General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 416 Norwich Road, IPSWICH, Suffolk, IP1 5DX

Pharmacy reference: 1037185

Type of pharmacy: Community

Date of inspection: 15/11/2022

Pharmacy context

The pharmacy is located on a busy street in a largely residential area. It provides a range of services, including the New Medicine Service, flu vaccines and blood pressure checks. 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. And it provides substance misuse medications to some people. The pharmacy receives most of its prescriptions electronically.

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

Overall, the pharmacy adequately 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 learns from mistakes that happen during the dispensing process to help make its services safer. It mostly keeps the records it needs to keep by law, to show that its medicines are supplied safely and legally. Team members understand their role in protecting vulnerable people. And people can feedback about the pharmacy's services. The pharmacy largely protects people's personal information.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. 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. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded and reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The dispenser said that she was not aware of any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. And errors of this type were recorded on a designated form and a root cause analysis was undertaken.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription. And team members marked 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. One of the dispensers said that the pharmacy would remain closed if the pharmacist had not turned up in the morning. He knew which tasks he should not undertake until there was a responsible pharmacist (RP) signed in. And other dispenser knew that she should not sell any pharmacy-only medicines or hand out any dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. And there were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly. The CD running balances were checked at regular intervals and liquid overage was recorded in the registers. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly. The private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. And the nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to find these details if there was a future query.

Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. Bagged items waiting collection were kept behind the medicines counter. And some people's personal information on the bags could potentially be read by people using the pharmacy. One of the dispensers turned the bags around so that the information was not on show.

One of the dispensers said that some people who had used the pharmacy were sent a text message asking for feedback about the service they had received. The complaints procedure was available for team members to follow if needed and details about how people could complain were available on the pharmacy's website. The dispenser said that there had not been any recent complaints.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had received some safeguarding training provided by the pharmacy. One of the dispensers described potential signs that might indicate a safeguarding concern and said that they would refer any concerns to the pharmacist. Team members were not aware of any safeguarding concerns at the pharmacy.

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 some ongoing training to support their learning needs and maintain their knowledge and skills. They can discuss any concerns openly and have regular team meetings. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one locum pharmacist and two trained dispensers working in the pharmacy on the day of the inspection. The dispensers had both completed an accredited course for their role. The pharmacy had been using a relief pharmacist recently, but they were on leave. The team worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed.

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

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And he said that he felt able to take professional decisions. He explained that he had recently completed some training about inhaler techniques and blood pressure checks. And he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The dispenser said that team members were provided with ongoing training on a regular basis. And this was checked by the pharmacy's regional manager. He explained that he could sometimes complete the training in the pharmacy during quieter times or he could access the training modules at home and complete these in his own time.

Team members felt comfortable about discussing any issues with the pharmacist. And the dispenser said that there were regular informal team meetings to discuss any issues or tasks that needed completing. He said that team members had yearly appraisals and performance reviews. Targets were set for the New Medicine Service. The pharmacist said that he did not feel under pressure to meet the targets and he carried out the service for the benefit of the people using it.

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 bright, clean, and tidy throughout and it was secured from unauthorised access. Air conditioning was available and the room temperature was suitable for storing medicines. There were some pharmacy-only medicines on shelves to the side of the medicines counter and these were potentially accessible to people using the pharmacy. An extendable barrier was available but it was not being used at the start of the inspection. One of the dispensers moved it during the inspection to ensure that these medicines were not available for self-selection.

There was seating available in the shop area for people to use while they waited. The consultation room was accessible to wheelchair users and was located in the shop area. It was suitably equipped and well-screened. And conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. And it responds appropriately to drug alerts and product recalls.

Inspector's evidence

The pharmacy's services and opening times were clearly advertised and a variety of health information leaflets was available. And there was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed.

The pharmacist said that prescriptions for higher-risk medicines were highlighted. He explained how he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of the results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. One of the dispensers said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist was aware that some people might need to be on a PPP and he would refer them to their GP if they were not on one. The pharmacy had the relevant patient information leaflets, warning stickers and warning cards available.

CDs were stored in accordance with legal requirements and they were kept secure. 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. Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Short-dated items were not marked and there were several medicines found with dispensing stock which had expired. The dispenser said that he would ensure that expiry dates were checked more frequently in future and in line with the pharmacy's SOP. Some medicines found with dispensing stock were not kept in their original packaging. And the packs they were in did not include all the required information on the container such as batch numbers or expiry dates. Not keeping the medicines in appropriately labelled containers could make it harder for the pharmacy to date-check the stock properly or respond to safety alerts appropriately.

Part-dispensed prescriptions were checked frequently. And '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. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. One of the dispensers said that the prescriptions were usually checked each month. And people were sent a text message if they had not collected their medicines after around two months.

People had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs to show that they needed them. Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. 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.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. And the delivery driver left a note at the person's address asking them to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Fridge temperatures were checked daily and the 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. Drug alerts and recalls were received from the pharmacy's head office. One of the dispensers explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference which 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 largely 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 some equipment for measuring liquids available but not for volumes less than five millilitres. And some of the measures were plastic. The dispensers said that they would order suitable measures and not use plastic ones in future. Triangle tablet counters were available and clean and a separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. The pharmacy had access to up-to-date reference sources.

The blood pressure monitors had been in use for less than a year. And these would be replaced in line with the manufacturer's guidance. The weighing scales were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

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.