General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 4 The Parade, White Point Road, Whitby, North Yorkshire, YO21 3JP

Pharmacy reference: 9010042

Type of pharmacy: Community

Date of inspection: 29/02/2024

Pharmacy context

This pharmacy is amongst a small parade of shops in the coastal town of Whitby. The pharmacy dispenses NHS prescriptions and sells over-the-counter medicines. It supplies several people with their medicines in multi-compartment compliance packs to help them take their medication correctly. And it delivers medicines to some people's homes. The pharmacy provides other NHS services including the Pharmacy First Service and the hypertension case finding service.

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	2.2	Good practice	The pharmacy actively supports team members to develop their knowledge and skills. It provides a range of opportunities for team members to identify their training and development needs. Team members receive encouragement and help to take on new roles and responsibilities.
		2.4	Good practice	The pharmacy is good at giving team members regular feedback on their performance. So, they benefit from identifying areas of their own practice they wish to develop. The pharmacy proactively encourages team members to share their experience and ideas so they can improve the efficient delivery of services.
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 the risks associated with its services well. It has written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it generally keeps the records it needs to by law. The pharmacy suitably protects people's private information, and it provides team members with training and guidance to help them respond correctly to safeguarding concerns. Team members respond competently when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) that provided team members with information to perform tasks supporting the delivery of its services. Team members had read the SOPs and signed them to show they understood and would follow them. They demonstrated a clear understanding of their roles and worked within the scope of their role.

Team members were asked to find and correct errors spotted at the final check of a prescription. The pharmacy kept records of these errors known as near miss errors. Team members were asked to complete the record after discussing the error with the pharmacist or the accuracy checking pharmacy technician (ACPT). A sample of records showed details of what had been prescribed and dispensed. But the cause of the error and the actions taken by the team member to prevent the error from happening again were not always recorded. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. This included completing an online report. All team members were informed of the dispensing incident so they could learn from it and were aware of the actions taken to prevent such errors from happening again.

A detailed monthly review of errors took place to identify patterns and included reflections on why the patterns were emerging. Information from the reviews was used by the pharmacists when completing the annual patient safety report. The outcome of the monthly review was shared with the team who discussed how to prevent errors from happening. For example, a review had identified a pattern with the wrong type of inhaler being selected. So, team members were asked to double check the inhaler they had selected with a colleague. To prevent errors involving medicines that looked alike and sounded alike (LASA) the pharmacy had a stamp with the word 'LASA' embedded. Team members used the stamp on prescriptions containing these medicines to prompt them, when dispensing the prescription, to check the medication they had taken from the shelf. They also read the pharmacy's annual safety report and signed it to say they'd read it. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And the company's website provided people with information on how to raise a concern.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drugs (CD) registers generally met legal requirements. On a few occasions the pharmacist on duty had not signed out of the RP record. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. The pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. To support the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacists to provide medication such as antibiotics. And had been signed by the pharmacists to show they had read them, understood

them and would follow them.

Team members completed training about protecting people's private information and the pharmacy displayed a privacy notice. Team members separated confidential waste for shredding offsite. The pharmacy had safeguarding procedures and guidance for the team to follow. And team members had completed training relevant to their roles. The delivery driver reported concerns about people they delivered to back to the team who took appropriate action such as contacting the person's GP. The pharmacy displayed information advising people it was part of the Safe Space initiative which supports people experiencing domestic abuse.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work very well together, and they support each other in their day-to-day work. They discuss ideas and implement new processes to enhance the safe and effective delivery of the pharmacy's services. The team members have opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

Two part-time pharmacist managers covered the pharmacy's opening hours with a locum pharmacist providing support when required. The pharmacy team consisted of a full-time pharmacy technician, two part-time ACPTs, a full-time trainee pharmacy technician, one full-time dispenser and one part-time dispenser. The pharmacy also employed a part-time delivery driver. At the time of the inspection one of the regular pharmacist managers, the pharmacy technician, the trainee technician, a dispenser and the delivery driver were on duty. The trainee pharmacy technician had protected time at work to complete their training modules. And they received support from the qualified technicians in the team. The trainee technician had also been nominated in 2023 by team members for the company's colleague of the year award which they'd won. One of the ACPT's was the assistant pharmacy manager and was the pharmacy lead for the local Primary Care Network (PCN).

The team's workload had increased after several people had relocated from other pharmacies in the area. Team members worked very well together to manage the workload and they ensured people presenting at the pharmacy were promptly helped. They had some specific roles but were all trained on key tasks. This ensured these tasks were completed regularly, including times when team numbers were reduced such as planned and unplanned absence.

Team members used company online training modules to keep their knowledge up to date. And had completed Pharmacy First online training modules specific to their role. The pharmacists had also attended local face-to-face training which included the use of otoscopes to examine people's ears. All team members had been trained or were completing training on taking blood pressure (BP) readings to support the NHS hypertension case finding service. Team members read the SOPs and guidance covering this service. And they were supported by experienced team members. Team members observed a trained colleague taking a person's BP. Then an experienced colleague observed them take a BP reading and gave them feedback. Team members received formal performance reviews so they could identify opportunities to develop their knowledge and skills. One of the dispensers had used the opportunity to discuss training to be an accuracy checking dispenser.

The team held regular meetings and team members could suggest changes to processes or new ideas of working. For example, the trainee technician had rearranged some of the shelves holding LASA medicines such as pregabalin and gabapentin. And separated oral contraceptive medicines from Hormone Replacement Therapy (HRT). So, the medicines were easy to locate and reduced the risk of the wrong medicine being picked. As the number of people receiving multi-compartment compliance packs grew team members had identified there was an increased risk of errors. So, they discussed what could be done to manage the volume. They'd re-read the SOPs and the pharmacy technicians created a laminated sheet summarising the key points from the SOP. This was attached to the wall in the area where the packs were dispensed for team members to refer to. The team had also developed a record

to capture when each stage of the dispensing and checking of the packs was completed. Team members used an online communication platform to share key pieces of non-confidential information with each other, especially if they couldn't attend the team meeting.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and provide a suitable environment for the services provided. It has suitable facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy team kept the premises tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, and alcohol gel was also available for hand cleansing. Team members kept the work surfaces in the dispensary tidy and they kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy had enough storage space for stock, assembled medicines and medical devices. And it had a defined professional area where medicines for sale were healthcare related. The pharmacy had a large soundproof consultation room which the team used for private conversations with people and when providing services. The pharmacy had systems in place to prevent public access to the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a wide range of services which are easily accessible for people. Team members manage the pharmacy services well to help people receive appropriate care and to make sure people receive their medicines when they need them. The pharmacy obtains its medicines from recognised sources and it stores them properly. The team regularly carries out checks to make sure medicines are in good condition and are suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step-free entrance. A small range of healthcare information leaflets were available for people to read or take away. And team members provided people with information on how to access other healthcare services when required. They wore name badges detailing their role so people using the pharmacy knew who they were speaking to. Team members asked appropriate questions of people requesting to buy over-the-counter medicines to ensure the most appropriate product was supplied. And they knew when to refer requests to the pharmacist.

The ACPT as the local PCN pharmacy lead had met with the team at the GP surgery to promote the NHS Pharmacy First service. However, only a few people had been referred so the team was further promoting the service to ensure people were aware of the healthcare support the service provided. The hypertension case finding service was popular and a few people had been referred for further tests. Team members discussed results with the pharmacist when a person's reading was raised. And provided additional information from questions they'd asked the person such as what medication they were currently taking.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. People requesting to use the service were assessed to ensure it met their healthcare needs. Team members divided the preparation of the packs across the month to manage the workload. And recorded when each stage of the dispensing and checking of the packs was completed. Each person had a record listing their current medication and dose times which team members referred to during the dispensing and checking of prescriptions. And the record was used to create an audit trail of any changes to the person's medication. Team members added the descriptions of what the medicines looked like on to the packs. And supplied the manufacturer's packaging leaflets on most occasions. This meant people could identify the medicines in the packs and had information about their medicines.

Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) including the requirement to supply original packs of valproate. They reviewed people prescribed valproate to identify anyone who may meet the PPP criteria. And reported that no-one prescribed valproate met the criteria or had their medication in multi-compartment compliance packs.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Pharmacy team members initialled 'dispensed by' and 'checked by' boxes on dispensing labels, to record their actions in the dispensing process. And they used a separate system to capture the pharmacist's clinical check which enabled the ACPTs to complete their check. The pharmacy had a stamp with the word 'child' embedded on which team members used to mark prescriptions for

children. This acted as an alert for all team members involved in dispensing and checking of the prescription. The pharmacy had CD and fridge stickers which team members attached to bags and prescriptions to remind them when handing over medication to include these items. People received a text message from the pharmacy advising them when their prescription was ready to collect. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose. If the person was not at home the delivery driver left a card informing the person of the failed delivery.

The pharmacy obtained medication from several reputable sources. Team members followed procedures to ensure medicines were safe to supply and they securely stored CDs. They checked the expiry dates on stock received from the wholesaler when putting the stock away on shelves. And they regularly checked the expiry dates on all stock. They recorded when the date checking was completed, and they marked medicines with a short expiry date to prompt them to check the medicine was still in date. Team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and a sample of records were within the correct range. The pharmacy had medicinal waste bins for out-of-date stock and patient-returned medication. And the team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via the company communication platform. The team responded appropriately to these alerts and kept a record of their actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure it uses its equipment appropriately to protect people’s confidential information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date information. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And two fridges to hold medicines requiring storage at these temperatures. The pharmacy kept in-date adrenaline injections in the consultation room in the event of a person having an anaphylactic reaction to the vaccine. The pharmacy completed safety checks on the electrical equipment and equipment such as the blood pressure monitor was regularly replaced to ensure accurate readings were taken.

The pharmacy 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. It stored completed prescriptions away from public view and held private information in the dispensary and rear areas, which had restricted public access.

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.