General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 5 York Street, Dunnington, York, North Yorkshire, YO19 5PN

Pharmacy reference: 9010100

Type of pharmacy: Community

Date of inspection: 11/09/2024

Pharmacy context

The pharmacy is in a parade of shops in Dunnington, near York. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide other healthcare services including the NHS Pharmacy First Service, NHS Contraceptive service, and various private travel vaccinations. They also deliver 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	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 effectively identifies and manages risks associated with its services. It has written procedures relevant to its services to help team members provide them safely. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. They record and discuss the mistakes they make so that they can learn from them. And they capture key information to help them make effective improvements to the safety and quality of their services.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage risks. These were available for team members online. Pharmacy team members received new and updated SOPs each month to read via the company's online training system. And the system recorded to confirm they had read each procedure. The pharmacy received a patient safety bulletin every month from the company's head office, which communicated professional issues and learning from across the organisation. The bulletin also provided best practice guidance on various topics and case studies based on real incidents that had occurred. It detailed how pharmacy team members could learn from these. Pharmacy team members read the bulletin and signed the front to confirm they had done so. A recent example of a case study highlighted how team members could effectively diagnose and treat shingles. And how to recognise the symptoms of MPOX.

The pharmacy provided various services to people. These included the NHS Pharmacy First service, seasonal flu vaccinations and private travel vaccinations. Pharmacy team members explained how the pharmacy had considered some of the risks of providing the services, such as the suitability of the pharmacy's consultation room to deliver the service from. And ensuring they had stock of the relevant medicines and the availability of the necessary equipment. They also completed the necessary training and had the correct SOPs, patient group directions (PGDs) and supporting documents in place. Team members had documented their risk assessments for each service. The documents provided clear information about any risks they had identified and the steps taken to reduce these risks. The pharmacist also reviewed the assessments each year to establish if there had been any changes or new risks identified.

The pharmacy used a system, called a Quality Criteria Toolkit, to monitor various governance criteria that needed to be completed each month. The system was managed by a team member that had been appointed quality criteria champion. They used the toolkit to monitor whether various governance tasks had been properly completed each month, such as whether fridge temperatures were being monitored and maintained within the correct range. And whether team members had completed training for various services. The champion clearly explained how they used the toolkit and how team members used it to make sure key tasks were regularly completed. And to help clearly define people's responsibilities.

Pharmacy team members highlighted and recorded mistakes identified before people received their medicines, known as near misses. There were documented procedures to help them do this effectively. Pharmacy team members discussed their mistakes and why they might have happened. And they captured some of this information in their records to help inform the analysis process. Team members

analysed the data they collected each month to help identify patterns. And they made changes to help minimise the risks of patterns recurring. The pharmacy recorded dispensing errors, which were errors identified after the person had received their medicines. But the pharmacy team members present during the inspection could not access the electronic system to be able to view record they had made.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. Pharmacy team members explained feedback was usually received verbally. And any complaints were immediately referred to the pharmacist to resolve. There was information available for people in the retail area about how to provide the pharmacy with feedback. Team members did not have any examples of any changes they had made to improve their services in response to people's feedback.

The pharmacy had current professional indemnity insurance. It kept accurate controlled drug (CD) registers, with running balances in all registers. Pharmacy team members checked these registers against the physical stock quantity every week. The pharmacy maintained a register of CDs returned by people for destruction, and this was correctly completed. It maintained a responsible pharmacist record, which was also up to date and completed accurately. The pharmacist displayed their responsible pharmacist notice so they could be identified. Team members accurately recorded private prescriptions and emergency supplies.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags, which were collected periodically by a waste disposal contractor and taken away for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage people's sensitive information. Team members explained how important it was to protect people's privacy and how they would maintain confidentiality. And they completed mandatory training on this each year. A pharmacy team member gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would refer to the pharmacist. The pharmacy had procedures for dealing with safeguarding concerns. Pharmacy team members completed mandatory safeguarding training every two years.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They regularly complete training to help keep their knowledge and skills up to date. Pharmacy team members feel comfortable raising concerns and discussing ways to improve services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist, two pharmacy technicians and a qualified dispenser. Team members completed online training modules every two to three months when asked to by head office, as well as regularly reading new and updated SOPs. Recent examples included training on vaccinations and infection prevention and control. Team members received an appraisal with their manager each year. They explained how this gave them the opportunity to discuss how well they were performing. And to address and learning needs. They also explained the company's developing focus on team members' mental health by introducing an employee assistance programme. The programme offered various element of support, including access to counselling.

Pharmacy team members explained how they would raise professional concerns with the pharmacist, regional support pharmacist, regional manager, or head office. They felt comfortable sharing ideas to improve the pharmacy or raising a concern. And they were confident that their concerns would be considered, and changes would be made where they were needed. The pharmacy had a formal whistleblowing policy. And pharmacy team members were aware of how to access the process to report concerns anonymously.

Team members communicated with an open working dialogue during the inspection. They felt comfortable making suggestions to improve their ways of working. They explained how they had recently changed the way they assembled and dispensed medicines into multi-compartment compliance packs. And how the changes had reduced the risks of making errors. The pharmacy asked team members to achieve various targets, mainly relating to the services they provided to people. The pharmacy received regular progress updates from their regional manager. And the team were supported to meet their targets by the regional support pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it provides. The pharmacy has a consultation room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. Its floors and passageways were free from clutter and obstruction. And it kept equipment and stock on shelves throughout the secure premises.

The pharmacy had a consultation room, which was clearly signposted, and pharmacy team members used the room to deliver some services and have private conversations with people.

There was a clean, well-maintained sink in the pharmacy, which team members used for medicines preparation. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy kept heating and lighting to acceptable levels.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely. The pharmacy suitably sources its medicines. And it stores and manages its medicines appropriately and securely. The pharmacy's services are easy for people to access. And it has processes to help people understand and manage the risks of taking higher-risk medicines.

Inspector's evidence

The pharmacy had level access from the health centre car park. Pharmacy team members could provide large-print labels and instruction sheets to help people with a visual impairment access the pharmacy's services. The pharmacy also had a magnifier available for people to use at the pharmacy counter. Team members explained how they would use written communication to help people with a hearing impairment.

Pharmacy team members signed the 'dispensed-by' and 'checked-by' boxes on dispensing labels during the dispensing process. This maintained an audit trail of the people involved. They used baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy delivered some medicines to people, and it kept a record of the deliveries it made. The delivery driver left a card through the letterbox if someone was not at home when they attempted delivery. The card asked people to contact the pharmacy. People signed a record to confirm receipt of their deliveries.

The pharmacist counselled people receiving prescriptions for valproate when appropriate. And they checked if the person was aware of the risks if they became pregnant while they or their partner was taking the medicine. They also checked if the person was on a Pregnancy Prevention Programme. The pharmacy had printed materials available to provide to people to help them manage the risks of taking valproate. Team members were aware of the requirements to dispense valproate in manufacturer's original packs. And of the new requirements to help people taking topiramate manage similar risks. Team members were also aware of other higher-risk prescriptions and medicines. They explained how they managed prescriptions for children by stamping it with the word "child". This highlighted the prescription to all team members to ensure they took care to carefully check the medicines and dosages prescribed were suitable for the child's age and weight. And to make sure parents and carers were provided with the right information to help them administer them medicines to children properly. Team members also highlighted prescriptions where medicines had been prescribed in an unusual form, or when someone's medicines had changed. This helped them to prevent mistakes and to make sure people were provided with the right information to help them take their medicines safely.

The pharmacy supplied medicines for some people in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Team members included descriptions of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month. Pharmacy team members documented any changes to medicines provided in packs on the person's master record sheet. This was a record of all their medicines and the times of administration. They also recorded this information on the person's electronic patient medication record (PMR).

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridges each day and recorded their findings. The temperature records seen were within acceptable limits. Team members recorded weekly checks of medicine expiry dates. They completed checks in various areas of the pharmacy on a rolling cycle. This meant they checked all stock medicines every three months. They highlighted any short-dated items up to six months before their expiry. And they removed expiring items during the month before their expiry. Pharmacy team members responded to any alerts or recalls they received about medicines from manufacturers and other agencies. They removed any affected medicines from the shelves, and they recorded the actions they had taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains its equipment properly, so it is safe to use. And pharmacy team members manage and use the equipment in ways that protect people’s confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services it offered. It also had various reference resources available and use of the internet. The pharmacy had a set of clean, well-maintained measures available to help prepare liquid medicines. It had suitable equipment available to collect its confidential waste. And it kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view and where people's private information was protected.

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.