General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 135 London Road, Southborough, Tunbridge Wells, Kent, TN4 0NA

Pharmacy reference: 9011686

Type of pharmacy: Community

Date of inspection: 15/03/2022

Pharmacy context

The pharmacy is next to a medical centre in Tunbridge Wells town centre in a largely residential area. The pharmacy receives over 95% of its prescriptions electronically. It provides its services to a wide range of people across a variety of age ranges. And its services include, the New Medicine Service, blood pressure checks, flu vaccinations, travel vaccinations. It is also able to supply a variety of medicines using Patient Group Directions. It provides medicines as part of the Community Pharmacist Consultation Service. And it supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. The pharmacy also provides substance misuse medications to a small number of people. The inspection was carried out during the Covid-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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 is good at recording and reviewing any mistakes that happen during the dispensing process. It uses this information to help reduce future risks and to make its services safer. And it shares learning points with other pharmacies in the group. Staff are open about any mistakes that happen. And they regularly discuss them to help make the pharmacy's services safer.
2. Staff	Standards met	2.2	Good practice	The pharmacy is good at supporting the ongoing learning of its staff. It promotes learning, continuous improvement and the personal development of its team members. Team members are given time set aside to do ongoing training.
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 to help provide them safely. It routinely records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk. The pharmacy protects people's personal information well. And people can provide feedback about the pharmacy's services. The pharmacy keeps its records ;largely up to date and accurate. Team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted measures for identifying and managing risks associated with its activities. It had carried out workplace risk assessments in relation to Covid-19. And there were documented, up-to-date standard operating procedures (SOPs), and processes for reporting and reviewing dispensing mistakes. Team members had signed to show that they had read, understood, and agreed to follow the SOPs. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And the outcomes from the reviews were discussed openly during the regular team meetings. Learning points from the reviews were also shared with other pharmacies in the group. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. A recent error had occurred where the wrong strength of medicine had been supplied to a person. The person was given the correct strength and the pharmacy's head office was informed. Team members were reminded to take care when selecting these medicines. The pharmacy kept a record of interventions where prescribing errors had been made. And what action had been taken in response and the outcome.

Workspace in the dispensary was well organised and there was a clear workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. The accuracy checking technician (ACT) knew that she should one carry out an accuracy check on prescriptions that had been stamped by the pharmacist to show that a clinical check had been carried out. And she knew that she should not check items if she had been involved in the dispensing process. She did not check prescriptions for controlled drugs (CDs).

Team members' roles and responsibilities were specified in the SOPs. Team members could access the pharmacy if the pharmacist had not turned up. They knew which tasks could and should not be carried out before there was a responsible pharmacist (RP). And they knew that they should not sell pharmacy-only medicines or hand out dispensed prescriptions if the pharmacist was absent from the pharmacy during opening times.

The pharmacy had current professional indemnity and public liability insurance. All necessary information was recorded when a supply of an unlicensed medicine was made. The nature of the emergency was routinely recorded when a supply of a prescription-only medicine was supplied in an

emergency without a prescription. This made it easier for the pharmacy to show why the medicine was supplied if there was a query. There were signed in-date patient group directions available for the relevant services offered. The pharmacy used an electronic CD register. It was filled in correctly, and the CD running balances were checked regularly. Any CD liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right RP notice was clearly displayed, and the RP record was largely completed correctly. But there were a few occasions when the pharmacists had not completed the record when they had ceased to be the RP. The private prescription records were mostly completed correctly, but the prescriber details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The pharmacist said that she would remind team members to ensure that this information was recorded when the prescription was entered onto the computer.

Confidential waste was removed by a specialist waste contractor. Computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. Team members had completed training about the General Data Protection Regulation.

The pharmacy had not carried out a patient satisfaction survey since it had opened. But one was due to be started soon. The complaints procedure was available for team members to follow if needed and one of the dispensers said that any complaints would be referred to the pharmacist. And the area manager would be informed. Team members were not aware of any recent complaints.

The pharmacist and ACT had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had completed some safeguarding training provided by the pharmacy's head office. The ACT could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that she was not aware of any safeguarding concerns at the pharmacy. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. It provides team members with structured ongoing training to help support their training needs and maintain their knowledge and skills. And they are provided with time to complete this at work. The team discusses adverse incidents and uses these to learn and improve. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one regular full-time pharmacist, three trained dispensers and one trainee dispenser working during the inspection. The trainee dispenser had completed all of his training and was undergoing his final assessment during the inspection. Team members wore name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The inspector discussed with the pharmacist about the reporting process in the event that a team member tested positive for the coronavirus.

The trainee dispenser was working on the medicines counter at the start of the inspection. He appeared confident when speaking with people. And he was aware of the restrictions on sales of pseudoephedrine-containing products and knew the reason for this. He said that he would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. And he used effective questioning techniques to establish whether the medicines were suitable for the person.

The pharmacist and ACT were aware of the continuing professional development requirement for the professional revalidation process. The pharmacist felt able to take professional decisions and would contact the pharmacy's head office if she was unsure about anything. She had completed declarations of competence and consultation skills for the services offered, as well as associated training. And she had undertaken recent training about inhaler technique, health inequalities and consultation skills. The pharmacist ensured that team members had undertaken mandatory training provided by the pharmacy's head office. And this was also monitored by the head office. Team members had access to the pharmacy's online training suite and 'Academy Plus'. They were allowed protected training time each week and received rewards for completing certain numbers of training modules. The team also had regular reviews of any dispensing mistakes and discussed these openly during the meetings.

The pharmacist said that team members had yearly appraisals and performance reviews which were carried out be either the pharmacist or the assistant manager. The regional support manager would carry out the assistant manager's review and the pharmacists would be carried out the area manager. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. There were informal meetings held each morning to allow team members to discuss any issues and allocate tasks.

Targets were set for the New Medicine Service. The pharmacist said that the target was achievable, and she would not let any targets affect her professional judgement. She explained that she carried out the

services for the benefit of people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

People can have a conversation with a team member in a private area. The premises generally provide a safe, secure, and clean environment for the pharmacy's services. But the pharmacy has limited storage space and not all items are stored as securely as they could be.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter and an extendable barrier was used to restrict access. There was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There was a one-way system in shop area to help people keep a suitable distance from each other. A clear screen at the medicines counter was used to help minimise the spread of infection. There were three chairs in the shop area. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and could be accessed from the shop area and the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

Toilet facilities were clean and there were separate hand washing facilities available. The room was used to store some items which should not be kept in there. And this made it harder for the pharmacy to show that these were being kept securely. There was minimal storage space in the dispensary area and the pharmacist had mentioned this to the pharmacy’s head office. The pharmacy had attempted to find alternative places not in the pharmacy to store some items but had not yet been successful. The pharmacist said that she would look into the issue again.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services. It dispenses medicines into multi-compartment compliance packs safely and manages the service well.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance, with an automatically opening door. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The pharmacist explained that the pharmacy often produced large-print labels for those people who needed them.

The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacist said that she would ensure that records were kept in future. Prescriptions for higher-risk medicines were not always highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. Prescriptions for Schedule 3 and 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The pharmacist said that prescriptions for these medicines would be highlighted in the future. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said that team members checked CDs and fridge items with people when handing them out. The pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist explained the checks she would carry out with someone who had been recently prescribed one of these types of medicines. And she would make a record on the person's medication record if they were on a PPP. The pharmacist said that she would request additional patient information leaflets from the manufacturer so that these could be given to people when needed. The warning cards were attached to the medication boxes.

Stock was stored in a well-organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months were clearly marked and the month of expiry was added to the stickers to help team members while dispensing them. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked frequently. People were kept informed about supply issues and 'owings' notes were provided when prescriptions could not be dispensed in full. Prescriptions for alternate medicines were requested from prescribers where needed. And prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacist said that uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their items after around two months. The pharmacy scanned the barcode on the prescription which generated the text message to send to the person. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where

possible.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. Around 75% of the prescriptions for these packs were dispensed at the pharmacy's hub. Prescriptions for people receiving their medicines in these packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested by the pharmacy. The dispenser said that the pharmacy usually contacted people to see if they needed them when their packs were due. But there were a small number of people who were not able to manage this themselves. The pharmacy had discussed this with the people's GP and ordered the prescriptions on their behalf. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. This made it easier for people to have up-to-date information about how to take their medicines safely. Team members wore gloves and used tweezers when handling medicines that were placed in these packs.

CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned, and expired CDs were clearly marked and kept separated from dispensing stock. Returned CDs were recorded in a register and destroyed with a witness, and two names were recorded. There were some Schedule 3 and 4 CDs found in the pharmaceutical waste bins. The pharmacist said that she would remind team members about the need for these medicines to be denatured before disposal. The medicines found were removed from the waste bin and the pharmacist said that these would be disposed of appropriately.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery. The pharmacist explained that the driver discussed with a team member when a person was not in and these undelivered medicines were kept separated. The person would be contacted before another delivery attempt was made to ensure that they would be at home to accept the delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS, the MHRA and the pharmacy's head office. Team members explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Separate liquid measures were marked for use with certain liquids. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only to help avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was less than one year old. The pharmacist said that it would be replaced in line with the manufacturer’s guidance. The weighing scales were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed. The pharmacy had personal protective equipment such as gloves, masks, and hand sanitiser. These were used to help minimise the spread of infection.

Fridge temperatures were checked daily; maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

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.