General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 242 Main Road, Parson Drove, WISBECH, Cambridgeshire, PE13 4LF

Pharmacy reference: 1102849

Type of pharmacy: Community

Date of inspection: 10/03/2020

Pharmacy context

This busy pharmacy dispenses prescriptions under an NHS community pharmacy contract, and it also processes prescriptions associated with a dispensing doctor service. It is in a largely rural location. The pharmacy premises are adjacent to the GP practice and had been refitted since the last inspection to create extra space for dispensing and storage. The pharmacy manager provides a large range of services under patient group directions including; seasonal flu vaccinations, treatment for erectile dysfunction, period delay, travel medicines, and salbutamol inhalers. The pharmacy sells a range of medicines over the counter and gives advice to people about healthcare matters. Some people receive their medication in multi-compartment compliance packs. And the pharmacy delivers some medicines to people at home.

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	The pharmacy reviews and monitors its risks regularly and it makes changes when needed to protect people's safety and wellbeing.
2. Staff	Good practice	2.1	Good practice	The team members are well-trained. There is a good skill mix and tasks are shared well to ensure services are provided safely in a busy environment.
		2.4	Good practice	The pharmacy team members receive good support in keeping their skills and knowledge up to date. And they are encouraged to learn from mistakes in an open and honest way.
3. Premises	Standards met	3.1	Good practice	The pharmacy premises are well-organised, well-maintained and cleaned regularly. They present a very professional image to the public.
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 manages and identifies risks in the pharmacy well to make sure its services are safe. Its team members are encouraged to learn from their mistakes. And they review and monitor how the pharmacy is working, to continually improve. The pharmacy keeps people's information safe. And its team members know what actions to take to protect vulnerable people if they have concerns about people's welfare. The pharmacy keeps the records it needs to by law, and these are largely complete.

Inspector's evidence

Pharmacy services were supported by written procedures issued by head office and these were reviewed regularly (last reviewed in May 2019). The procedures included management of controlled drugs (CDs), responsible pharmacist (RP) procedures, dispensing higher-risk medicines, and sales of over-the-counter medicines. There was an audit trail to show that staff had read procedures relevant to their roles. Prescription labels were initialled at the dispensing and checking stages to create an audit trail showing who had been involved in these tasks. The pharmacist stamped and initialled prescriptions when she had clinically checked them which provided assurance to the ACTs that those prescriptions were suitable for them to check. Designated areas of the pharmacy were used for separate tasks such as dispensing and checking prescriptions to reduce the risk of distractions.

Staff said that any dispensing mistakes they made that were spotted before the medicines were handed out (referred to as near misses) were pointed out to them. They were asked to rectify these themselves whenever possible and make records about these. Staff said it was important for them to record their own mistakes where possible so they could reflect on how it had happened and what changes they could make in future to improve. There was evidence of near misses being recorded and reviewed regularly. Dispensing mistakes on medicines which were handed out to people were also recorded and reported electronically to the pharmacy's head office. Incidents and learning points were shared with the team during monthly staff meetings to reduce similar mistakes happening. The storage locations of some medicines had been highlighted and altered to reduce selection errors, particularly for medicines with similar names or packaging. The registrants had all completed specific training about reducing errors associated with sound-alike and look-alike medicines and relevant information had been cascaded to the rest of the team. The team members said the pharmacy manager reminded them each month about taking particular care when selecting pregabalin or gabapentin because of the risk of dispensing errors.

Staff members had a clear understanding of their roles and responsibilities. Members of the team could explain what they could and couldn't do when the pharmacist was not present. They also knew the types of medicines that could be liable to abuse and under what circumstances they needed to refuse to supply or refer requests for these medicines to the pharmacist for further advice. Staff members wore uniforms so they could be readily identified by members of the public. The pharmacy gathered customer feedback though an annual patient satisfaction survey. There was also a means of capturing instant feedback at the pharmacy counter and this reported back to head office. Results of the patient survey were displayed on the NHS website so people could see them. The pharmacy had a complaints procedure and information about this was displayed in the pharmacy. Staff could explain how a complaint should be managed; the pharmacy had not received any complaints recently.

There was a consultation room available for people who wanted to have a private conversation with the pharmacy staff and this facility was signposted; it was kept locked when not in use. There were written procedures and staff training about protecting confidentiality. The staff had completed training about the General Data Protection Regulation. And there was a poster telling people how the pharmacy protected their information. Sensitive information was stored out of the reach and sight of the public and confidential waste was disposed of securely. The IT system was password protected. Staff used their own NHS smartcards and passwords to access electronic prescriptions and did not disclose passwords to each other.

The pharmacy had procedures to help make sure it took appropriate action to protect vulnerable people and this had been read by staff. Registrants had completed level 2 training about safeguarding. There was a chaperone policy for using the consultation room and a poster about this was displayed. Staff gave an example of how they had raised concerns about a person's welfare so that others involved in their care could intervene.

The pharmacy had current professional liability and public indemnity insurance. Records about CDs were kept electronically and complied with legal requirements. CD running balances were kept and checked for accuracy though not as frequently as recommended by the company. The pharmacy had a separate register for patient-returned CDs. The stock of a CD chosen at random agreed with the recorded balance. Records about the RP were kept electronically. These were largely complete though did not always include the time at which the pharmacist finished their shift. The correct RP notice was displayed where members of the public could see it.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy's team members work well together, and they are suitably trained for the roles they undertake. There are enough of them to cope with the workload safely. They regularly rotate through a variety of tasks so they can keep their skills up to date. And they are given good support by their company to keep their knowledge current. Team members learn from their mistakes to reduce risks in the pharmacy and make services safer.

Inspector's evidence

The pharmacy team consisted of the pharmacist pharmacy manager (not present during the inspection), an assistant pharmacy manager (an ACT), another ACT, four full-time trained dispensers, and a part-time trained dispenser. A locum pharmacist was providing responsible pharmacist cover during the inspection. Certificates for the accredited training completed by staff were displayed in the pharmacy. The pharmacy team rotated through various tasks so that team members maintained their skills and competencies and could provide cover for each other. Rotas were in place for the ACTs so there was clear separation of dispensing and accuracy checking activities. This also meant that the ACTs were regularly using their checking skills. The team members were coping well with the workload during the inspection and worked closely together, discussing queries, sharing information and referring to more senior members of staff including the pharmacist when needed. People were served efficiently.

The company provided ongoing training to staff to help them keep their skills and knowledge current. The training was largely web-based. Some of this training was considered mandatory by the company and there was a process to track completion of this by the staff. Staff said they sometimes got time at work to do training when it was quiet but also did training at home. The company had a rewards programme to encourage staff to complete their training. There were annual performance appraisals which covered achievements as well as areas for development and additional coaching needs.

The team members described how information was shared with them by the company and the pharmacy manager. They had regular discussions about any issues or incidents in the pharmacy, so they could share learnings. One of the ACTs explained how she used dispensing mistakes as opportunities to do continuing professional development. As a result of mistakes involving part-dispensed prescriptions, she had reflected on how the mistakes were occurring and had altered her approach to dispensing these items. The team members said they could make suggestions about how to improve the pharmacy and these would be acted on where appropriate. They also felt comfortable about raising any concerns with the pharmacy manager, the regional support manager and the superintendent's office if needed. They also felt able to contact these sources of support for advice and said there was good information sharing within the company.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are safe, secure, and suitable for the services it provides. They are well-maintained. And the premises are accessible to people with mobility problems. The staff are aware of the increased risks to people associated with coronavirus outbreak and have changed their cleaning routines accordingly.

Inspector's evidence

The premises were spacious, with ample space in the shop area for people waiting for their prescriptions to be dispensed. The size of the dispensary, the workbench space, and storage capacity had been increased since the last inspection, reducing risks in the dispensing activities. The pharmacy was very clean and well-maintained throughout; the staff were responsible for cleaning. Since the coronavirus outbreak, the team was following updated cleaning guidelines issued by head office, meaning that door handles and counters were being cleaned every two hours. Staff had access to a rest area, and hand sanitizers, soap and hot water were available to maintain good hand hygiene. The premises could be secured outside of opening hours and were accessible to people with mobility issues or those with prams or wheelchairs. There was free parking on site and there were seats in the pharmacy for people waiting for services. The seating was set away from the counter to protect people’s privacy.

The dispensary was clearly separated from the shop area and access by the public was suitably restricted. Pharmacy-only medicines were kept out of reach of the public so their sales could be supervised appropriately. Dispensed medicines were protected from public view. Sections of the dispensary were reserved for specific activities to reduce risks in the dispensing process. The dispensary, benches and prescription storage areas were reasonably well-organised.

Room temperatures in the premises were controllable, and levels of ventilation and lighting were appropriate for the activities undertaken. A well-screened consultation room was available and signposted. There was no patient identifiable information on display in the room. Equipment used for services was stored securely.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. It gets its medicines from reputable sources and generally stores them correctly. And it dispenses all prescriptions in an orderly way, making good use of the skills of the pharmacy team. The staff regularly date-check medicines so they are safe to supply. And the pharmacy takes the right action if there are concerns about the quality of medicines. The pharmacy team is aware of the need for extra care when supplying medicines which may be higher risk. However, prescriptions for these medicines are not always highlighted so it may be harder for staff to give people all the information they need to take their medicine safely.

Inspector's evidence

The pharmacy's opening hours were displayed at the entrance. The main entrance door was power assisted and level with the pavement and there was onsite parking for patients. The pharmacy offered a prescription delivery service to help housebound and elderly people get their medicines. There were records kept for the prescription delivery service and these included signatures from recipients. Medicines were not left unattended at a person's home. Other services were advertised to people through posters and leaflets on display. There were also some posters giving information about other healthcare support services or services not provided by the pharmacy. A poster giving people information about coronavirus and what to do was displayed. The pharmacy also displayed a notice issued recently by the General Pharmaceutical Council, telling people what they could expect when visiting a pharmacy.

Dispensing was carried out in an orderly way. All prescriptions, whether originating from the dispensing doctor service or from the community pharmacy, were clinically checked by the responsible pharmacist and the dispensed medicines accuracy checked by the pharmacist or ACT before supply. Baskets were used to keep prescriptions for different people separate and to prioritise workload. When insulin was dispensed, it was placed in a clear bag and stored in the fridge before collection. When people came to collect their prescription, pharmacy staff showed them the dispensed insulin as an additional check to make sure the right item was supplied.

Staff were aware of the checks to make when they gave out prescriptions for warfarin. This included asking about recent blood tests. But these prescriptions were not flagged in any way. And there wasn't a similar process in place for prescriptions for methotrexate. This could mean the pharmacy misses some opportunities to provide people with additional advice when they collect their medicines. When asked, the team members knew how long prescriptions for Schedules 2, 3 and 4 CDs were valid for. In most cases, prescriptions for these items were stored separately and an alert sticker used to highlight the prescription form. The team members knew about the advice to give to people about pregnancy prevention when supplying valproate medicines. The pharmacy had the relevant educational literature available to give to people and were reordering safety stickers to apply to dispensed items when the original pack could not be used.

The pharmacy manager offered a large range of services under patient group directions (PGDs), improving access to healthcare for the local, mainly rural population. There was information available to show the pharmacy manager (not present) had completed the necessary training for these services,

including the flu vaccinations. The pharmacy kept copies of the PGD documents so these could be referred to when providing the services. Adrenaline auto-injectors to use in the event of an anaphylactic reaction to a vaccine were available and were in date.

The assistant manager explained their involvement in blood pressure checks. They had been trained to provide the service and knew how to make the appropriate records. They also understood the need to involve the pharmacist, especially if the person's readings were outside the usual range. They didn't often receive feedback about any interventions they had made but gave an example about a person whose blood pressure was very high when tested. The person was referred to their GP, and they were now taking medicines to reduce their blood pressure.

The pharmacy prepared multi-compartment compliance packs according to a four-week rota, so the workload was manageable. There were plans for some of this activity to transfer to a dispensing hub offsite in the future. These packs were dispensed in an orderly way, in an area away from other dispensing activities to reduce distractions. All the dispensing team could dispense these packs meaning there was adequate cover for people on holiday. There was an audit trail showing who had prepared and checked the packs. People were supplied medicine information leaflets regularly. And there was a process to retrieve and re-issue packs if there were mid-cycle changes. Staff understood the types of medicine that weren't suitable for putting into the packs.

Medicines were obtained from licensed wholesalers and specials were obtained from specials manufacturers. No extemporaneous dispensing was carried out. Medicines stored directly on shelves were well-organised. Some other items were stored in labelled boxes on shelves below the work benches. In some cases, the contents of these boxes were not well-organised. This could increase the chance of selecting the wrong medicines when dispensing. The medicines fridges were equipped with maximum and minimum thermometers. Fridge temperature ranges were checked daily and recorded and the recorded temperatures were appropriate for the safe storage of medicines. Date checking was carried out regularly and recent records about this were up to date. Stickers were applied to short-dated medicines so they could be readily identified when dispensing and date checking. Medicines were kept in appropriately labelled containers and there were no date-expired medicines found amongst dispensing stock when a sample of items were checked at random. Out-of-date medicines and patient-returned medicines were transferred to designated bins and stored separately from dispensing stock. Appropriate arrangements were in place for storing CDs securely. The pharmacy had the equipment it needed to authenticate medicines, in line with the Falsified Medicines Directive but the team was not yet using it. The staff were waiting for additional training and procedures about this.

The pharmacy could show that recent drug recalls and safety alerts had been received and appropriate action had been taken to protect people's health and wellbeing. There was an audit trail to evidence that the pharmacy had received recent recalls and had checked their stocks. They knew that people potentially affected stock by a recent recall of Emerade pens had been contacted by the surgery.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has access to the equipment and facilities it needs to provide its services safely. And it has systems in place to make sure its equipment is working properly.

Inspector's evidence

The pharmacy had measuring equipment of a suitable standard and this was clean. It had a range of up-to-date reference sources available to assist with clinical checks and other services. All portable electrical equipment was safety tested regularly and appeared to be in good working order. The pharmacy's patient medication records including those linked with the dispensing doctor's service were kept secure. Screens for the pharmacy's computers were not visible to the public and there were enough of them to manage the workload efficiently. The pharmacy had cordless phones and team members could make phone calls out of earshot of waiting customers if needed.

The assistant manager explained how testing equipment used for the commissioned health check service was subject to regular testing to make sure people were receiving accurate test results. This included the equipment used to test for blood glucose. The equipment was issued by the commissioners.

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.