General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 28 Court Gardens, Snaith, GOOLE, North Humberside, DN14 9JP

Pharmacy reference: 1090054

Type of pharmacy: Community

Date of inspection: 21/11/2019

Pharmacy context

This community pharmacy is in the village of Snaith. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the seasonal flu vaccination service. And it offers people free health checks such as blood pressure checks.

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	2.5	Good practice	The team members discuss and share ideas. They proactively identify areas of concern that impact on the safe delivery of services. And they work together to address these concerns and make improvements to the delivery of pharmacy services. The team members change the way they work to improve their efficiency.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The team members manage the pharmacy services well. The team members clearly highlight medicines awaiting collection. So, they can undertake appropriate checks and provide advice to the person collecting their medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team identifies and manages the risks associated with the delivery of its pharmacy services. The team members have training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members record and discuss errors that happen whilst dispensing. And they respond appropriately. As they make changes to the way they work to reduce the risk of similar errors happening. The pharmacy has arrangements to protect people's private information. And people using the pharmacy can raise concerns and provide feedback. The pharmacy keeps the records it needs to by law.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read the SOPs and signed the signature sheets to show they understood and would follow them. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. And the team member involved made a record of their own error. The form used to record these errors had codes to capture the type of error, the cause of the error and the actions taken by the team to prevent the error from happening again. A sample of the near miss error records looked at found that the team also recorded details of what had been prescribed and dispensed to spot patterns. Most near miss records looked at had the same information captured, so there was little evidence of individual reflection. Team members typically used the code with the number one in the section detailing the action taken to prevent similar errors. This code referred to the team member amending the medicine in accordance with the prescription. The other codes on the form provided more detailed action such as dispensing one prescription at a time. The team used the code with the number three in the causative factors section for many entries. This captured the cause as similar packaging. The pharmacist manager entered the details from the near miss error reports on to an online platform to share with the company. So, the company could gather information on near miss errors for all teams to learn from. The pharmacist manager reviewed the near miss records each month to spot patterns and make changes to processes. And shared the results with the team. From these reviews the pharmacist manager identified that dispensers were not always checking their own work before passing it to the pharmacist. And had reminded the team members to do this. So, they could spot errors before the final check by the pharmacist. The pharmacy completed an electronic report for dispensing errors. These were errors identified after the person had received their medicines. The team sent the report to head office. The pharmacy had trained all the team to complete the report. So, completion of the report was in a timely manner. The team also completed a root cause analysis (RCA) to identify why the error happened. All the team members were made aware of any dispensing incident, so everyone could learn from it.

The pharmacy received a monthly patient safety newsletter from head office that all the team read. The newsletter included raising awareness of medicines that that looked and sounded alike (LASA). As these medicines were often linked to dispensing errors. The newsletter also included common near miss

errors identified across the company and recent drug alerts. The team members attached stickers to shelves holding LASA medicines to prompt them to check the medicine selected. And the pharmacy displayed in the dispensary a list of common LASA medicines. After receiving notification of the risk of serious errors with rivaroxaban the team separated these medicines by placing them in to a labelled basket.

The pharmacy completed an annual patient safety report. The latest report focused on the impact on the pharmacy team on receiving several multi-compartment compliance packs from another pharmacy. The report stated the team struggled to accommodate the packs due to the small size of the dispensary. And this led to an increase in near miss errors the team linked to high stress levels. The report stated the team felt there was a risk of a serious incident because the dispensing benches were cluttered with the volume of work. The report stated that team members tried to make more space available to store baskets and packs. But space remained a problem. So, the pharmacist manager spoke to the team's line manager to explain the situation. And asked for the packs from the other branch to be prepared elsewhere. The report stated that after the packs from the other branch were moved the team members felt they had returned to safe practice when dispensing. And they felt less stressed.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. And it displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite. The pharmacy had recently changed the layout of the retrieval area to create more space to store completed prescriptions awaiting supply. The location of some shelves in this area meant that the bag labels containing people's names and address faced towards the pharmacy counter. There was some distance between this section and the pharmacy counter. But the pharmacist tested this with the team to make sure the confidential information was not seen by people at the pharmacy counter.

The pharmacy had information and guidance for the team members to follow when they had safeguarding concerns. The team members had access to contact numbers for local safeguarding teams. The pharmacist had recently completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team responded well when safeguarding concerns arose. One of the dispensers spent time with a person who claimed they did not have enough medicines. And the dispenser realised the person was confused about their medicines. The dispenser discussed this with the pharmacist manager who spoke to the person's GP who arranged a home visit. The delivery driver reported to the pharmacist manager concerns they had about persons they delivered to. The concerns raised by the delivery driver included a person who was not taking their medicines. The pharmacist manager had shared this concern with the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The pharmacy provides the team members with opportunities to develop their knowledge and skills. And it gives team members regular feedback on their performance. The team members support each other in their day-to-day work. And they use the information they share from mistakes they make during dispensing to improve their performance and skills. The team members discuss and share ideas. They proactively identify areas of concern that can impact on the safe delivery of services. And they work together to address these concerns and make improvements to the delivery of pharmacy services. The team members change the way they work to improve their efficiency.

Inspector's evidence

The pharmacist manager covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of six part-time qualified dispensers, one part-time trainee dispenser and a delivery driver. At the time of the inspection the pharmacist manager and three of the qualified dispensers were on duty. All team members were trained to complete a range of tasks. So, the delivery of service was not affected during absences.

The pharmacy team completed extra training through monthly online learning modules. Recent modules included sepsis training. The pharmacy held team meetings including a monthly safety meeting to discuss errors within the dispensing process. The pharmacy provided performance reviews to the team. So, they had a chance to receive feedback and discuss development needs. The pharmacist manager had discussed with one of the dispensers about training to be an accuracy checker. The dispenser was interested in training to be a pharmacy technician at a later stage. And both agreed the accuracy checker training would be a useful step towards the technician training.

Team members could suggest changes to processes or new ideas of working. And the pharmacy had a whistleblowing policy. The team had introduced a dedicated section for storing baskets containing prescriptions waiting for items to be added. The team members found that separating the baskets prompted them to ensure they used medicine stock received from the wholesaler for these prescriptions before other prescriptions. And if the person came for their prescription it was easy to locate. This system also allowed the team members to spot medicines not sent from the wholesaler. So, they could re-order them or contact the wholesaler to see if there were problems such as out of stock medicines. The pharmacy had targets for services such as Medicine Use Reviews (MURs). But the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy had recently had a refit. This created more space for holding completed prescriptions awaiting supply. But the dispensary remained small. The team managed this by keeping the dispensing benches uncluttered. The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The team members used disposable gloves when dispensing medicines in to the multi-compartment compliance packs. The team kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team members provide services that support people's health needs. The team members manage the pharmacy services well. The team members clearly highlight medicines awaiting collection. So, they can undertake appropriate checks and provide advice to the person collecting their medicines. The team members keep records of deliveries made to people's home. So, they can effectively deal with any queries. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via a small step. And there was a handrail next to the front door. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. Several team members were trained to do the blood pressure checks. So, this service could be offered promptly to people when they asked about it. The pharmacy used a section of the retail area to promote healthy living advice. One of the dispensers led on this. And had created a range of eye-catching displays on a range of topics. The latest focus was promoting the flu vaccination service. The pharmacy had a range of up-to-date patient group directions (PGDs). These provided the pharmacist with the legal authority to provide services such as administering the flu vaccination. The pharmacy had in-date adrenaline injections in case a person had an anaphylactic reaction to the flu vaccine.

The pharmacy provided multi-compartment compliance packs to help around 22 people take their medicines. The pharmacy also provided this service to people living in two care homes. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions one week before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Most prescriptions came as electronic repeat dispensing so the team could download the prescription when it was needed. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team used a section of the main dispensary to dispense the medication. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. And liaised with the GP team to request prescriptions when required. The team at one care home ordered the prescriptions around two weeks before supply. The pharmacy sent the care home team the prescriptions before dispensing the packs. So, the care home team could check the prescriptions and spot any missing medicines. The pharmacy team ordered the medicines for the other care home after checking what medicines were needed. The pharmacy sent the packs a few days before the next cycle started so the care home team had chance to check the supply and query any missing medicines. The pharmacy kept a range of palliative care medicines so the teams in the care home could obtain these medicines when needed.

The pharmacy supplied methadone as supervised and unsupervised doses. And it mostly prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet with the

prescription attached to the dose due. The pharmacist completed a second check of the dose prepared in advance before handing the medicine to the person. The pharmacist asked the person if they were feeling OK before administering the dose. To check it would be suitable for the person to have their dose at that time. The team members provided a repeat prescription ordering service. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team kept a record of the prescription request. And the team regularly checked the record to identify missing prescriptions and chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The team used the bag labels to record this information to pass on to the person. And other information such as when the GP stopped a medicine.

The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy displayed a PPP poster to remind the team of the criteria and it had the PPP pack to provide people with information when required. The team attached a pharmacist sticker to bags holding completed prescriptions to prompt them to ask people with a diagnosis of diabetes if they'd had an eye check or foot check in the last 12 months. The team was also participating in an audit of people prescribed lithium. The pharmacist manager had produced a poster displayed near the retrieval area to remind the team to ask people prescribed warfarin if they had the book containing their latest blood tests. And if the person did not have the book to ask the person if they knew their latest blood test results. The poster reminded the team to ask the person what dose of warfarin they were taking. And to record this information on the top of the prescription. The team gave the prescription to the pharmacist to check the details and record the information on to the person's electronic medication record (PMR). The poster prompted the team to remind people who did not have their book with them to bring it the next time they visited the pharmacy.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication.

The pharmacy team checked the expiry dates on stock. And it kept a record of this. The last date check was on 08 November 2019. The team used brightly coloured stickers with the expiry date written on to highlight medicines with a short expiry date. No out of date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of cetirizine oral solution with six months use once opened had a date of opening of 18 November 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to

destroy CDs.

The pharmacy had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). The team had received notification from the company that the necessary upgrades for the pharmacy to be FMD compliant were due in January 2020. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And the team mostly uses the pharmacy's facilities and equipment in a way to protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a separate counting triangle for cytotoxic medicine such as methotrexate. The pharmacy had a fridge to store medicines kept at these temperatures. The pharmacy completed safety checks on the electrical equipment. And it regularly sent equipment such as the blood pressure monitor for checking. So, it gave correct readings.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy team kept the computer screen in the consultation room locked when it was not in use. The pharmacy stored completed prescriptions away from public view. And it held most private information in the dispensary and rear areas, which had restricted access. Some confidential information such as completed consent forms were on the desk in the consultation room. The cupboards in the consultation room holding confidential information were not locked. And the key was in the doors. The confidential information stored in these cupboards included baskets labelled with the person's name holding completed multi-compartment compliance packs. The team used cordless telephones to make sure telephone conversations were held in private.

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.