General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, Unit 2, Quarrydene Parade, Bletchingley Road, Merstham, Redhill, Surrey, RH1 3HU

Pharmacy reference: 9010461

Type of pharmacy: Community

Date of inspection: 10/10/2023

Pharmacy context

This NHS community pharmacy is located next door to a convenience store in a residential area of Merstham. The pharmacy is part of a chain of pharmacies. It opens six days a week. It sells medicines over the counter. It dispenses people's prescriptions. And it delivers medicines to people who have difficulty in leaving their homes. The pharmacy supplies multi-compartment compliance packs (compliance packs) to a few people who need help managing their medicines. It delivers the Community Pharmacist Consultation Scheme (CPCS) to help people who have a minor illness or need an urgent supply of a medicine. It provides a substance misuse treatment service. Its team can check a person's blood pressure. And people can get their flu jabs from the pharmacy too.

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 continually monitors the safety of its services to protect people and further improve patient safety.
2. Staff	Good practice	2.2	Good practice	The pharmacy provides its team members with the training and support they need. And it actively encourages them to improve their skills.
		2.4	Good practice	Members of the pharmacy team work well together and have a work culture of openness, honesty and learning.
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 appropriately identifies and manages its risks. It has written instructions to help its team members work safely. It continually monitors the safety of its services to protect people and further improve patient safety. It mostly keeps the records it needs to by law. It has the insurance it needs to protect people if things do go wrong. And people can share their experiences of using the pharmacy and its services to help it do things better. People who work in the pharmacy log and review the mistakes they make and learn from them to try and stop the same sort of things happening again. They can explain what they do, what they are responsible for and when they might seek help. They usually keep people's private information safe. And they understand their role in protecting vulnerable people.

Inspector's evidence

Members of the pharmacy team knew what to do if the pharmacy needed to close. They understood what they should do to make sure people could access the care they needed if the pharmacy could not open. The pharmacy had standard operating procedures (SOPs) for the services it provided. And these were reviewed by a team at the pharmacy's head office. A notice in the pharmacy told people who the responsible pharmacist (RP) was at that time. Team members were required to read and sign the SOPs to show they understood them and agreed to follow them. They knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. But the pharmacy could do more to make sure the tasks a student pharmacist could do were properly defined in the SOPs.

A team member explained that they couldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to the pharmacist. The team members who were responsible for making up people's prescriptions tried to keep the dispensing workstations tidy. They used baskets to separate each person's prescription and medication. They referred to prescriptions when labelling and picking medicines. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked and initialled by the RP.

The pharmacy had robust processes to deal with patient safety incidents and dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). And the safety and the quality of its services were monitored at least once a month. Members of the pharmacy team recorded the mistakes they made and any lessons they learnt from them. They reviewed their mistakes regularly to help them spot patterns or trends. And they shared any learnings with one another during team meetings. So, they could try to stop the same sorts of mistakes happening again and improve the safety of the dispensing service they provided. And they highlighted and separated look-alike and sound-alike drugs to help reduce the risks of them picking the wrong product.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. And it had a notice that told people how they could provide feedback about the pharmacy or its team. People could share their views and make suggestions to the pharmacy team about how the pharmacy could do things better. And, for example, the pharmacy team tried to order a person's preferred make of a prescription medicine when it was asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It had a controlled drug (CD) register. And the stock levels recorded in the register were checked regularly. But the pharmacy recently dispensed a schedule 3 CD against a private prescription which wasn't written on the designated standardised form. The pharmacy had appropriate records to show which pharmacist was the RP and when. It recorded the supplies of the unlicensed medicinal products it made. But it could do more to make sure its team routinely recorded when it received an unlicensed medicinal product. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. And a sample of these were looked at during the inspection and were generally found to be in order. But occasionally the reason for making a supply of a prescription-only medicine to a person in an emergency didn't provide enough detail.

People using the pharmacy couldn't see other people's personal information. The company that owned the pharmacy was registered with the Information Commissioner's Office. The pharmacy displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. It had arrangements to make sure confidential information was stored and disposed of securely. But people's details weren't always obscured or removed from the unwanted medicines people returned to it before being disposed of.

Members of the pharmacy team were required to complete training on data protection and safeguarding. They knew what to do or who they would make aware if they had a concern about the safety of a child or a vulnerable person. And the pharmacy's consulting room could be used by someone as a 'safe space' if they felt they were in danger.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has enough team members to provide its services safely and effectively. And it asks them to give feedback. Members of the pharmacy team work well together and have a work culture of openness, honesty and learning. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets. The pharmacy provides its team members with the training and support they need. It actively encourages them to improve their skills. And its team makes appropriate decisions about what is right for the people it cares for.

Inspector's evidence

The pharmacy team consisted of a pharmacy manager (the RP), a dispensing assistant, four trainee dispensing assistants and two delivery drivers. And a student pharmacist worked at the pharmacy occasionally too. The RP, a pharmacy technician, the student pharmacist, the dispensing assistant and two trainee dispensing assistants were working at the time of the inspection. The pharmacy relied upon its team and locum pharmacists to cover absences. But team members from another branch, such as the pharmacy technician, could provide cover too.

Members of the pharmacy team were up to date with their workload. They worked well together and helped each other so people were served quickly, and prescriptions could be dispensed safely. The RP led by example. And they supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding and people with long-term health conditions to a pharmacist.

The pharmacy had an induction training programme for its team. Members of the pharmacy team needed to complete mandatory training during their employment. They were required to undertake accredited training relevant to their roles after completing a probationary period. They regularly discussed how they were doing and their development needs with their line manager. And, for example, the dispensing assistant had completed appropriate training and were authorised under a national protocol to administer flu jabs to people. Team members were encouraged to ask questions, read newsletters from the pharmacy's head office and familiarise themselves with new products. They kept their knowledge up to date by completing online training. They had time set aside while they were at work to train and support their development. But they could choose to train in their own time too.

The pharmacy had a culture that encouraged its team to be open and honest about the mistakes people made and share learning at meetings or during one-to-one discussions. This meant it could improve the safety of the services it offered. People who worked at the pharmacy didn't feel the targets set for the pharmacy stopped them from making decisions that kept people safe. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew the pharmacy had a whistleblowing policy and who they should raise a concern with if they had one. And their feedback led to them to review and strengthen their process for dealing with part-dispensed prescriptions.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment to deliver it services from. Its premises are clean and tidy. And people can receive services in private when they need to.

Inspector's evidence

The pharmacy was air-conditioned, bright and clean. Its public-facing area was professionally presented. And its team members were responsible for keeping its premises tidy. The pharmacy generally had the workbench and storage space it needed for its workload. It had a consulting room for the services it offered that required one. Or if someone needed to speak to a team member in private. The consulting room was locked when it wasn't being used. So, its contents were kept secure. And people's conversations in it couldn't be overheard outside of it. The pharmacy had some sinks and a supply of hot and cold water. And its team members cleaned the pharmacy as often as they could when it wasn't busy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. Its working practices are generally safe and effective. And it keeps appropriate records for its vaccination service to show that it has given the right vaccine to the right person. But it doesn't always give people the information they need to take their medicines safely with their compliance packs. The pharmacy gets its medicines from reputable sources. And it stores them appropriately and securely. Members of the pharmacy team are friendly and helpful. They usually dispose of people's unwanted medicines properly. And they carry out checks to make sure the pharmacy's medicines are safe and fit for purpose.

Inspector's evidence

The pharmacy had an automated door. And its entrance was level with the outside pavement. These things made it easier for people to enter the building. The pharmacy had notices that told people about some of the services it delivered. And it had a seating area for people to use if they wanted to wait. The pharmacy team asked people who were prescribed a new medicine if they wanted to speak to the pharmacist about their medication. The pharmacy dealt with CPCS referrals. People benefited from this service as they could access the advice and medication they needed when they needed to. And this helped to reduce pressure on local GP surgeries to deal with people's urgent requests for medicines or treatments for minor illnesses. Members of the pharmacy team were friendly and helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. It kept an electronic audit trail to show it the right medicine had been delivered to the right person. But it could do more to make sure people routinely entered their signature into the delivery driver's terminal to acknowledge receipt of their medication. The pharmacy offered a walk-in flu jab service. But people could also book an appointment for their flu jab. The pharmacy had the anaphylaxis resources it needed for its vaccination service. And the pharmacy team members who vaccinated people were appropriately trained. The vaccinator asked another appropriately trained team member to check they had chosen the correct vaccine before administering it. The pharmacy kept a record for each vaccination it made. And this included the details of the person vaccinated, their consent and the details of the vaccine used. The pharmacy provided substance misuse treatments and a needle exchange service. The pharmacist could supervise the consumption of a substance misuse client's treatment. And the pharmacy team asked needle exchange clients to return spent sharps within the containers provided and deposit these into a designated waste receptacle.

The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And most of these were assembled off-site at another pharmacy (hub pharmacy). But people could choose not to have their prescriptions dispensed at the hub pharmacy. And the pharmacy team assembled these. Prescriptions dispensed at the hub pharmacy were returned to the pharmacy for people to collect or to be delivered. The pharmacy team checked if a medicine was suitable to be re-packaged. And the pharmacist assessed whether a person needed a compliance pack. The pharmacy usually kept an audit trail of the people involved in the assembly of each compliance pack. And a brief description or image of the medication contained within each compliance pack was provided. But patient information leaflets weren't routinely supplied, and people were asked to

download these instead. So, people didn't always have the information they needed to take their medicines safely.

The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. The pharmacy used reminder stickers to alert its team when these items needed to be added or if extra counselling was needed, for example, when someone collected a blood-thinning medicine. Assembled CD prescriptions awaiting collection were generally marked with the date the 28-day legal limit would be reached to help make sure supplies were made lawfully.

Members of the pharmacy team knew that women or girls able to have children mustn't take a valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed a valproate needed to be counselled on its contraindications. And the pharmacy had the resources it needed when its team dispensed a valproate.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices within their original manufacturer's packaging. But it could do more to make sure they were stored tidily on the shelves. Members of the pharmacy team checked the expiry dates of medicines as they dispensed them and at regular intervals which they recorded to show they had done so. They marked products which were soon to expire. But they didn't always mark containers of liquid medicines with the date they opened them. The pharmacy stored its stock, which needed to be refrigerated, at an appropriate temperature. And it also stored its CDs, which weren't exempt from safe custody requirements, securely.

The pharmacy had procedures for handling the unwanted medicines people brought back to it. And these medicines were kept separate from the pharmacy's stock and were placed in a suitable pharmaceutical waste bin. But some pregabalin capsules were found in one of the pharmaceutical waste bins. The pharmacy had a process for dealing with the alerts and recalls about medicines and medical devices issued by the Medicines and Healthcare products Regulatory Agency (MHRA). And, for example, the pharmacy team had removed pholcodine-containing cough and cold medicines following the receipt of an MHRA medicines recall. One of the team members described the actions they took and showed what records they made when they received an MHRA medicines recall.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's personal information is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

The pharmacy had a range of glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team checked and recorded each refrigerator's maximum and minimum temperatures on the days the pharmacy was open.

Members of the pharmacy team could check a person's blood pressure when asked. And the monitors they used for this service needed to be recalibrated every two years. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were stored securely when they weren't working.

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.