

Registered pharmacy inspection report

Pharmacy Name: Daytom Pharmacy, Unit 7, Stirlin Business Park,
185 Sadler Road, Lincoln, Lincolnshire, LN6 3AF

Pharmacy reference: 9011706

Type of pharmacy: Internet

Date of inspection: 08/06/2022

Pharmacy context

This is a distance selling pharmacy which offers services to people through its website, daytompharmacy.co.uk. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines. And it supplies medicines to people residing in care homes. The pharmacy premises are not generally accessible to members of the public due to its NHS distance selling model. This means the pharmacy supplies all medicines through either its local delivery service or through national postal services.

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	N/A	N/A	N/A
2. Staff	Standards met	2.5	Good practice	The pharmacy proactively engages with its team members by encouraging them to share their ideas and concerns.
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 acts to identify and appropriately manage the risks associated with providing its services. It clearly advertises how people can provide feedback about its services. And it acts on the feedback it receives to help inform improvement. The pharmacy generally keeps the records it needs to by law up to date and it protects people's private information appropriately. Pharmacy team members have the knowledge and ability to recognise and raise concerns to help safeguard vulnerable people. They behave openly and honestly by discussing mistakes they make during the dispensing process. And they act to reduce risk following these discussions.

Inspector's evidence

The pharmacy opened in November 2021, during the coronavirus pandemic. It had considered the risks of operating during a pandemic. This included having an up-to-date and personalised business continuity plan. And contingency arrangements for staffing the pharmacy should the current team be absent from work. Pharmacy team members worked at individual workstations and could socially distance with ease whilst working. A team member discussed extra precautions which the pharmacy continued to take when delivering medicines to care homes.

The pharmacy had standard operating procedures (SOPs) to support its team members in working safely and effectively. These had been implemented in November 2021 by the superintendent pharmacist (SI), but there was no current review date set. Recent changes made to the way the pharmacy managed its multi-compartment compliance pack service led to a discussion about the importance of ensuring practice reflected the process recorded within SOPs. And this discussion highlighted the need to schedule SOP reviews. The SOPs covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. And pharmacy team members had read and signed the procedures as part of their induction process. The pharmacy business continuity plan and SOPs formed part of the pharmacy's risk management approach. But the pharmacy had not completed a written risk assessment to help it identify and manage risks associated with providing its services at a distance.

The pharmacy had a near-miss error reporting tool. And team members consistently recorded mistakes they made during the dispensing process. Team members were encouraged to find and correct their own mistakes. And they regularly shared learning through team discussions. Recent actions taken to reduce the risk of near misses included a review of stock layout on dispensary shelves. And changes to the way the pharmacy managed its medicine compliance pack service. The pharmacy had a written procedure to follow in the event a person reported a dispensing incident. The SI confirmed no incidents had been reported to date. And they discussed the importance of sharing anonymised learning from incidents. For example, through the NHS Learn from patient safety events service (LFPSE).

The pharmacy had a complaints procedure in place and it advertised how people could raise a concern or provide feedback through its website and practice leaflet. It kept a copy of its complaints procedure displayed in the dispensary for team members to refer to if needed. The pharmacy had adapted the way it produced medication administration records (MARs), in response to feedback from care homes. The updated MARs provided more space for care home staff to sign to confirm the administration of a

medicine had taken place. The pharmacy had procedures relating to safeguarding vulnerable adults and children. Both team members on duty had completed level two safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE). And the SI had sought assurances that other team members had completed safeguarding training in previous roles. Pharmacy team members had access to contact information for safeguarding teams. And team members on duty had a good understanding of how they would act to identify and report a safeguarding concern. One team member discussed the steps they would take to gain assurance that a house-bound person was safe and well in the event of a failed delivery.

The pharmacy held all person identifiable information within the registered premises. And there was no public access into the dispensary. It had secure arrangements for disposing of confidential waste. The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed the correct details of the RP on duty. And the RP register was completed in full. The pharmacy kept records of the private prescriptions it dispensed within an electronic prescription only medicine (POM) register. It generally kept the register in accordance with legal requirements. But there was some inaccuracy on occasion as the date the prescription was written defaulted to the date of dispensing within the POM register. The pharmacy's CD register was maintained with running balances. But pharmacy team members didn't always make entries in the register on the day a CD was received or dispensed. Records made during the inspection to bring the register up to date spanned the last 48-hours. This heightened the risk of a mistake not being picked up and investigated immediately. Balance checks against physical stock took place regularly. A physical balance check of a CD conducted during the inspection complied with the running balance within the register. The pharmacy had a patient returned CD destruction register in the event it received returned CDs for destruction.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy employs suitably skilled team members to manage its workload. And it has appropriate contingency arrangements in place in case of staff absence. The pharmacy actively engages with its team members to help inform improvements to service delivery. And it encourages its team members to speak up by openly informing them of how to raise concerns. Pharmacy team members work well together and are fully supportive of each other. They engage in regular conversations related to patient safety and workload management.

Inspector's evidence

The pharmacy team consisted of the SI, a pharmacy technician, a qualified dispenser and a delivery driver. The pharmacy had good contingency plans to cover both planned and unplanned leave if needed. This included the strict management of work timescales and access to additional qualified team members, including dispensers and pharmacists. The delivery driver was enrolled on an accredited training course to support them in their role. Team members on duty shared examples throughout the inspection of learning associated with the safe delivery of services. For example, learning how to use a new patient medication record (PMR) system effectively. The pharmacy team regularly discussed ideas related to growing the business. But the pharmacy did not set specific targets related to pharmacy services.

It was evident that team members worked together well to manage workload. And they benefitted from having worked together for some time in previous roles. Continual learning related to workflow and patient safety took place through discussions. But the team did not always record the outcome of these discussions. This meant there could be some missed opportunities to measure the effectiveness of any changes made as a result of sharing the learning. Pharmacy team members had a good understanding of how to raise a concern at work. All team members had been briefed about the importance of acting openly and honestly. And they had been made aware of how to escalate a concern to either the NHS or GPhC if required. The pharmacy fully encouraged feedback from its team members. And the SI used this feedback to help inform the way the pharmacy provided its services. For example, team members had been fully involved in contributing to the layout of the pharmacy at the design stage. And a team member demonstrated how they were empowered to make changes following regular discussions.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and secure. It offers a suitable environment for delivering healthcare services.

Inspector's evidence

The pharmacy website included the name, address, and contact information for the pharmacy. It also advertised details of the company that owned the pharmacy and the SI's name. The website provided a link to the GPhC register for checking the pharmacy, but not to the registration status of the SI. This appeared to be an oversight, as there was clear information relating to a link for both the pharmacy and the SI. The pharmacy had not applied to display the GPhC voluntary internet logo to date. The SI explained that this was due to the temporary halt on applications following the UK's departure from the European Union. The pharmacy did not sell any medicines through its website.

The pharmacy was a good size for the level of activity taking place. There was clearly designated space for different types of dispensing activity. This reduced the risk of distraction when team members were concentrating on their work. And staff break facilities were suitably located at the back of the premises, away from working areas. The pharmacy was clean throughout. It was protected from unauthorised access. And it was maintained to a good standard. Lighting throughout the pharmacy was bright and air-conditioning helped to maintain an ambient temperature.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy makes its services accessible to people. It obtains its medicines from reputable sources. And it has systems to ensure it stores its medicines safely and securely. The pharmacy team members work well to manage dispensing services efficiently. And they provide relevant information to people to help them take their medicines safely. But there are occasions when pharmacy team members work outside of documented procedures when supplying medicines. This could mean they are not always working consistently or in the safest way.

Inspector's evidence

People accessed the pharmacy's services through either its website, by email or by telephone. The pharmacy's website provided further information about some of the services available and explained how people could contact the pharmacy and speak with a member of the team. Pharmacy team members were aware of sign-posting arrangements in the event they could not provide a service or a medicine.

The pharmacy had processes in place to identify and support people taking higher risk medicines. Interventions and counselling took place through telephone calls. The pharmacy kept some paper-based intervention records. But team members did not regularly record interventions and monitoring checks within individual PMRs. This made it more difficult for the team to consistently check intervention notes when dispensing medicines. Pharmacy team members demonstrated a sound understanding of the requirements of the valproate pregnancy prevention programme (PPP). This included counselling and checks associated with having a pregnancy prevention plan in place, issuing the patient card and the correct placement of dispensing labels on valproate packs.

The pharmacy team planned its workload well. The team used baskets throughout the dispensing process. This kept medicines with the correct prescription. And team members signed their initials on dispensing labels to identify who had assembled and checked a medicine. The inspection identified that pharmacy team members did not routinely place dispensing labels on bottles of liquid medicines, instead they placed labels on the outer container. A discussion took place to highlight the risks of this practice should a person remove a bottle from its original packaging. The pharmacy kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. Due to the COVID-19 pandemic it did not ask people to sign when accepting their medicine from the delivery driver. But the pharmacy did keep a delivery audit trail identifying all deliveries made. The pharmacy had procedures to support the supply of medicines through postal services. But all deliveries to date had been made through the local delivery service.

The pharmacy used planners to support team members in ensuring work associated with care home services and deliveries was carried out efficiently. A 'processing tracker' supported workflow associated with the supply of medicines in multi-compartment compliance packs. This provided details of the prescription journey from ordering to delivery. Assembled compliance packs included full dispensing audit trails and descriptions of the medicine inside. And the pharmacy supplied patient information leaflets (PILs) at the beginning of each four-week cycle. The pharmacy assembled some compliance packs against the first prescription in a four-week cycle, ahead of it receiving prescriptions for the

following three weeks. It had appropriate measures in place to manage the risks associated with this practice. But the practice observed was not in accordance with what was recorded within the pharmacy's SOPs. The pharmacy team took care to communicate regularly with its care homes. It supplied MARs alongside medicines. And it supplied PILs to care homes monthly. Care homes returned completed re-ordering MARs to the pharmacy. This informed checks prior to the dispensing process beginning. And it allowed the pharmacy team to manage queries and inform care homes of any missing prescriptions ahead of each medicine cycle beginning.

The pharmacy sourced medicines from licensed wholesalers. Medicine storage in the dispensary was orderly with medicines generally stored in their original packaging. An amber bottle containing some tablets that had been removed from a compliance pack was identified and segregated ready for destruction during the inspection. The pharmacy had a secure cabinet to store higher risk medicines. Medicines inside the cabinet were stored in an orderly manner. And the pharmacy identified these medicines during the dispensing process to ensure additional legal and safety checks took place prior to delivery. The pharmacy stored medicines subject to cold chain requirements safely in a refrigerator. It kept a fridge temperature record to ensure it stored these medicines at the correct temperature. The team followed a date checking rota. This helped to manage stock and identify short-dated medicines. No out-of-date medicines were found during random checks of dispensary stock. The pharmacy had medical waste bins available to support the team in managing pharmaceutical waste. The pharmacy received details of drug alerts and recalls by email. And it kept an audit trail of the action taken in response to these alerts.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has a suitable range of equipment to support the delivery of its services. Members of the pharmacy team use the equipment and facilities in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members had access to up-to-date electronic reference resources. For example, the British National Formulary (BNF). And they could access the internet to help resolve queries and to obtain up-to-date information. The pharmacy stored some records electronically on password protected computers. And pharmacy team members used personal NHS smart cards to access this information. The pharmacy had a range of clean equipment available to support the delivery of pharmacy services. This equipment included counting apparatus for tablets and capsules, and British Standard measuring cylinders for measuring liquid medicines. Equipment associated with the supply of medicines in compliance packs was single use.

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.