General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 72-74 Cottage Beck Road, Scunthorpe, South Humberside, DN16 1LE

Pharmacy reference: 1032502

Type of pharmacy: Community

Date of inspection: 27/08/2024

Pharmacy context

The pharmacy is in on a residential street in Scunthorpe, North Lincolnshire. Its main services are dispensing prescriptions and selling over-the-counter medicines. The pharmacy provides a range of NHS consultation services including the Pharmacy First Service, New Medicine Service, contraception, and blood pressure check services. It also offers a range of private consultation services for common health conditions. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers medicines to people's homes.

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	1.2	Good practice	Pharmacy team members engage well in processes designed to reduce risk following the mistakes they make during the dispensing process. They actively participate in structured conversations to support them in identifying and managing risk. And they keep the actions they take under review to ensure they remain effective.
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 identifies and manages the risks of providing its services well. Its team members act with care to reduce risk following the mistakes they make during the dispensing process. And they keep these actions under review by engaging in regular and comprehensive patient safety reviews. Pharmacy team members have the knowledge and confidence to identify, and report concerns to help keep vulnerable people safe from harm. And they understand how to respond to feedback from people accessing the pharmacy's services. They treat people's confidential information with care. And they mostly make the records as required by law.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. The superintendent pharmacist's team periodically reviewed these. Team members received notification of new and updated SOPs and were required to complete learning for these SOPs within a standard time limit. The pharmacy manager received regular training reports to help ensure all team members completed this learning. A team member discussed the tasks that they could not complete should the responsible pharmacist (RP) take absence from the pharmacy. And a pharmacy technician, working in an accuracy checking role (ACPT), described how they would complete a final accuracy check of a medicine only after the RP had completed a clinical check of the prescription. The ACPT felt able to refer any concerns they had to the RP when working in this role. But confirmation of the clinical check took place verbally rather than being documented on the prescription to refer to should any queries arise following a medicine being dispensed. The pharmacy completed risk assessments ahead of new services commencing. Risk assessments showed details of the identified risks and the actions taken to manage these risks. The pharmacy also engaged in some audits related to its services to help it monitor how it delivered its services. The trainee pharmacist demonstrated the findings of an audit they had completed of the pharmacy's NHS blood pressure check service.

Pharmacy team members engaged in regular learning to help maintain patient safety. This learning included reading newsletters and safety bulletins and using the information within these publications to help inform change. For example, by reviewing which medicines it stored within a 'high risk' section of the dispensary. A team member explained how they paid extra care and attention when dispensing medicines from this section, many of which had similar names to other medicines. Team members corrected and recorded the mistakes they made and identified during the dispensing process, known as near misses. They engaged well in monthly patient safety reviews which helped to identify trends in mistakes. And they clearly identified the steps they took to help reduce risk. For example, by separating different formulations of the same medicine on the dispensary shelves. And in some cases, holding only medicines from one manufacturer within dispensary stock, with the same medicine from other manufacturers held in the stock room. A team member explained how this helped to reduce picking errors caused by stock misplacement. The team used the patient safety reviews to monitor the actions it took to ensure they remained effective. The pharmacy reported mistakes identified following the supply of a medicine to a person, known as dispensing incidents. Incident reporting included an investigation into the root cause of a mistake. They clearly identified learning points and actions taken to reduce the risk of a similar mistake occurring.

The pharmacy advertised how people could provide feedback. A team member explained how they would take details of a concern and refer to the RP to support local resolution whenever possible. And they understood how they could provide information to help a person escalate their concern should they wish to. Pharmacy team members engaged in safeguarding learning to help keep vulnerable people safe from harm. They collaborated with local prescribers to monitor the frequency of collection of some medicines for vulnerable people. Team members had information available to support them in raising a safeguarding concern. And a team member provided an example of how they had raised a potential safeguarding concern and how the RP had managed this concern effectively.

Team members completed mandatory learning on the importance of keeping confidential information secure. And they stored all personal identifiable information in the staff-only areas of the pharmacy. The pharmacy disposed of its confidential waste securely. It had current indemnity insurance. The RP notice was updated to reflect the correct details of the RP on duty as the inspection began. A sample of pharmacy records found most records were made in accordance with legal and regulatory requirements. There were some minor gaps in the sign-out time of the RP within the RP record. And team members did not always record the prescriber details in the private prescription register accurately. The pharmacy held its controlled drug (CD) register electronically. It completed frequent full balance audits of physical stock against the running balance in the register. Physical balance checks of CDs conducted during the inspection matched the running balances in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the right skills and qualifications to provide pharmacy services safely. They engage in regular learning and development reviews and undertake continual training relevant to their roles. Pharmacy team members contribute to ongoing discussions about workload management and patient safety. They are confident in providing feedback at work. And they know how to raise concerns.

Inspector's evidence

The RP was the pharmacy manager, they worked four days each week at the pharmacy and spent another day each week in a regional role supporting other pharmacies within the company. Also on duty was the ACPT, a trainee medicine counter assistant, a trainee pharmacist, and two qualified dispensers. A pharmacy technician was on long-term planned leave and a dispenser had recently changed to a zero-hour contract to support a move into full-time higher education. The pharmacy also employed two delivery drivers. The pharmacy had employed another qualified dispenser and had enrolled two qualified dispensers on pre-registration pharmacy technician training in response to these recent staffing changes. Team members worked flexibly when needed to cover during periods of planned and unplanned leave.

Pharmacy team members completed ongoing learning relevant to their roles through a series of e-learning modules. They received some learning time during working hours, this included protected learning time for team members enrolled on GPhC accredited training courses. The trainee pharmacist felt supported in their role, they attended monthly training sessions alongside other trainee pharmacists. And they received daily protected learning time at work. They understood how to provide feedback and raise a concern about their placement if required. The pharmacy displayed certificates showing its team members qualifications to people using the pharmacy. It supported team members through a structured appraisal system, this helped to monitor their learning and development. The pharmacy had some targets for the services it provided. The RP felt able to apply their professional judgement when delivering the pharmacy's services. They discussed how they managed workload through an online booking system which supported them in balancing the safe delivery of consultation services alongside dispensary workload.

Pharmacy team members engaged in continual conversations about workload management, and they contributed to regular briefings about patient safety. The pharmacy had a whistleblowing policy, and it clearly advertised its confidential employee assistance programme to team members. Team members felt able to provide feedback at work. And they knew how to escalate a concern at work, should they need to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and well maintained. It offers a professional environment for delivering its services to people. People have the opportunity to speak with team members in confidence in a private consultation space.

Inspector's evidence

The pharmacy was secure and well maintained. Team members knew how to report maintenance concerns. There was one outstanding maintenance issue waiting to be addressed. The issue did not affect the safe and effective running of the pharmacy. Lighting was bright throughout the premises. Heating and ventilation arrangements were adequate. Team members had access to sinks equipped with antibacterial hand wash and paper towels. Hand sanitiser was available in both the staff-only and public area of the premises.

The public area was open plan and led to the medicine counter. The pharmacy's consultation room and a semi-private hatch leading into the dispensary were available for people to use to the side of the main entrance. The consultation room was professional in appearance and offered a protected space for conducting private consultations. People were observed accessing both the consultation room and the hatch during the inspection. People using the pharmacy's automated collection point to collect their medicine had the option to access it from the pharmacy's public area during the pharmacy's opening hours and from a 24/7 collection point from the street outside the pharmacy.

The dispensary was behind a part-height partition wall. Retail displays in front of the wall helped to ensure people could not see directly into the dispensary. The dispensary was a good size for the level of activity taking place and space was generally managed well. There were separate areas for completing higher-risk tasks such as dispensing medicines in multi-compartment compliance packs. Due to the pharmacy dispensing a large volume of appliances to people some floor space was taken up with boxes and bags of appliances. This was appropriately managed to avoid trip hazards. To the back of the dispensary was access to storerooms and staff facilities. Space in these rooms was appropriately managed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible for people. It obtains its medicines from licensed sources, and it stores its medicines safely and securely. Its team members conduct a series of regular checks to ensure medicines are safe to supply. Pharmacy team members follow effective processes when completing tasks and they refer to current information to support them in providing services safely. They provide relevant information when supplying medicines and they establish any additional support people need to help them to take their medicines safely.

Inspector's evidence

People accessed the pharmacy from a small step from street level. The pharmacy advertised its opening times to people. And it provided a wealth of information to people about the services it provided. This included providing factual information to people to encourage uptake of the pharmacy's services, such as the increased risks to health of having high blood pressure. The pharmacy shared details of the services it provided with other healthcare services to support people in accessing care efficiently. Pharmacy team members had appropriate local knowledge and could refer people to other pharmacies or healthcare services should the pharmacy be unable to provide a service.

People had the option to use an online booking platform to arrange a consultation appointment at the pharmacy. It provided private consultations for a range of health conditions including erectile dysfunction, oral thrush, and the supply of emergency hormonal contraception. These services involved a private face-to-face consultation with the RP followed by the supply of medicine, if deemed appropriate. Current patient group directions (PGDs) used to support the supply of the medicines were readily available for the RP to refer to. The RP had completed learning to support them in delivering consultation services safely. And they kept records of the consultations and medicines supplied through the service. Information to support the safe delivery of the NHS consultation services was also readily available, including current PGDs for these services. The pharmacy stored Pharmacy (P) medicines behind the medicine counter. The RP had appropriate supervision over the medicine counter and public area. And team members were aware of the need to monitor requests for some higher-risk P medicines liable to abuse. A team member discussed how they managed these requests and referred them to the RP if they had any concerns that a medicine sale was not appropriate.

The pharmacy had a good range of monitoring tools to supply to people when dispensing higher-risk medicines requiring ongoing monitoring. There was a clear process for identifying the need to refer people to the RP before a supply of medicine could be made. The RP discussed the conversations they had with people to support them in taking these medicines safely. This included providing telephone counselling to people when they chose to collect their medicine from the pharmacy's automated collection point. But the team did not always record these types of interventions to support continual care. Pharmacy team members generally understood the requirements of dispensing higher-risk medicines, such as those requiring compliance with Pregnancy Prevention Programmes (PPPs). But the team did not fully understand all recent legal changes about supplying valproate in original packs. A discussion about these changes highlighted the need to complete risk assessments when the pharmacy identified an exceptional need to supply valproate outside of the manufacturer's original packaging. The pharmacy had effective processes when dispensing prescriptions for opioid treatment programmes.

This included a pharmacist entering data onto the pharmacy's automated dispensing machine used to dispense a higher-risk liquid medicine. And team members checking doses dispensed by the machine with the RP for supply. The team communicated with prescribers and people's key workers when needed.

The pharmacy team used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Team members took ownership of their work by applying their dispensing signatures to medicine labels. They provided relevant safety information when supplying medicines, including patient information leaflets. The pharmacy kept an audit trail of the medicines it owed to people, and team members made regular checks of medicine availability and informed people of supply problems to help ensure they had enough time to discuss this with their prescriber before their current supply ran out. The pharmacy kept an audit trail of the medicines it delivered to people to support it in answering any queries about the service.

The pharmacy had effective processes for managing the supply of medicines in multi-compartment compliance packs. It had work trackers to help ensure it completed tasks in a timely manner. And it kept information to support the checks it made to confirm changes to people's medicine regimens. Team members applied a four-way check against the prescription, patient medication record, medicine administration record and the backing sheet attached to the compliance pack when assembling medicines in compliance packs. And the RP accuracy checked the medicines picked for each compliance pack before team members started the assembly process. A sample of compliance packs examined were labelled clearly with descriptions of the medicines inside the compliance pack provided. The pharmacy regularly spoke to people receiving their medicines in this way to ensure they were taking their medicines safely. And to help identify any adjustments required. For example, it supplied dexterity aids to some people to support them in opening individual compartments within their compliance packs easily.

The pharmacy obtained its medicines from licensed wholesalers and a specials manufacturer. It stored them neatly and within their original packaging. The team conducted and recorded regular checks of stock medicines. It identified medicines with short expiry dates. A random check of dispensary stock found no out-of-date medicines. The team marked liquid medicines with details of their opening dates and details of their shortened expiry date, when applicable, to ensure they remained safe to supply. The pharmacy kept CDs securely in cabinets, there was designated space within the cabinets for holding assembled medicines, date-expired and patient-returned CDs. The pharmacy stored medicines requiring cold storage in a medical fridge. Medicines inside were stored in an orderly manner and the team monitored the temperature range of the fridge to ensure medicines were kept within the right conditions.

The pharmacy had appropriate medical waste receptacles to support the safe disposal of medicine waste. The pharmacy received medicine alerts electronically and it kept records of the checks it made in response to these alerts. Team members applied a number of checks when supplying medicines and they took the opportunity to raise any safety concerns they had directly with manufacturers.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has equipment and facilities readily available to support its team members in delivering its services safely. It applies regular monitoring checks to ensure its equipment remain safe to use. And its team members use the equipment and facilities in a way which protects people's confidentiality.

Inspector's evidence

Team members had access to a range of paper-based and digital reference resources. They also had access to the company's intranet and the internet to help obtain information to support them in answering queries. The pharmacy protected its computers from unauthorised access through the use of passwords and NHS smart cards. Information displayed on computer monitors was protected from unauthorised view. The pharmacy stored bags of assembled medicines within a retrieval area in the dispensary. This meant details on bag labels and prescription forms could not be read from the public area. Pharmacy team members used cordless telephone handsets to support them in maintaining people's confidentiality when speaking to them on the telephone.

The pharmacy team used standardised equipment for counting and measuring medicines. It clearly marked equipment for counting and measuring higher-risk medicines separately. The pharmacy had maintenance support arrangements for its automated collection point and automated dispensing machine. Team members knew how to report concerns with the machines, and they received timely support when they had required assistance. Equipment was stored safely and was readily available to support the team in delivering its services. The team cleaned and checked reusable equipment, such as the ambulatory blood pressure monitors between use. The pharmacy's electrical equipment was annotated to show it had last been assessed in February 2024.

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.