General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 443 Downham Way, BROMLEY, Kent, BR1 5HS

Pharmacy reference: 1032613

Type of pharmacy: Community

Date of inspection: 24/06/2019

Pharmacy context

This is a busy pharmacy in a parade of shops on a main road. It is close to a doctor's surgery. It is used by people with a range of ages, with a higher proportion of older people. It offers a range of services, including an anticoagulant clinic on Wednesdays, and a travel vaccination service. It supplies medicines in multi-compartment compliance packs to some people to help them take their medicines.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	Team members do not always start the required accredited training course in a timely manner. This could increase the risk that they do not have the skills and knowledge they need to provide the services safely.
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 manages its risks appropriately and generally provides its services safely. It records when dispensing mistakes happens and learns from them to make the services safer for people. It largely keeps the records it needs to by law. And it asks people using the pharmacy for their views. Team members know how to protect people's personal information. And they know how to safeguard vulnerable people.

Inspector's evidence

Near misses were recorded on an ongoing basis using a sheet in the dispensary. They were reviewed every couple of months by the pharmacist and assistant manager to help identify any patterns and find ways to make the dispensing safer. The results of these reviews were discussed with the team members. The dispenser said that the team held the meetings at least once a month and aimed for weekly meetings. She explained that they discussed any incidents and any other issues arising. She said that the pharmacy had a no-blame culture, and they all felt comfortable about making any suggestions to improve safety. She gave an example of a near miss between the 10mg and 20mg strengths of citalopram and showed that they had been segregated on the shelf to help avoid a repetition. She explained how the strengths had come in similar packaging and they had asked the wholesaler for different brands to help address this.

Dispensing errors were recorded on the company intranet by the pharmacist and the form was sent to head office for review. The pharmacist gave an example of a recent error where a medicine had been delivered the wrong patient. He believed that it had happened because the addresses were similar, and the driver had been very busy that day. He said that they were planning to address this by asking the driver to tell them if there were too many to do, and possibly by employing another driver.

The pharmacy received a patient safety letter from head office each month. This included information about dispensing errors elsewhere in the company and how the pharmacy could learn from them. The dispenser confirmed that they discussed the letters during their regular meetings.

The dispenser explained that deliveries to people were done by regular drivers, with a courier delivering on Fridays. An audit trail was kept of the deliveries where the recipients signed to indicate safe receipt, but the book was with the driver during the inspection and unable to be examined. The dispenser said that the driver obtained people's signatures on separate sheets to help protect other people's personal information. Deliveries made by the couriet could be tracked by contacting the courier firm.

A range of standard operating procedures (SOPs) was in place, but several were overdue for review. The dispenser understood that these were under review by head office, and new versions would be put on the intranet when this was completed. Most team members had signed the SOPs to indicate that they had read and understood them. The assistant manager had not yet done this but said that she would and that she was familiar with the procedures.

The dispenser could describe what she would do if a person came in repeatedly to buy a medicine that could be abused. She and other team members could explain what they could and couldn't do if the pharmacist did not turn up in the morning.

The pharmacy did an annual survey for the people who used the pharmacy. The results were displayed on the NHS website and were largely positive, with around 90% of respondents rating the pharmacy overall as good, very good, or excellent. A complaints procedure could not be located but the dispenser said that a copy was available on the intranet. There was no leaflet or sign found in the shop area to explain to people how they could provide feedback or raise a concern. This could make it harder for people to know how to do this. The pharmacy had a 'buzz box' where people could press a button to give on-the-spot feedback, but this was currently charging in the dispensary.

The pharmacy had current indemnity insurance, and this was arranged by head office. The responsible pharmacist (RP) log largely complied, but there were a few gaps where the RP had not signed out. This could make it harder for the pharmacy to show who the pharmacist was at a specific time if there was a query. The correct RP notice was displayed. Private prescription and emergency supply records seen were in order. The controlled drug (CD) registers examined complied with requirements. The CD running balances were generally checked when dispensed or otherwise at least monthly. But the liquid methadone balance had not received a recorded check since February 2019. The pharmacist said that he would ensure the checks were done more regularly in the future. Specials records seen contained all the required information.

At the start of the inspection there were some baskets of dispensed medicines on the counter, and people's personal details could be seen on these. The baskets were immediately moved by the dispenser when this was highlighted and put on the floor behind the counter. She agreed that this was not an ideal place and said that they would find more space to store them elsewhere. She said that they would not keep the baskets on the counter in the future and informed the team of this during the inspection. Confidential waste was generally placed into a designated sack for secure offsite disposal. But one label containing someone's personal information was found in the general waste bin. Team members were distressed to see it, and it was immediately removed. Computer terminal screens were turned away from the public, and access to the computers was password protected. Staff had individual smartcards to access the NHS electronic systems.

Team members had read and signed the safeguarding policy, and the dispenser was able to describe what she would do if she had any concerns. The pharmacist confirmed that he had completed the level 2 safeguarding course and was also able to explain what he would do if concerned. He had contact details for the local safeguarding agencies.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough team members to provide its services. But they do not always start the required accredited training course in a timely manner. This could increase the risk that they do not have the skills and knowledge they need to provide the services safely. They are encouraged to do ongoing training to keep their learning up to date. And they can raise concerns or make suggestions to help make the services safer.

Inspector's evidence

At the time of the inspection there was a pharmacist, two trainee dispensers, a dispenser (who was also the assistant manager), and a work experience student. There was also a member of relief staff who was working on the medicines counter. He said that he had started doing this in around Summer 2015 and had started working in the dispensary around two months ago. He worked on an occasional basis in several pharmacies in the chain but had not yet been registered on the required accredited training course.

The pharmacy also employed a pharmacy apprentice and a medicines counter assistant. Team members were up to date with dispensing and appeared to be managing their workload well. They said that they received support from other stores where possible to help cover holidays and sickness. A second pharmacist worked at the pharmacy when the anticoagulant clinic was running.

The pharmacist felt able to comply with his own professional and legal obligations. He gave an example of a person who had been prescribed standard-release nitrofurantoin twice a day, and this was queried with the prescriber and changed to the modified-release version.

The pharmacist confirmed that he had completed training for the anticoagulant service. He said that he had completed a peer review with another anticoagulant pharmacist, and as a result they had identified a potential issue regarding people’s ongoing care. For example, people who were given their medicines by a nurse potentially didn’t receive it if the nurse thought they were in hospital. He said that they now knew to query with the person’s carer how they would be taking the medicines to help prevent this happening.

Team members could access ongoing training using the online training academy provided by the company. They reported being up to date with their training, but it was sometimes hard to get time during work to complete it. Team member’s progress through the training packages was monitored by head office, and there were certificates awarded for the various levels they achieved.

Team members felt comfortable about raising any concerns and said that they could also raise any issues or make suggestions for improvements in the regular meetings. The pharmacy had a whistleblowing policy. Team members had targets around the level of business and services, but they did not feel under any undue pressure and said that they provided the services for the benefit of people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are secure and largely suitable for the pharmacy's services. People can have a conversation with a pharmacist in a private area.

Inspector's evidence

The pharmacy was generally clean and tidy. There was a large amount of workspace for dispensing; this was a little cluttered in areas but there was still sufficient space for staff to safely dispense medicines. Lighting throughout was good. Assembly of compliance packs was done in one area of the dispensary, with enough space to work on all four packs at a time.

The room temperature was suitable for the storage of medicines and was maintained with air conditioning. Staff had access to handwashing facilities and there were cleaning products available. The pharmacy had two consultation rooms; both allowed a conversation to take place inside which would not be overheard. Both were unlocked at the start of the inspection and the pharmacist said that they would be kept locked when not in use in the future. The pharmacy premises were kept secure overnight.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy largely manages its services well and provides them safely. It manages its medicines appropriately to make sure that they are safe for people to use. And it takes the right action in response to any safety alerts.

Inspector's evidence

The pharmacy had step-free access from outside. There was enough space inside to allow people with wheelchairs or pushchairs to manoeuvre. The seating area was away from the counter to help prevent people overhearing other people's conversations. The pharmacy computers could print large print labels as required to assist people with visual problems. The pharmacist said that they offered the anticoagulant service remotely to people who were housebound so that they were able to access the service.

Colour-coded baskets were used during the dispensing process to help avoid people's medicines becoming mixed up. There was a clear workflow through the pharmacy. Dispensed multi-compartment compliance packs examined were labelled with a description of the tablets and capsules to help people identify their medicines. Patient information leaflets were routinely supplied. The pharmacist initialled the labels when they had checked the packs, but the dispenser didn't always do this. This could make it harder for the pharmacy to show who had done this task if there was a query. People who needed the packs were referred to the pharmacy by the Lewisham Integrated Medicines Optimisation Service (LIMOS). And they could also refer people who just needed an administration chart to help them take their medicines. People using the service were monitored on an ongoing basis by LIMOS to see if they were able to take their medicines properly. The dispenser showed how they recorded changes in medicines or conversations with the prescriber on the patient medication record system. The examples seen were clear and comprehensive.

Team members were aware of the additional information about pregnancy prevention to be provided to people taking valproate who were in the at-risk group. They said that they didn't currently have any people in this group. The additional literature such as cards and stickers could not be found, and the dispenser said that they would order more in. Stickers were used to highlight dispensed prescriptions that needed additional care, such as CDs, medicines for children, and fridge lines. The team members were aware of the higher-risk medicines such as methotrexate or lithium, but the pharmacist accepted that they did not always highlight these prescriptions if the person had taken them before. He said that he would review this when the new SOPs came out.

A range of patient group directions were examined, and they were in date with signed copies available in paper format or electronically. The pharmacist gave an example of a person he had done a Medicines Use Review with. The person was taking metformin and had been experiencing bloating and diarrhoea. He advised the person's GP to switch to the modified release version and the person reported that their symptoms had improved.

Medicines were obtained from licenced wholesale dealers and specials suppliers. The dispenser said that the pharmacy had a wholesale dealer's licence. Medicines were stored in an orderly manner on the shelves. Team members confirmed that they regularly date-checked the stock, but they were unable to find the recent records due to a reorganisation of paperwork. There were no date-expired medicines

found on the shelves sampled. Medicines for destruction were segregated from stock and placed into designated bins or sacks.

CDs were generally kept securely. Medicines that needed cold storage were stored in two fridges; one was used for vaccinations and the second for other stock. The temperatures were monitored daily and this was supported by records. Records examined were within the appropriate range. The dispenser showed how they received drug alerts and recalls via the intranet and described a recent one for paracetamol. A confirmation that action had been taken was recorded on the intranet and this was accessible if there were future queries.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services and generally maintains it properly.

Inspector's evidence

Suitable measuring cylinders were available, and there were separate ones for liquid methadone to help avoid cross-contamination.

The pharmacist calibrated the measuring equipment used in the anticoagulant service with in-house and external control solutions and could demonstrate this with records. There were two blood pressure machines. The pharmacist said that one was around a year old and the other was older. He said that they would record when they started using the machines in the future, so that it was clearer if they were still capable of giving accurate readings.

Up-to-date reference sources were available online. There was an anaphylaxis kit available for use with the vaccination services. The phone was cordless and could be moved to a more private area in the pharmacy to help protect people's personal information. The fax machine was in the dispensary and away from the public area.

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.