General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 6 The Parade, Thorogate, Rawmarsh, ROTHERHAM, South Yorkshire, S62 7HX

Pharmacy reference: 1079093

Type of pharmacy: Community

Date of inspection: 16/09/2024

Pharmacy context

The pharmacy is adjoined to a surgery in the village of Rawmarsh, on the outskirts of Rotherham in South Yorkshire. Its main services are dispensing prescriptions and selling over-the-counter medicines. The pharmacy provides a range of NHS consultation services including the Pharmacy First Service, New Medicine Service, contraception, and blood pressure check services. It also offers a range of private consultation services for common health conditions. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers medicines to people's homes.

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	1.2	Good practice	Pharmacy team members work effectively together to share learning and reduce risk through regularly monitoring how they work. They continually reflect on the mistakes they make during the dispensing process. And they keep their actions under review to help measure their effectiveness.
2. Staff	Standards met	2.2	Good practice	The pharmacy actively encourages its team members to develop their skills through training aligned to the pharmacy services they provide. Its team members clearly demonstrate how they use the knowledge they gain to support them in delivering the pharmacy's services safely.
		2.4	Good practice	The pharmacy demonstrates a clear culture of openness, and honesty through engaging its team members in regular shared learning events which supports them in working together to achieve common goals.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	Pharmacy team members keep effective records of the conversations they have with people to support them in taking their medicines properly. And the team keeps effective records to monitor the safe delivery of the pharmacy’s services.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy acts effectively to identify and manage the risks of providing its services. It keeps people's confidential information safe, and it mostly keeps its records as required by law. Pharmacy team members reduce risk by conducting regular monitoring checks and through sharing learning following the mistakes they make during the dispensing process. They keep these actions under review by engaging in regular and comprehensive patient safety reviews. Pharmacy team members know how to manage feedback and concerns. And they understand how to act to help safeguard vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. The superintendent pharmacist's team periodically reviewed these. Team members received notification of new and updated SOPs and were required to complete learning for these SOPs within a specific time frame which was monitored. A sample of training records found most team members were up to date with this learning with the exception of those who were either on leave or who had recently been on leave. Team members were knowledgeable about the tasks they completed, and they were observed working in accordance with the pharmacy's SOPs. One team member undertook accuracy checking tasks. They explained how they worked in this role under the supervision of a regular pharmacist and discussed how the pharmacist physically marked prescriptions to indicate they had clinically checked a prescription prior to them completing the final accuracy check of a medicine.

The pharmacy had a process for reporting and learning from the mistakes team members made and identified during the dispensing process, known as near misses. Team members were keen to show how they managed risk throughout the dispensing process by introducing a series of checks for medicines to reduce a mistake being made. For example, the team displayed clear signs on shelf edges with tall-man lettering to prompt additional checks when picking medicines. And whenever possible three people completed different stages of the dispensing process to support independent checks throughout the process. The pharmacy had a procedure for learning from mistakes made and identified following the supply of a medicine to a person, known as a dispensing incident. The responsible pharmacist (RP) on duty was a locum pharmacist. They explained clearly how they would engage with the team to report a dispensing incident. Information within incident reports was comprehensive and clearly identified the root cause of a mistake and the actions taken to reduce the risk of a similar mistake occurring. A random check of these actions found them to be completed. The team was committed to reducing risk through identifying trends in mistakes and discussing the actions required to reduce risk during formal patient safety reviews. Notes of these reviews showed comprehensive learning and ongoing monitoring of the actions the team had taken to reduce risk. The notes looked at factors outside of the team's direct control including recent staffing pressures. And the importance of team members taking particular care during periods of pressure. The team also used the patient safety review process to share learning from national, regional, and company-led safety briefings to support it in identifying and managing risk at a local level.

The pharmacy completed risk assessments ahead of new services commencing. The risk assessments seen clearly showed the mitigations implemented to manage the identified risks. The pharmacy team

also engaged in some ongoing audits to help ensure it was operating safely and effectively and to monitor the way it provided its services. A regular pharmacist, who was not on duty took the opportunity to provide information shortly after the inspection of the pharmacy's adherence to ongoing audits which reviewed the pharmacy's practice in line with the company's quality criteria scheme which covered a different topic each month. For example, monitoring compliance with the pharmacy's process with the valproate pregnancy prevention programme (PPP).

The pharmacy advertised how people could provide feedback about its services. Team members were confident in managing feedback and they knew how to escalate feedback if required. The team demonstrated how it reflected on feedback and used it to inform the safety of the services it provided. For example, it had implemented a diary to support it in monitoring the supply of medicines in multi-compartment compliance packs to vulnerable people. A team member discussed how this supported the team in managing any queries and helped the team to recognise any concerns that required sharing with prescribers. Pharmacy team members engaged in mandatory safeguarding learning to help keep vulnerable people safe from harm. They had contact information for local safeguarding teams. And they provided examples of how they shared concerns with prescribers and key workers when they had identified potential concerns. A team member discussed the action they would take should a person attend the pharmacy requiring access to a safe space.

Team members completed mandatory learning on data security and confidentiality requirements. It mostly stored personal identifiable information in staff-only areas of the pharmacy. The pharmacy disposed of its confidential waste securely. It had current professional indemnity insurance. The RP notice displayed contained the correct details of the RP on duty. A sample of pharmacy records found most records were made in accordance with legal and regulatory requirements. There were some minor incomplete entries within the RP record, as some entries did not show what time the RP had ceased their role. Accurate details of the prescriber were not always recorded within the private prescription register. And a recent record for the supply of a human medicine under the veterinary cascade showed it had not been labelled as required. The pharmacy held its controlled drug (CD) register electronically. It completed frequent full balance audits of physical stock against the running balances in the register. Physical balance checks of CDs conducted during the inspection matched the running balances in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a dedicated team of people with the appropriate knowledge and skills to safely deliver its services. It supports its team members through structured reviews which focus on developing its team members roles. Pharmacy team members engage in continuous learning. And they clearly show how they use the knowledge they gain from this learning when providing pharmacy services. They take continual opportunities to share learning together as a team by engaging in meaningful reviews about risk and patient safety. And they understand how to provide feedback at work.

Inspector's evidence

The RP on duty was a locum pharmacist working their first shift at the pharmacy. They were supported by the accuracy checking dispensing assistant, a dispenser, and a trainee dispenser. The pharmacy also employed two regular part-time pharmacists, three other dispensers and a delivery driver. One pharmacist was on annual leave and the other on long-term leave, two dispensers were on unplanned leave, and another was on their day off. The team reported that recent absences within the team had caused some staffing pressures. Team members demonstrated how they worked together to ensure services were provided safely and efficiently during this time. There was no reliance on support from relief or locum staff. Instead, team members worked flexibly to help manage cover for leave. The team on duty was coping well, team members demonstrated how they planned the pharmacy's workload as much as possible. The team was working hard to ensure medicines were ready for people to collect. The pharmacy had a whistleblowing policy, and its team members had access to a confidential employee assistance programme. Team members expressed that they were able to provide regular feedback at work and fed their thoughts into team briefings. They knew how to escalate a concern at work, should they need to.

The pharmacy had some targets for the services it provided, these had not been discussed directly with the RP. Team members explained how they felt supported in meeting these targets. For example, team members received protected time at work to complete learning relevant to their roles and to support them in acquiring competencies for the tasks they undertook. Team members demonstrated how they applied this learning when delivering services, such as the blood pressure checking service. They engaged in a structured appraisal system which supported their ongoing learning and development. For example, upskilling a dispenser into an accuracy checking role. Team members completed regular e-learning modules relevant to their roles. They demonstrated how they regularly shared learning through team discussions. For example, a recent shared learning session as part of their monthly patient safety review that had focussed on medicines that required pregnancy prevention plans, such as topiramate. Team members took the opportunity to discuss this learning and to demonstrate the tools they had implemented to support them supplying these medicines safely and in accordance with the requirements of the PPPs. The trainee team member felt supported in their role and was supported well by other team members. There was a clear focus on the team member completing formal learning to support them in working safely and effectively in their role.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, appropriately maintained, and secure. People visiting the pharmacy have access to private consultation areas to speak to a team member in confidence.

Inspector's evidence

The pharmacy was secure and maintained well. Team members knew how to report maintenance concerns. Lighting was sufficient throughout the premises. Heating and ventilation arrangements were appropriate with air conditioning in use to provide a stable temperature year-round. Team members had access to sinks equipped with hand washing supplies and they had access to hand sanitiser.

The public area was relatively small, it was open plan and accessible with some seats provided for people waiting. The pharmacy's consultation rooms were modern and provided good private spaces for holding confidential discussions. The dispensary was accessed to the side of the medicine counter, a part-height partition wall allowed the team to monitor activity in the public area from the dispensary. The wall was high enough to avoid the risk of people looking directly into the dispensary. The dispensary was small for the workload. The team demonstrated how they used space effectively. For example, it completed higher-risk tasks in other parts of the premises to help manage space. A door leading off the dispensary led to a very small room that provided access to an automated dispensing machine for use when dispensing medicines to people on an opioid treatment program. A flight of stairs just off the dispensary provided access to the first-floor level of the premises. The first floor was open plan and consisted of sizeable stock room, staff area and protected dispensing space for completing tasks for the multi-compartment compliance pack service.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members provide valuable information when supplying medicines, to help people use their medicines safely. And they follow clear processes and keep effective records to ensure they deliver the pharmacy's services safely and effectively. The pharmacy's services are accessible to people. It obtains its medicines from reputable sources. Overall, it stores and manages medicines appropriately. And it makes regular checks of its medicines to ensure they are safe to supply.

Inspector's evidence

People accessed the pharmacy from street level. The pharmacy advertised its opening times and helpful information to people about the services it provided. It also promoted local support services such as support groups for carers, and details of how people could seek help if they were struggling with their mental health. The pharmacy had a prominent health promotion zone which was promoting the uptake of flu vaccinations. Pharmacy team members knew to refer people to other pharmacies or healthcare services should the pharmacy be unable to provide a service.

People had the option to use an online booking platform to arrange a consultation appointment at the pharmacy. Its regular pharmacists provided private consultations for a range of health conditions. These services involved a private face-to-face consultation with the RP followed by the supply of medicine through a patient group direction (PGD), if deemed appropriate. Information to support the delivery of these services was available. They were not being provided on the day of inspection. Supportive information for the pharmacy's NHS consultation services was available to locum pharmacists. The RP on duty explained how they provided evidence of learning they had completed for the provision of these services when registering with their locum agency.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. The RP had appropriate supervision over the medicine counter and public area. And the trainee team member confidently discussed how they would manage a repeat request for higher-risk P medicines liable to abuse. They explained how the team monitored these requests and referred people to their GP when repeat sales were identified. The pharmacy had effective monitoring arrangements for supplying higher-risk medicines requiring ongoing monitoring. Team members demonstrated a good understanding of these medicines and they effectively recorded details of the checks they made with people when supplying these medicines. And they demonstrated the range of tools they provided to people. For example, information to support them in safely using paraffin-based emollient creams and providing patient guides to medicines requiring PPPs. The RP was familiar with general requirements of medicines requiring compliance with Pregnancy Prevention Programmes (PPPs). But they had not updated their knowledge to include the most recent drug safety update for the valproate PPP which may require them to provide advice to men taking valproate. The pharmacy had effective monitoring processes when dispensing prescriptions for opioid treatment programmes. This included a pharmacist making checks of the data entered onto the pharmacy's automated dispensing machine used to dispense a higher-risk liquid medicine. And team members checking doses dispensed by the machine with the RP for supply. The team completed records at the time of making a supply and it communicated with prescribers and people's key workers when needed.

The pharmacy team used coloured baskets throughout the dispensing process to help keep medicines with the correct prescription and to identify workload priority. Team members took ownership of their work by applying their dispensing signatures to medicine labels. They also completed dispensing audit trails which were retained within the pharmacy on prescription forms and on multi-compartment compliance pack monitoring records. These audit trails effectively supported the team in identifying who had been involved in dispensing a medicine and resolving any queries that arose. The pharmacy kept records of the medicines it owed to people, and team members made regular checks of medicine availability and provided advice to people if they needed to reach out to their prescriber for an alternative prescription. The team demonstrated how it had shared information from medicine supply notifications with prescribers to support it in sourcing medicines for people. The pharmacy's delivery driver discussed their role. They kept a digital audit trail of the medicines they delivered to people, and they returned any medicines which could not be delivered to the pharmacy and made a team member aware of the failed delivery attempt. This supported team members in identifying any monitoring checks required to ensure a person was safe and well.

The pharmacy used checklists to support it in monitoring the supply of medicines in multi-compartment compliance packs. This included ensuring any prescriptions it ordered on behalf of vulnerable people were submitted to GP surgeries in time. And some prompts for people ordering their own prescriptions to support them in ordering these in time. Pharmacists had completed assessments with people receiving their medicines in this way to help ensure this was the best method of supply for a person. A team member demonstrated robust checks against people's medication history to help identify any changes to people's medication regimens. The team obtained consent to access people's medical records through the national care record system to support in checking details of changes, and it clearly recorded the checks. A sample of compliance packs examined were labelled clearly with descriptions of the medicines inside the compliance pack provided. And the pharmacy routinely supplied patient information leaflets to people when supplying medicines in this way.

The pharmacy obtained its medicines from licensed wholesalers and a specials manufacturer. It stored them neatly and within their original packaging. The team completed regular checks of stock medicines to ensure they remained safe to supply to people. It identified medicines with short expiry dates. And it generally marked liquid medicines with details of their opening date to help ensure any medicine remaining in a bottle remained safe to supply. A random check of dispensary stock found no out-of-date medicines. But one liquid medicine with a shortened expiry date when opened was not marked with details of its opening date. The pharmacy kept CDs securely in cabinets, there was designated space within the cabinets for holding assembled medicines, date-expired and patient-returned CDs. The pharmacy stored medicines requiring cold storage in medical fridges. It maintained temperature records for the fridges which showed the medicines were kept between two and eight degrees Celsius and required.

The pharmacy had appropriate medical waste receptacles, CD denaturing kits and sharps bins to support the safe disposal of medicine waste. The pharmacy received medicine alerts and drug recalls electronically. It had a comprehensive approach to managing these alerts by creating a local record of the alert within its patient medication record system. This enabled team members to refer to alerts when supplying medicines or responding to queries from people visiting the pharmacy or from prescribers. It also printed and attached helpful information about medicine alerts and displayed this next to the medicine's stock location in the dispensary. And it recorded the checks it made in response to medicine alerts and drug recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has appropriately maintained equipment and facilities for providing its services. And its team members use the equipment and facilities in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had a range of written and electronic reference resources available. Pharmacy team members could access the internet to help resolve queries and to obtain up-to-date information. They used NHS smart cards to access people's medication records. Computers were password protected, and information displayed on monitors was protected from unauthorised view. The pharmacy stored bags of assembled medicines in a protected area. Due to space limitations in the dispensary, it stored some of these in plastic boxes on a stairway leading from the dispensary to the first floor of the pharmacy. The team had minimised the risk of trip hazards on the stairs by holding the boxes on one side against a wall. Members of the pharmacy team used cordless telephone handsets. This meant they could move out of earshot of the public area if the phone call required privacy.

The pharmacy had a range of clean equipment available to support the delivery of its services. Equipment included counting apparatus for tablets and capsules, and appropriate measuring cylinders for measuring liquid medicines. Equipment to support the delivery of consultation services was from recognised manufacturers and stored appropriately in the consultation rooms. This equipment included single-use tips in varied sizes for use with the otoscope. The pharmacy had a service contract for the automated dispensing machine and team members completed calibration checks of this machine daily. Team members reported that portable appliance tests of electrical equipment had recently been carried out.

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.