General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 108 Greenwood Way, Harwell, Didcot, Oxfordshire, OX11 6GD

Pharmacy reference: 9010860

Type of pharmacy: Community

Date of inspection: 02/09/2024

Pharmacy context

This is a community pharmacy in a residential area on the outskirts of Didcot, Oxfordshire. The pharmacy dispenses NHS and private prescriptions, sells over-the-counter medicines, and provides health advice. It also offers a few services such as the New Medicine Service (NMS), local deliveries, blood pressure checks and Pharmacy First. The pharmacy also provides multi-compartment compliance packs for people who find it difficult to manage their medicines. This includes people who live in their own homes and in residential care 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 identifies and manages the risks associated with its services in a satisfactory way. Team members understand their role in protecting the welfare of vulnerable people. They suitably protect people's confidential information. And the pharmacy generally keeps appropriate records that it needs to by law. Members of the pharmacy team manage their mistakes responsibly. But they cannot show that they are always documenting, formally reviewing, or being told about necessary details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. And some risks are not being managed as well as they could be.

Inspector's evidence

Members of the pharmacy team understood their roles well and they knew what they could or could not do in the absence of the responsible pharmacist (RP). People using the pharmacy's services could easily identify the pharmacist responsible for the pharmacy's activities as the correct notice was on display. Staff largely worked in accordance with the company's set procedures. This included current electronic standard operating procedures (SOPs) which provided the team with guidance on how to carry out tasks correctly. The pharmacy also had an appropriate complaints and incident management procedure where any issues raised were dealt with by the RP.

Prescriptions for people who had multi-compartment compliance packs were dispensed at the company's hub. Once the prescription had been labelled on the pharmacy system, and then marked as accuracy checked on the system, the details were submitted to the company's hub for assembly. Once received, the inspector was told that the previous pharmacy manager undertook a clinical check of each prescription and re-checked the contents of the compliance packs for accuracy. However, staff said that the details of the clinical check should have been marked on the prescription, but this was not seen to have been done or was being done at the point of inspection. This limited the ability of the pharmacy team to identify that this stage had been completed and the way that the pharmacy was managing this situation was not in accordance with the pharmacy's SOP for this procedure. In addition, people's consent to send their prescriptions elsewhere for assembly and to check summary care records was said to have been obtained in writing when people first signed up to this service. However, these records could not be located during the inspection, so it was not possible to verify that this had taken place. These points were discussed with the new regular pharmacist who was imminently starting at the pharmacy and was present during the inspection (see Principle 2).

To help ensure people's prescriptions were dispensed safely, staff used stamps to highlight look-alike and sound-alike medicines, prescriptions for children and controlled drugs (CDs), when they were being processed. They also identified and ensured that prescriptions for CDs had an appropriate date. Pharmacists and staff worked in different areas. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. There was a facility on the dispensing labels to help identify who had been involved in the dispensing process and team members routinely used these as an audit trail. However, most of the dispensary's workspaces were quite cluttered and taken up with baskets of prescriptions. The pharmacy's stock was also stored in a disorganised way (see Principle 4). This increased risks.

The pharmacy displayed details about how people could make a complaint or provide feedback and

pharmacists described handling incidents and complaints in a suitable way. This included investigating the situation, identifying the root cause, and reporting the details to the superintendent pharmacist (SI). Errors that occurred during the dispensing process (near miss mistakes) were also routinely passed back to staff for them to identify. They were seen to be regularly recorded. Staff explained that the details were reviewed, collated, and subsequently submitted to the company's head office. Every month, staff received a newsletter which identified safety concerns, patterns and trends seen across all the company's pharmacies, which the team read. However, the inspector was told that the previous pharmacy manager did not share details about the review of near misses with staff. And there were no documented details present which could help verify that this process had routinely taken place. This situation made it harder for staff to identify their own as well as the pharmacy's trends and patterns with respect to internal mistakes.

The pharmacy's team members had been trained to protect people's confidential information. Details were on display in the retail area explaining the pharmacy's privacy policy. The team used their own NHS smart cards to access electronic prescriptions. Confidential waste was separated and disposed of appropriately and there was no sensitive information visible from or left in the retail area. The RP had been trained to level two to safeguard the welfare of vulnerable people and the new, regular pharmacist was trained to level three. All members of the team could recognise signs of concern, this included newer team members who also knew who to refer to in the event of a concern and the pharmacy's chaperone policy was on display.

Most of the pharmacy's records were compliant with statutory and best practice requirements. This included a sample of electronic registers seen for CDs, records of emergency supplies and records of supplies of unlicensed medicines. On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of CDs that had been returned by people and destroyed at the pharmacy had been maintained and records verifying that fridge temperatures had remained within the required range had been completed. The RP record was mostly complete, but some details of when the pharmacist's responsibility had ceased were missing. There were also issues with the electronic register for private prescriptions as details of the prescribers were often seen to be missing, incomplete or incorrect. The pharmacy's professional indemnity insurance was with the National Pharmacy Association and was due for renewal after 30 April 2025.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s team members have a range of skills and experience. They can also progress and develop their essential training further. The company who owns the pharmacy gives the team access to training resources to complete their ongoing training. This helps keep their skills and knowledge up to date.

Inspector's evidence

On the day of the inspection, staff present included the RP who was a locum pharmacist, the newly employed pharmacist, the assistant manager who was a full-time, trained dispensing assistant, two medicines counter assistants (MCAs) and a part-time pharmacy student who arrived towards the latter half of the inspection, she had also completed formal dispensing training. The assistant manager was in training to complete an accuracy checking technician course and both MCAs were enrolled on appropriate accredited training to support this role. There were also another two part-time, trained dispensing assistants who were not working at the time of the inspection. The pharmacy was a few days behind with the workload and the inspection highlighted that staff were not always completing necessary paperwork or tasks in accordance with the company’s procedures as described under Principles 1 and 4. The assistant manager was due to relocate in the next six weeks and the pharmacy was currently advertising to recruit another member of staff. When it was put to the team that the pharmacy's current workload was seen to be stretching for the number of staff available on the day of the inspection, the inspector was told that the situation was manageable, staff said they worked extra hours and contingency cover was provided through relief staff who worked in other pharmacies owned by the same company.

Team members wore uniforms and name badges. The MCAs asked relevant questions before selling medicines and they referred appropriately. The company supported staff to progress and develop their training further. Team members described using SOPs, formal training material from accredited courses and access to online resources through the company’s intranet. They also had annual appraisals and verbally discussed details or were told about updates through the company’s intranet and emails.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises present a professional image and generally provide a suitable environment for people to receive healthcare services. A separate space is also available where people can have confidential conversations with the pharmacy team.

Inspector's evidence

The pharmacy was bright, and its retail area was professionally presented with modern fixtures and fittings. The pharmacy had suitable ambient temperature and ventilation for storing medicines and safe working. The retail area was clean and tidy and there was also a separate consultation room to hold private conversations and provide services. The room was kept locked, it was of an adequate size and clearly signposted. Some of the dispensary's fixtures and fittings however, appeared dated and in some places needed cleaning. There was an adequate amount of space for staff to carry out dispensing tasks safely. But as stated, under Principle 1, it was also quite cluttered.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services in a satisfactory way. Its team members help ensure that people with different needs can easily access the pharmacy's services. And the pharmacy sources its medicines from reputable suppliers. But the pharmacy does not always manage its medicines in the most effective way. The pharmacy has some checks in place to ensure that medicines are not supplied beyond their expiry date. But records to help verify this are missing. And the pharmacy's team members are not always identifying people who receive higher-risk medicines or making the relevant checks. This makes it difficult for them to show that people are provided with appropriate advice when these medicines are supplied.

Inspector's evidence

People could enter the pharmacy from the street which was step free and the pharmacy had automatic doors. The retail area consisted of clear, open space. This helped people with restricted mobility or using wheelchairs to easily access the pharmacy's services. There were a few chairs inside the pharmacy if people wanted to wait for their prescriptions and a few car parking spaces available outside. The pharmacy's opening hours were displayed alongside a few posters indicating the services it provided. Staff could make suitable adjustments for people with diverse needs, they offered a separate area or the consultation room when required, spoke slowly and clearly to help people to lip read, used written communication if needed and Google translate where possible. Some team members were also multilingual which assisted people whose first language was not English.

The pharmacy also had an automated collection point. Dispensed prescriptions were stored inside and could be collected from a vending machine. This could be accessed by people 24 hours a day and on seven days of the week. The machine was located to one side of the premises, with the internal section accessible from one end of the retail area. This section was kept locked. There was an SOP to provide guidance to the team about this service. Prescriptions for CDs, fridge, higher-risk medicines, and bulky items were not included as part of the service.

The pharmacy offered a delivery service for people who found it difficult to attend the pharmacy and the team kept suitable records about this service. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended.

All the pharmacy's multi-compartment compliance packs were dispensed at the company's head office and sent back to the pharmacy for collection. This included for people who lived at home as well as for residents in a few care homes. The pharmacy ordered prescriptions on behalf of people for this service and specific records were kept for this purpose. Any queries were checked with the prescriber and the records were updated accordingly. Descriptions of the medicines inside the packs were provided, all medicines were removed from their packaging before being placed inside the compliance packs and patient information leaflets (PILs) were routinely supplied. Staff had not been approached to provide advice regarding covert administration of medicines to care home residents.

Staff were aware of the additional guidance when dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). They ensured these medicines were dispensed in the original manufacturer's packs, that relevant warning details on the packaging of these medicines were not

covered when they placed the dispensing label on them, and appropriate educational material was available to provide if required. However, staff were unable to confirm whether the pharmacy had previously identified people in the at-risk group who had been supplied sodium valproate. The inspector was told that the previous pharmacy manager did not share this information with the team. In addition, team members did not routinely identify people prescribed medicines which required ongoing monitoring. The pharmacist was said to counsel people when these medicines were first prescribed but staff were not routinely making relevant checks or asking for details about relevant parameters, such as blood test results for people prescribed these medicines.

The pharmacy obtained its medicines and medical devices from licensed wholesalers. Short-dated medicines were seen to be identified. CDs were stored securely and medicines requiring refrigeration were stored in a suitable way. Records verifying that the temperature of the fridge had remained within the required range had been appropriately completed. Dispensed medicines requiring refrigeration and CDs were also stored within clear bags. This helped to easily identify the contents upon hand-out. Medicines returned for disposal, were accepted by staff, and stored within designated containers. People who brought sharps back for disposal were redirected accordingly. Drug alerts were received electronically. Staff explained the action the pharmacy took in response and relevant records were kept verifying this.

However, medicines were consistently stored on dispensary shelves in a disorganised and untidy way. This increased the risk of selecting an incorrect medicine. Team members said that they regularly checked medicines for expiry but current records of when this had taken place could not be located. Whilst there were no date-expired medicines seen, this limited the pharmacy's ability to demonstrate that this process had routinely been taking place. In addition, medicines requiring disposal had been stored in the staff WC. This increased risks.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. Team members largely keep them clean. And the pharmacy's equipment is used in an appropriate way to keep people's private information safe.

Inspector's evidence

The pharmacy's equipment included legally compliant CD cabinets and appropriately operating medical fridges. The pharmacy team had access to current reference sources, they could use standardised conical measures to measure liquid medicines and they had the necessary equipment for counting tablets. Some of this equipment, however, could have been cleaner. This included the dispensary sink for reconstituting medicines. The pharmacy had hot and cold running water available. Suitable equipment to carry out the Pharmacy First service and to measure people's blood pressure was present. This equipment was said to be new. The pharmacy used an automated software system (Methasoft) to dispense methadone for people. This was said to be calibrated and cleaned daily. However, the inspection took place early in the morning and when the cabinet holding the relevant equipment was opened, it was sticky with residue. The pharmacy's computer terminals were password protected. They were also positioned in places where unauthorised access was not possible. The pharmacy had portable telephones so that private conversations could take place away from being overheard and confidential waste was suitably disposed of.

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.