General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 7 Market Square, WESTERHAM, Kent, TN16 1AN

Pharmacy reference: 1033031

Type of pharmacy: Community

Date of inspection: 13/05/2021

Pharmacy context

The pharmacy is located on a main road in the centre of Westerham. The people who use the pharmacy are mainly older people. The pharmacy receives most its prescriptions electronically and it provides a range of services, including the New Medicine Service. It also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. The inspection was carried out during the Covid-19 pandemic.

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	The pharmacy records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer and reduce any future risk.
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 identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. Team members understand their role in protecting vulnerable people. And people who use the pharmacy are able to provide feedback about the services. The pharmacy largely keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. And it largely protects people's personal information.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. These included documented, up-to-date standard operating procedures (SOPs), and reporting and reviewing of dispensing mistakes. Team members had signed to show that they had read, understood and agreed to follow the SOPs. And the pharmacy had carried out workplace risk assessments in relation to Covid-19. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And the outcomes from the reviews were discussed openly during the regular team meetings. Prednisolone was kept in separate baskets in a different area from other medicines as there had been several near misses while selecting these medicines. This had helped to minimise the number of mistakes. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong type of medicine had been supplied to a person. The error had been discussed with the team members and was likely due to the similar names of the medicines. The pharmacy regularly received a newsletter from the pharmacy's head office. It highlighted potential patient safety issues and learning points from other pharmacies in the group.

There was ample clear workspace and separate areas for dispensing and checking. An organised workflow helped staff prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The dispenser knew that she should not carry out any dispensing tasks if there was no responsible pharmacist (RP). And she knew that she should not sell any pharmacy-only medicines or hand out dispensed items until the pharmacist had turned up.

The pharmacy had current professional indemnity and public liability insurance. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. The nature of the emergency was routinely recorded when a supply of a prescription only medicine was supplied in an emergency without a prescription. This made it easier for the pharmacy to show why the medicine was supplied if there was a query. Controlled drug (CD) registers examined were filled in correctly, and the

CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. The pharmacy team members had completed training about how to manage people's information. But some people's personal details were potentially visible on some bagged items waiting collection. The pharmacist said that he would review the area where these were kept and ensure that people's details were protected from the view of people using the pharmacy.

The pharmacy had carried out yearly patient satisfaction surveys, but because of the pandemic it had not carried one out for 2020 to 2021. The results from the 2019 to 2020 survey were available on the NHS website. The pharmacy scored highly in all areas of the survey. The complaints procedure was available for team members to follow if needed. The pharmacist said that there had not been any recent complaints. The pharmacist had received a mention in the pharmacy's recent newsletter after he had received a letter of thanks from someone.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (level 2) training about protecting vulnerable people. And other team members had completed some safeguarding training, either provided by the pharmacy or another organisation. One of the dispensers described potential signs that might indicate a safeguarding concern and said that she would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy. An example was given of action the pharmacy had taken in response to a safeguarding concern. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with ongoing training to support their learning needs and maintain their knowledge and skills. They are able to raise any concerns or make suggestions and have regular meetings. And the team regularly discusses adverse incidents and uses these to learn and improve. The team members can take professional decisions to ensure people taking medicines are safe, and these are not affected by the pharmacy's targets.

Inspector's evidence

There was one regular full-time pharmacist, two trained dispensers and one trained MCA working during the inspection. Team members had completed an accredited course for their role and the two dispensers had been enrolled on the NVQ level 3 pharmacy course. One had almost completed the course and the other had not long started it. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised and the workload was well managed. Team members had either received two Covid-19 vaccinations, or they were due to have the second dose soon.

The team members appeared confident when speaking with people. The dispenser was aware of the restrictions on sales of pseudoephedrine-containing products. And she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Team members used effective questioning techniques were used to establish whether the medicines were suitable for the person.

The pharmacy held informal team meetings to share learning and pass on information from the pharmacy's head office. And team members had access to online training provided by the pharmacy's head office. They were allowed time during the day when the pharmacy was quieter to undertake training. But this had been limited recently due to the increased workload during the pandemic. The team could also access the training modules in their own time. They also had regular reviews of any dispensing mistakes and discussed these openly in the team. Team members had set tasks to complete each day, and they ensured that messages were left for other team members if they were not working the following day.

The pharmacy had a whistleblowing policy and team members felt comfortable about making suggesting changes in the pharmacy. A medicine had been moved to a different area, following a suggestion from a team member. This had meant that the medicine was kept with the specific group and not in alphabetical order with other medicines. And it had made it easier for team members to find. Team members had ongoing informal appraisals and a yearly formal performance review

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And he felt able to take professional decisions. He explained that he needed to undertake the face-to-face flu training before he could provide the service next season. Targets were set for the New Medicine Service and the pharmacy was encouraged to meet the targets. But the pharmacist said that the pharmacy carried out the services for the benefit of people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean and tidy throughout; this presented a professional image. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available and the room temperature was suitable for storing medicines.

Screens had been installed at the medicines counter and at the dispensary to help minimise the spread of infection. Team members worked in separate areas where possible and this helped them to maintain a suitable distance from each other.

The pharmacy's consultation room was accessible to wheelchair users and it could be accessed from the dispensary or the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the room could not be heard from the shop area. Toilet facilities were clean and there were separate hand washing facilities. This area was not used for storing pharmacy items.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. The pharmacy highlights prescriptions for higher-risk medicines so that there is an opportunity to speak with people when they collect these medicines. And the pharmacy dispenses medicines into multi-compartment compliance packs safely.

Inspector's evidence

Services and opening times were clearly advertised and a variety of health information leaflets was available. Team members had a clear view of the main entrance from the medicines counter and dispensary, and they could help people into the premises where needed. There were two steps up to the pharmacy from street level. A doorbell was available at the entrance so that people who could not access the pharmacy could alert the team. One door opened automatically when the sensor was triggered and the other door could be opened by a team members when needed. The pharmacist said that usually needed to be opened to allow access to people with pushchairs. The pharmacist explained that people were sometimes served at the entrance to the pharmacy or they were signposted to another pharmacy which could accommodate their needs better. The pharmacy also offered a delivery service to those who needed it.

Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were also highlighted. This helped to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items and CDs were checked with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people. And he had spoken with those in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). And notes had been added to their medication record that they had confirmed that they were on the PPP. The pharmacy had the relevant patient information leaflets and warning cards available. But a notice displayed in front of these medicines directed staff to supply the cards to women aged 12 to 49. The inspector directed the pharmacist to read the information provided by the manufacturer which directed pharmacies to supply them to all females who were taking valproate, regardless of their age. The pharmacist said that he would brief the team and ensure that this happened in the future.

Stock was stored in a well organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging.

Part-dispensed prescriptions were checked regularly. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. There were very few part-dispensed prescriptions at the pharmacy. A copy of the prescription was kept at the pharmacy until the medicines were dispensed, but not always until they were collected. This could make it harder for team

members to refer to the original prescription if there was a query. The pharmacist said that uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their items after around three months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible

People who wanted their medicines in multi-compartment compliance packs were assessed by their GP to show that they needed the packs. The pharmacy ordered prescriptions in advance for people receiving their medicines in these packs so that any issues could be addressed before people needed their medicines. People usually contacted the pharmacy to order 'when required' medicines when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied.

CDs were stored in accordance with legal requirements. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. The driver checked a person's details before leaving items with them. And they wore personal protective equipment (PPE) while making the deliveries. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

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

Suitable equipment for measuring liquids was available. Separate liquid measures were marked for methadone use only. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The phone in the dispensary was portable so it could be taken to a more private area where needed. The weighing scales were in good working order. The pharmacy had plenty of PPE. Team members wore masks where needed and used hand sanitiser. And they had twice weekly lateral flow tests to help minimise the spread of infection.

Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

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.