete and they were given time to complete this. The apprentice was provided with training time on Monday and did not come in to work.

The team discussed things as they came up and tried to have a catch-up on Mondays when all but one team member was in. The team also communicated via a group on an electronic messaging application. The assistant manager briefed the team on Thursdays. Communication from head office was received by the team via the intranet. Pharmacists and technicians also attended conferences and passed on relevant information to the team. The last conference had discussed the new NHS services being launched and discussed providing quality care.

Targets were in place for services such as MUR and NMS, there was no pressure on team members to meet these. Team members explained that they were achievable and did not affect their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services and are largely clean, tidy and well maintained. Space is effectively managed to improve the work flow. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was in the main clean and suitable for the pharmacy's services. However, the appearance of the premises reflected their age; the paint was peeling in places and the ceiling tiles stained. The dispensary had ample space which was clear and organised. Workbenches were roughly allocated for certain tasks. Multi-compartment compliance packs were prepared on an island worktop. The dispensary was tidy and organised and the work load was organised in baskets to keep the benches clear. The shelves were organised. Cleaning was done by team members. A sink was available in the dispensary for the preparation of medicines.

The consultation room was spacious and clean. The room was kept unlocked and people's private information was stored inside the room. The pharmacist was advised to keep the records securely or remove the confidential information. Following the inspection, the RP confirmed that records and medicines had been moved out of the room.

The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally provides its services safely and effectively. It gets its stock from reputable sources and mostly stores it properly. The pharmacy takes the right action in response to safety alerts to make sure that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy. A bell was available on the front door which people could press if they required assistance. Team members were able to assist when needed; there was a clear view from the counter to the main entrance. There was easy access to the medicine counter. The pharmacy was able to generate large print labels when needed. A variety of patient information leaflets were available in the shop area. Services and opening times were clearly advertised. Team members knew what services were available and described signposting people to other providers if a service was not offered at the pharmacy. People were also provided with details of a local doctor hub which could be used out-of-hours.

The RP felts that the flu vaccination service, New Medicine Service (NMS) and Medicines Use Reviews (MUR) had the most impact. The pharmacy was easily accessible for people to come in for their vaccinations and vaccinations were offered on a walk-in basis. With NMS and MURs, the RP felt that they allowed him to follow up how people were getting on with their new medicines and also reassured people that there was someone looking out for them. An example was given of a person who had been prescribed apixaban. During the NMS consultation the RP had learnt that they were not taking the medication as they had read the leaflet which came with the medicine and were concerned. The person had an increased risk of having a stroke. The RP had spoken to them and provided reassurance as a result of which the person had started taking their medicines.

Teams were provided with training and support by head office before new services were launched. The RP had attended a workshop and had a few sessions at a conference to cover the new Community Pharmacist Consultation Service (CPCS). Since attending the training, the pharmacy had received a few referrals via the NHS 111 system.

The pharmacy had an established workflow. Baskets were used as part of the dispensing process to separate prescriptions. Prescriptions were printed off by the RP or one of the dispensers, dispensed and then checked by the RP. The RP occasionally self-checked walk-in prescriptions where there was only one item. He described that he double-checked, read the prescription, gathered the stock and read and attached the label. Dispensed and checked-by boxes on labels were initialled by members of the team to create an audit trail for the dispensing and checking processes.

The RP was aware of the change in guidance for dispensing sodium valproate. The team had completed an audit on the use of sodium valproate and identified two people who fell within the at-risk group. The pharmacist had a conversation with these people and had made a record on the audit from which had been sent to head office. No notes had been made on the person's electronic record. The RP made these retrospectively on the day of the inspection. The RP had not been aware of the need to use the warning labels. The inspector reminded the RP of the requirements.

The RP was not aware of how the INR service operated as this service was provided by another accredited pharmacist. As part of the service people were supplied with their medicines as part of the patient group direction. The RP described how the accredited pharmacist made records on 'INR star' and sent information to people's GP. The pharmacy supplied warfarin to a small number of people who were not part of the service. The RP said in this instance he checked the INR readings; this was not recorded. Similarly, for people who collected methotrexate or lithium the pharmacist checked with people if they were having regular blood tests.

The list of people who had their medicines supplied in multi-compartment compliance packs was divided into four separate weeks to help manage the workflow. Team members usually prepared four packs at a time and used a tracker to mark off when packs were collected. Prescriptions were ordered every three weeks and a diary was used to audit requests. Once the prescription was received, the dispenser checked this against the previous record. Any missing items or changes were queried with the surgery and a note was made of this on the individual record sheet. In the event that someone was admitted into hospital in most cases the pharmacy received a call from the hospital. In this instance any packs were 'put on hold.' The RP prepared backing sheets after which packs were prepared by the dispenser. The packs were then checked and sealed by the RP. The pharmacy carried out ongoing reviews to see if the service was still appropriate for people. One person had been changed back to having their medicines supplied in original packs.

Assembled multi-compartment compliance packs observed were labelled with product descriptions and there was also an audit trail in place to show who had prepared and checked the pack. Patient information leaflets were handed out monthly. However, mandatory warnings were missing from the backing sheets. The RP said that he would speak to the systems provider to have these included.
The pharmacy had a delivery driver, a book was used for obtaining signatures from people when their medicines were delivered. In the event that a person was not home a note was left by the driver and the medicines bag was returned to the pharmacy. Some people had signed a disclaimer to say that they wanted their medicines posted through the letter box. The RP said that there were not many people who had signed the disclaimer and it was mainly for people who were bed bound and could not open the door.

Medicines were obtained from licensed wholesalers. Fridge temperatures were monitored daily and recorded; these were observed to be within the required range for the storage of medicines. CDs were held securely.

Expiry date checks were carried out every three months by the team. Short-dated stock was marked. A date-checking matrix was in place. This was last updated in June 2019. The RP said that a date check had been done since then but was unsure of where the assistant manager had filed the matrix. There were no date-expired medicines found on the shelves checked. Out-of-date and other waste medicines were segregated from stock and then collected by licensed waste collectors.

The pharmacy was not compliant with the Falsified Medicines Directive (FMD). The RP said that the company was installing a new computer system within the next three months which would have the capability to use FMD.

Drug recalls were received on the company's intranet. The assistant manager usually printed these and checked against stock, if the affected batches were found these were quarantined and action was taken following instructions received from head office. The pharmacy was required to respond to head office reporting on the action taken. If the system was not updated the regional supporting manager would call to check. The last actioned alert had been for Emerade.

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 calibrated glass measures, and tablet counting equipment. Equipment was clean and ready to use. A separate tablet counting triangle was used for cytotoxic medicines to avoid cross-contamination. The pharmacy also had an electronic tablet counter. This was calibrated by head office every 12 months.

The CoaguCheck monitor calibration was done by the pharmacist who provided the service. The RP was unaware of what was done as he did not provide the service. He was aware that there was a testing solution available in the fridge.

Up-to-date reference sources were available including access to the internet. The computer in the dispensary was password protected and out of view of people using the pharmacy. Confidential waste was collected in a segregated box and shredded.

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.