

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 127 Bellenden Road,
LONDON, SE15 4QY

Pharmacy reference: 1040864

Type of pharmacy: Community

Date of inspection: 28/05/2019

Pharmacy context

This is a community pharmacy situated on a main road. It serves a diverse local community. The pharmacy dispenses NHS prescriptions. It also supplies medicines in multi-compartment compliance trays to help people take their medicines safely. And it offers other services including a delivery service, flu vaccinations and Medicine Use Reviews.

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	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 identifies and manages most of the risks associated with its services. The pharmacy's team members record their mistakes and review these in detail. The pharmacy generally keeps the records it is required to by law and team members understand their role in protecting vulnerable people.

Inspector's evidence

Prescriptions were mostly received via the electronic prescription system. The system was checked throughout the day and prescriptions were dispensed in advance. The prescriptions were placed in labelled baskets according to the number of items prescribed; those with less than three items were placed in one basket and those with more than three items were placed in another. The team prioritised the longer prescriptions to help reduce waiting times and pressure.

Prescriptions for Schedule 2 and 3 controlled drugs (CDs) were stored in a separate basket. These were dispensed when the person presented at the pharmacy. Baskets were used throughout the dispensing process. This helped prevent transfer between people's prescriptions. A double-check was obtained most of the time. This helped reduce the chance of errors. The trainee accuracy-checking technician (ACT) conducted accuracy checks on assembled multi-compartment compliance trays in addition to the pharmacist. The pharmacist had set up a new 'patient safety' folder to organise and store near miss records, monthly and annual patient safety reports, prescription interventions, drug alerts, and monthly meeting agendas.

Near misses were seen to be recorded frequently. A paper log was filled by all team members and these were then copied onto an online system, to be shared with the superintendent pharmacist (SI). The pharmacist said that documenting near misses enabled the team to identify what they were not doing correctly, any trends and what could be done to minimise errors. The near miss log was reviewed with the team during the monthly team meetings and a patient safety review form was filled in. These reviews were seen to be done in detail. The team had been briefed to inform people of the scheduling change for gabapentin and pregabalin as it may affect the quantities they were prescribed. Members of the team were also reminded to separate electronic CD prescriptions when printing these out in order for them to be processed correctly and in a timely manner.

There were only two other members of staff when the current pharmacist started in February 2019, and the team had been struggling with the workload. She had therefore raised concerns with the regional manager and regional support manager who agreed to send a trainee dispenser from another branch for two days week. The pharmacist had noticed a decrease in near misses since then.

Some higher-risk medicines, for example, digoxin, warfarin, lithium and methotrexate, were highlighted using shelf-edge labels. An alert sticker was also placed to remind members of the team of the change in scheduling of pregabalin and gabapentin. The pharmacist said that dispensing errors would be documented on an online form and sent to head office. She said that there had not been any incidents since she had started working at the branch.

Up-to-date standard operating procedures (SOPs) were in place to support the safe and effective provision of services. Members of the pharmacy team had signed the relevant SOPs to confirm they had understood them. In date indemnity insurance was in place. The responsible pharmacist (RP) sign was clearly displayed and samples of the RP record examined were complete.

Emergency supply records were held electronically; the nature of the emergency was not recorded for a number of entries checked. So it may not be possible to know why a supply was made, in case of a query. The private prescription record was generally in order. Private prescriptions were conveniently stored in alphabetical order once the medication was collected. 'Specials' records for unlicensed medicines were filled out in line with MHRA requirements.

CDs were stored in an organised manner; in-date stock was stored separately from expired CDs. CD running balance audits were generally conducted weekly; a random stock check of a CD agreed with the recorded balance. A destruction register was available to document CDs that people had returned, and these were destroyed promptly.

Feedback from people was sought through an annual survey and a 'buzz box' located at the medicines counter. The pharmacist was observed contacting a local surgery to follow up a repeat prescription which had not been received back. She remained calm and spoke slowly to the person who was agitated and had run out of their medicine. She informed them that the surgery would fax their prescription over to the pharmacy.

Computers were password protected and access to the patient medication record (PMR) system was via individual smartcards. Confidential waste was shredded at the pharmacy. Team members were in the process of reading the updated information governance SOPs and General Data Protection Regulation guidance which had recently been sent to the branch. Copies of the 'your data matters to the NHS' information leaflets were displayed on the medicines counter.

The pharmacist and trainee ACT had completed Level two training on safeguarding vulnerable people from the Centre of Pharmacy Postgraduate Education. Other members of the team had completed the online Day Lewis training module on the subject.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team are under some pressure to manage their workload but are currently coping well. Members of the team are provided with training resources, but they do not always have time set aside to complete them. This may reduce the opportunities they have to help keep their skills and knowledge up to date.

Inspector's evidence

At the time of inspection, there was a regular pharmacist (who was also the pharmacy manager), a trainee ACT, a trainee dispenser, and a trainee medicine counter assistant (MCA). The trainee dispenser was from another branch and covered two days a week at this pharmacy. The pharmacy also employed an MCA who was currently on long-term leave.

Members of the team said that shifts were previously covered by a regular pharmacist, a pre-registration student, the trainee ACT and the trainee MCA. But, since the pre-registration student moved to another branch and the MCA went on long-term leave, a part-time dispenser had been drafted in to cover two days a week, which they felt had not been sufficient at the time. Some members of the team said this had previously affected their workload and had resulted in a back-log of prescriptions to dispense, as well as other tasks, such as date checking, sorting deliveries and following up repeat requests. The pharmacist was observed contacting the GP to query a repeat request which had been ordered one week ago but the team had not followed up in a timely manner. Some members of the team said the insufficient staff cover had led to longer waiting times. However, the team members were currently managing their workload and were now up-to-date with dispensing and other tasks.

The trainee MCA was going to work at another branch for a trial period of one week. The trainee MCA said she had been told by the regional support manager that the other branch was busier and that would provide her with more experience. The trainee dispenser, who was currently only working two days at this branch, would also be working full time for a trial period of one week. The team did not know what would happen following the trial periods.

The trainee MCA described using the WWHAM questioning technique before selling Pharmacy-only medicines (P-medicines). She described refusing to sell a medicine which was liable to abuse to a person frequently requesting it. She said she would not sell P-medicines or hand out dispensed medicines in the absence of the RP.

Protected study time was not provided for team members. The trainee ACT completed her modules at home and she only briefly discussed her progress with her tutor. The trainee MCA mostly completed her modules at home. She discussed her performance with the pharmacist every now and then.

Although training modules were available on the online 'Day Lewis Academy', members of the team said they did not always have time to do these and completed them as and when they could. The trainee ACT had completed a module on children's oral health in January 2019. The trainee MCA said she completed online modules at home.

Targets were set for the team. A member of the team said that a previous pharmacist was removed from the branch and made a relief pharmacist as she had not met the company's targets. And, as a result, the pre-registration student had to move branches. Other current members of the team said that targets were reasonable and did not affect their professional judgement.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is maintained and secured properly and provides an environment that is suitable for its services.

Inspector's evidence

This was a relatively small pharmacy but there was sufficient work and storage space for the services provided. The dispensary was organised, and workbenches were kept clean and tidy; there was a clear workflow in the dispensary. P-medicines were stored securely behind the medicines counter. The retail area was small but well maintained.

A clean sink, with hot and cold running water, was used for the preparation of medicines. The room temperature and lighting were suitable for the provision of pharmacy services. A small, clearly signposted consultation room was available for private conversations and services. The premises were secure.

Principle 4 - Services ✓ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy has some systems in place for making sure that its services are organised. And it generally provides them safely. But people taking some higher-risk medicines might not get all the information they need to take their medicines safely. The pharmacy generally manages medicines well to make sure that they are safe for people to use.

Inspector's evidence

Access into the pharmacy was step-free and there was sufficient space for wheelchairs or pushchairs in the retail area. The pharmacist described using an online translating service or contacting multilingual colleagues at other branches to help with translating. Large font labels were printed for people with poor vision and a delivery service was available for housebound people.

Letters, detailing services available at the pharmacy, had been sent to local GP surgeries. Members of the team described signposting people to other providers if a service was not available at the pharmacy.

Members of the team were observed confirming people's names and dates of birth before requesting their repeat medication. They checked what medication they wanted to order from their GP and provided them with an estimated date of when their medication would be ready for collection before placing the order.

The pharmacist was observed discreetly providing additional information about medicines to people, including how to take them and possible side-effects. Coloured stickers were placed on prescriptions for Schedule 2, 3 and 4 CDs. This helped prevent the supply of these medicines past the valid date on the prescription.

Dispensing audit trails were maintained to help identify team members involved in dispensing and checking prescriptions. Dispensed fridge items, CDs and multi-compartment compliance trays were stored in clear plastic bags. This allowed for an additional check when handing these out to people.

Higher-risk medicines were flagged up on the shelves using shelf-edge labels. 'Pharmacist required' stickers were placed on prescriptions for higher-risk medicines to ensure people were referred back to the pharmacist for additional counselling and advice. The pharmacist said that she checked if people taking these medicines were being monitored, if they experienced any adverse effects and checked if they were aware of signs of toxicity and any dietary advice.

The team had read the valproate guidance. The pharmacist checked if women receiving this medicine were in the 'at-risk' group but was not entirely sure of the age range, which may mean some women in the at-risk group could be missed. She said she would check if women were on the Pregnancy Prevention Programme and provide advice. Information cards and additional warning stickers were not available to hand. The trainee dispenser and trainee ACT did not know to label valproate removed from its original pack and supplied to women in the at-risk group.

A chart was used to keep track of when prescriptions for multi-compartment compliance trays were due, whether the trays were due monthly or weekly, and if they were collected or delivered. The chart was checked daily by the team and repeat prescriptions were ordered one to two weeks in advance. A record of repeat orders was maintained using a diary. Prescriptions were checked against the PMR system and labels were generated. These were handed to the trainee dispenser, alongside the prescriptions. The trainee dispenser generated backing sheets and picked stock against the prescriptions before assembling the trays. The trays were labelled with medicine labels as well as backing sheets, which were annotated with drug descriptions to help people identify their medicines. Patient information leaflets were routinely supplied. The trays were then sealed and placed in a designated area for the pharmacist to check.

Equipment required for the Falsified Medicines Directive (FMD) was available, but the pharmacy's systems had not been updated. The pharmacy team had been told that head office was working on the system but did not know when this would be ready for use.

Stock was obtained from reputable wholesalers and was stored in an organised manner. Expiry date checks were conducted every three months but records for checks conducted in 2018 could not be found. Samples of recent records examined were up-to-date. Short-dated medicine was highlighted with a marker pen; no out-of-date medicines were found at the time of inspection.

The fridge temperatures were checked daily and kept within the required range of 2 to 8 degrees Celsius. Drug alerts and recalls were received electronically, printed out and annotated with action taken. Recent alerts were seen to be actioned in a timely manner.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy generally has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

There were several glass measures for use with methadone liquid as well as two plastic measures for water and other liquids. The pharmacist said that she would order additional glass measures to use instead of the plastic measures. A new blood pressure monitor was in use.

Clean counting triangles were available, including a separate one for cytotoxic medicine. This helped avoid cross-contamination. The fridge was clean and suitable for the storage of medicines. Waste medicine bins and destruction kits were used to dispose of waste medicines and CDs respectively. Members of the team had access to the internet and several reference sources.

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.