General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 11 - 12 Orion Parade, HASSOCKS, West Sussex, BN6 8QA

Pharmacy reference: 1037330

Type of pharmacy: Community

Date of inspection: 12/01/2023

Pharmacy context

This is an NHS community pharmacy on a row of shops in Hassocks. The pharmacy opens six days a week. It sells over-the-counter medicines and a few health and beauty products. It dispenses people's prescriptions. And it delivers medicines to people who can't attend its premises in person. The pharmacy provides multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. Its team can check a person's blood pressure. And people can get their flu vaccination (jab) at the pharmacy too.

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

The pharmacy appropriately manages its risks. It has written instructions to help its team members work safely. It mostly keeps the records it needs to by law. It has appropriate insurance to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy talk to each other about the mistakes they make to try and stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They keep people's private information safe. And they understand their role in protecting people who may be at risk.

Inspector's evidence

The pharmacy had considered the risks of coronavirus. And, as a result, it put some plastic screens on its counters to try and stop the spread of the virus. Members of the pharmacy team had the personal protective equipment they needed. And hand sanitising gel was available for people to use. The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. And these were reviewed by a team at the pharmacy's head office. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to say they understood them and would follow them. The team members responsible for making up people's prescriptions kept the dispensing and checking workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP) who also initialled the dispensing label. The pharmacy had processes to deal with dispensing mistakes that were found before reaching a person (near misses) and those which hadn't (dispensing errors). Team members generally highlighted and separated medicines involved in dispensing errors or were similar in some way, such as medicines that looked alike and whose names sounded alike, to help reduce the risks of the wrong product being picked. They usually discussed and recorded the mistakes they made to learn from them and to reduce the chances of them happening again. And, for example, they strengthened their dispensing procedures to make sure people got the right number of tablets. But they haven't reviewed the near misses they made or the lessons they learnt from them for a while. So, they may have missed opportunities to spot patterns or trends in the mistakes they made.

The pharmacy had a notice that told people who the RP was at that time. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. Some people have shared their experiences of using the pharmacy and its services online. The pharmacy had a complaints procedure. It had a notice which asked people to share their views and suggestions about how the pharmacy could do things better. And, for example, the pharmacy team tried to keep a person's preferred make of a prescription medicine in stock when it was asked to do so. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had an electronic controlled drug (CD) register which was generally in order. And the stock levels recorded in the CD register were checked regularly. The pharmacy kept records to show which pharmacist was the RP and when. But occasionally a

pharmacist forgot to record when they stopped being the RP. The pharmacy kept an appropriate record for the supplies of the unlicensed medicinal products it made. And it recorded the emergency supplies it made and the private prescriptions it supplied on its computer. But the prescriber details were sometimes incomplete or incorrect in the private prescription records.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy displayed a notice that told people how it gathered, used and shared their personal information. It had arrangements to make sure confidential information was stored and disposed of securely. And its team needed to sign a confidentiality agreement and complete training on data security. The pharmacy had a safeguarding procedure. Members of the pharmacy team knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough people in its team to deliver safe and effective care. But team members are sometimes so busy they struggle to do all the things they are asked to do. Members of the pharmacy team do the right training for their roles. They work well together and use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. And they know how to raise a concern if they have one.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist store manager (the RP), a part-time pharmacist, a full-time trainee pharmacist, a full-time accuracy checking pharmacy technician (ACPT), a part-time trainee pharmacy technician, a full-time medicines counter assistant (MCA) and two part-time MCAs. The RP, the trainee pharmacist, the trainee pharmacy technician, a relief dispensing assistant and two MCAs were working at the time of the inspection. The pharmacy relied upon its team, regional support staff and team members from other branches to cover absences. And it had a vacancy for a dispensing assistant. Members of the pharmacy team sometimes struggled to do all the things they were asked to do as they didn't always have enough time to do them as they were so busy. And they started early in the morning from time to time to catch up with the work they needed to do. But they worked well together and helped each other to serve people and dispense prescriptions safely. They were nearly up to date with their workload. And they didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. The RP led by example. And they supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. And they explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist.

The trainee pharmacist had completed some induction training. They confirmed that the RP was their designated supervisor. And there was a training plan in place for their foundation training year. The trainee pharmacist felt supported. They were encouraged to attend regular training events with other trainee pharmacists. They had regular discussions and reviews with their supervisor. And they received time to study. People working at the pharmacy needed to complete mandatory training during their employment. They were required to do accredited training relevant to their roles after completing a probationary period. They discussed their performance and development needs with their manager when they could. They could share learning from the mistakes they made and were usually kept up to date during one-to-one discussions or ad hoc meetings. And they were encouraged to complete training when they could. Members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback led to the procedure to process surgical products being strengthened.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides an adequate environment to deliver it services from. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was air-conditioned, bright, clean, secure and appropriately presented. The pharmacy generally had the workbench and storage space it needed for its workload. And a prescription collection kiosk (kiosk) was installed in an area of the building that wasn't part of the registered premises. The pharmacy had a consulting room for the services it offered and if people needed to speak to a team member in private. The consulting room was locked when it wasn't being used. So, its contents were kept secure. And people's conversations in it couldn't be overheard outside of it. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water too. Members of the pharmacy team were responsible for keeping the premises clean and tidy. And they wiped and disinfected the surfaces they and other people touched as often as they could.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are generally safe and effective. And it keeps appropriate records for its vaccination service to show that it has given the right vaccine to the right person. But it doesn't always give people the information they need to take their medicines safely with their compliance packs. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team are friendly and helpful. They dispose of people's unwanted medicines properly. And they usually carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy had an automated door. And its entrance was level with the outside pavement. These things made it easier for people to enter the building. People could ask to use the kiosk to collect their medication at a time convenient to them. But the pharmacy team needed to assess the suitability of each request. And, for example, newly prescribed medication, bulky prescriptions and medicines requiring secure storage or refrigeration couldn't be collected from the kiosk. The pharmacy notified people and provided them with a code when their prescription was ready to collect from the kiosk. People were reminded a few days later if they hadn't collected their prescription. And their prescription was generally removed from the kiosk if it wasn't collected within a week. The pharmacy had some notices that told people about the services it delivered. And it had a seating area for people to use if they wanted to wait. The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. The pharmacy dealt with CPCS referrals. People benefited from the CPCS as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses. Members of the pharmacy team were friendly and helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. And it kept a written record to show when it delivered someone their medicines. But an electronic delivery record was soon to be introduced so it would have a better audit trail to show the right medicine had been delivered to the right person. The pharmacy provided winter flu jabs. People eligible for a flu jab were asked to book an appointment when demand was at its greatest. This helped the pharmacy better manage its workload and make sure it had the people it needed to deliver the service safely. The vaccinators administered the flu jab under the relevant national protocol. The RP confirmed that a registered healthcare professional completed the stages of the national protocol they needed to. The national protocol afforded the pharmacy some flexibility in arranging vaccinators to be on-site to deliver the service if needed. But the appropriate patient group direction could be used if the vaccination service was solely provided by a pharmacist. The pharmacy had the anaphylaxis resources it needed for its vaccination service. And the vaccinators were appropriately trained to vaccinate people. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacist checked that the correct flu jab had been selected before a vaccinator administered it. But an appropriately trained team member wasn't generally asked to do this before a pharmacist administered a flu jab as they weren't required to do so. The pharmacy used a disposable and tamper-evident system for people who received

their medicines in compliance packs. And most of these were assembled off-site at another pharmacy (hub pharmacy). But people could choose not to have their prescriptions dispensed at the hub pharmacy. And the pharmacy team assembled these. Prescriptions dispensed at the hub pharmacy were returned to the pharmacy for people to collect or to be delivered. The pharmacy team checked if a medicine was suitable to be re-packaged. And the pharmacist assessed whether a person needed a compliance pack. The pharmacy usually kept an audit trail of the people involved in the assembly of each compliance pack. And a brief description or image of the medication contained within each compliance pack was provided. But patient information leaflets weren't routinely supplied, and people were asked to download these instead. And cautionary and advisory warnings about the medicines contained within the compliance packs, which were assembled by the pharmacy team, weren't included on the backing sheets. So, people didn't always have the information they needed to take their medicines safely. The pharmacy team needed to add medication to a few off-site-assembled compliance packs as the hub pharmacy didn't have any stock of some medicines at the time the compliance pack was assembled. The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. The pharmacy used reminder stickers to alert its team when these items needed to be added or if extra counselling was needed. And assembled CD prescriptions awaiting collection were generally marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully. Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And the pharmacy had the resources it needed when its team dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. And it kept its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team marked products which were soon to expire. They were required to check the expiry dates of medicines at regular intervals and record when they did these. But the last recorded date check was a while back. The pharmacy team gave an assurance that it would review and strengthen its date checking process. The pharmacy stored its stock, which needed to be refrigerated, at the appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy team recorded the destruction of the CDs that people returned to it. And out-of-date CDs and patient-returned CDs were kept separate from in-date stock. The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in an appropriate pharmaceutical waste bin. The pharmacy had a process in place for dealing with alerts and recalls about medicines and medical devices. But while the pharmacy team reviewed the alerts or recalls it received, it didn't always record the actions it took following the receipt of a drug alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. And it uses its equipment to help protect people's personal information.

Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had three medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded each refrigerator's maximum and minimum temperatures. The pharmacy team could check a person's BP when asked. And the monitor it used to do this was recently changed. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy put its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were stored securely when they weren't working.

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.