General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, 24 Market Place West, Ripon, North Yorkshire, HG4 1BN

Pharmacy reference: 9011976

Type of pharmacy: Community

Date of inspection: 12/01/2024

Pharmacy context

This community pharmacy is in the centre of Ripon, a small city in North Yorkshire. The pharmacy dispenses NHS prescriptions and sells over-the-counter medicines. It supplies several people with their medicines in multi-compartment compliance packs to help them take their medication correctly. And it delivers medicines to some people's homes. The pharmacy provides other NHS services including the hypertension case finding service. And the community pharmacist consultation service (CPCS). The pharmacy has an automated prescription collection point that allows people to collect their medication 24-hours a day, seven days a week.

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 well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it generally keeps the records it needs to by law. Team members suitably protect people's confidential information, and they understand their role to help protect vulnerable people. The team members respond appropriately when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) that provided team members with information to perform tasks supporting the delivery of its services. Several SOPs had review dates due in 2023 but this had not been completed. Team members had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. They demonstrated a clear understanding of their roles and worked within the scope of their role. The pharmacy had risk assessments in place for the services it offered including the hypertension case finding service. One of the pharmacy technicians, with support from the pharmacist manager, completed the risk assessments and shared them with the team.

Team members were asked to find and correct errors spotted at the final check of a prescription. The pharmacy kept records of these errors known as near miss errors. The records were completed by the pharmacist or the accuracy checking pharmacy technician after discussing the error with the team member. A sample of records showed details of what had been prescribed and dispensed and the actions taken. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. This included completing an online report and a root cause analysis. All team members were informed of the dispensing incident so they could learn from it and were aware of the actions taken to prevent such errors from happening. The accuracy checking pharmacy technician (ACPT) regularly reviewed the near miss errors and dispensing incidents. And discussed the outcome from the review with the pharmacist manager before sharing it with team members. Recent reviews resulted in team members attaching warning stickers to shelves holding medicines that looked alike and sounded alike. The stickers reminded team members to double check the medication they had selected. And to remind them when they were putting the medication stock away to ensure these medicines were separated from each other. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And the company's website provided people with information on how to raise a concern.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers generally met legal requirements. On a few occasions the pharmacist on duty had not signed out of the RP log. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. Appropriate records were kept of the receipt and supply of unlicensed medicines. Team members completed training about protecting people's private information and they had signed confidentiality agreements. Information on the company's website included a privacy policy. Team members separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. And team members had completed training relevant to their roles. The delivery driver reported concerns about people they delivered to back to the team who took appropriate action such as contacting the person's GP. The pharmacy displayed information advising people it was part of the Safe Space initiative which supports people experiencing domestic abuse.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work very well together, and they are good at supporting each other in their day-to-day work. They discuss ideas and implement new processes to enhance the effective delivery of the pharmacy's services. Team members have opportunities to receive feedback and they are encouraged to complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist manager and regular locum pharmacists covered the opening hours. They were supported by a part-time ACPT, two part-time pharmacy technicians, two full-time dispensers and three part-time dispensers. At the time of the inspection most team members were on duty. The pharmacist manager was reviewing the team profile and working hours to ensure there was sufficient cover to support the services.

The team had faced some staffing challenges in the previous few months and an increased workload following the merger of this pharmacy with another one owned by the company. This took place at the same time the pharmacy relocated from a retail unit close by. Team members worked well together to manage the workload and they ensured people presenting at the pharmacy were promptly helped. They had specific roles, but all team members knew how to undertake key tasks to ensure the tasks were completed. And to help the team prepare for busy periods such as Bank Holidays.

The team held meetings as and when required and team members were encouraged to share ideas. The pharmacist manager had developed a schedule for processing the multi-compartment compliance packs sent to the company's offsite dispensing hub. This allowed time for the team to manage any additional dispensing when the packs were returned. The pharmacist manager had been involved with the plans for the new pharmacy such as the layout of the consultation room.

The team members used online training modules to keep their knowledge up to date. Most training modules were linked to regulatory training but occasionally an opportunity arose for a team member to complete training linked to their own development. The pharmacy usually provided formal performance reviews for the team, but they had been paused during the move and merger. Team members continued to receive informal feedback from the pharmacist manager and could discuss their development needs. One of the pharmacy technicians had taken the opportunity to discuss the accuracy checking course which was agreed. Similarly, one of the dispensers had discussed the accuracy checker role which they were due to start training for. One of the pharmacy technicians had expressed interest in supporting the seasonal flu vaccination service and had completed a vaccinator training course. Recently other team members had been enrolled onto the vaccinator training course.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services it provides. It has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy team kept the premises tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, and alcohol gel was also available for hand cleansing. Team members kept the work surfaces in the dispensary tidy and they kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy had enough storage space for stock, assembled medicines and medical devices. And it had a defined professional area where medicines for sale were healthcare related. The pharmacy had a soundproof consultation room which the team used for private conversations with people and when providing services such as the flu vaccination. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which help people to meet their healthcare needs. Team members manage the pharmacy services well to help make sure people receive medicines when they need them. They store medicines properly and they complete regular checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via an automatic door. Team members provided people with information on how to access other healthcare services. And they kept a small range of healthcare information leaflets for people to read or take away. Team members wore name badges detailing their role so people using the pharmacy knew who they were speaking to. They asked appropriate questions of people requesting to buy over-the-counter medicines to ensure the most appropriate product was supplied. And they knew when to refer requests to the pharmacist. The computer on the pharmacy counter had access to the pharmacy's electronic patient records (PMR). So, when a person presented the team member could check what stage their prescription was at.

The NHS CPCS service was popular, but all referrals came from NHS 111 rather than local GP teams. People contacting their GP surgery were directed to the pharmacy for advice and treatment for minor conditions without the NHS referral pathway being used. Some team members had been trained to support the pharmacists to deliver the NHS hypertension case finding service which many people used. Several people who had accessed the service were identified as having undiagnosed hypertension and were referred to their GP for further tests and medication.

The pharmacy provided multi-compartment compliance packs to help many people take their medicines. People new to the service were assessed by the pharmacist to ensure the service was suitable for them. And to offer alternatives if the service was not appropriate. This led to the pharmacist contacting the person's GP to discuss the alternate support that could be provided such as a medication review. To manage the workload team members divided the preparation of the packs across the month. They usually ordered prescriptions two weeks before supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication and dose times which team members referred to during the dispensing and checking of prescriptions. And to record information received about the person's medication such as dose changes. Most prescriptions for this service were sent to the company's offsite hub pharmacy for the packs to be assembled there. Before sending the prescription information, the team processed the prescription, and the pharmacist completed a clinical check of the prescriptions along with an accuracy check of the information generated. The sheet that accompanied the packs detailing the medication and dose times was generated by the pharmacy and sent with the prescription to the hub. A copy was kept at the pharmacy for the team to refer to. Packs returned to the pharmacy were colour coded to indicate actions the team had to take such as dispensing a medicine that was not available at the hub. Descriptions of the products within the packs were either handwritten when dispensed at the pharmacy or displayed as a photograph when dispensed at the hub. So, people could identify the medicines in the packs. Information provided by the manufacturer about the medication was accessed via a bar code attached to the packs. Team members identified people who did not have the technology to scan the bar code and provided them with the paper version.

The team provided medicines to people living in two local care homes. The care home team ordered the prescriptions each month. And provided the pharmacy with copies of the medication requested for the pharmacy team to refer to when the prescriptions arrived. The pharmacist manager provided advice and support for one of the care home teams on how to manage prescriptions for people new to the care home. So, they had their medication when they needed it.

The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. And were stored securely with each person's dose separated from other people's doses. The team used a communication book to record information such as when a person was going on holiday and the date they would collect their medication.

Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) including the requirement to supply original packs of valproate. They reviewed people prescribed valproate to identify anyone who may meet the PPP criteria. And reported that no-one prescribed valproate met the criteria or had their medication in multi-compartment compliance packs.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Pharmacy team members initialled 'dispensed by' and 'checked by' boxes on dispensing labels, to record their actions in the dispensing process. And they used a separate system to capture the pharmacist's clinical check which enabled the APCT to complete their check. Team members used clear bags to hold dispensed CDs and fridge medicines which allowed them, and the person collecting the medication, to check the supply. They also used fridge and CD stickers on bags and prescriptions to remind them when handing over medication to include these items. The pharmacy used an online application to track the delivery of medicines to people which included details of failed delivery attempts. This ensured team members had access to up-to-date information when dealing with queries. People using the automated prescription collection point were advised by an electronic message that their prescription was ready. And were given a code to access the collection point. CDs and medicines requiring storage in a fridge were not stored in the collection point. And prescriptions that needed the pharmacist to speak to the person or to offer a service such as the NHS New Medicines Service were not kept in the collection point. Team members promoted the collection point so more people could use it and to help reduce the number of people presenting at the pharmacy.

The pharmacy obtained medication from several reputable sources. Team members followed procedures to ensure medicines were safe to supply and they securely stored CDs. They regularly checked the expiry dates on stock and kept a record of this. They marked medicines with a short expiry date to prompt them to check the medicine was still in date, no out-of-date medication was found. Team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and a sample of records were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient-returned medication. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via the company communication platform. The team responded appropriately to these alerts and kept a record of their actions.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date information. The pharmacy had equipment available for the services provided. The equipment included a range of CE equipment to accurately measure liquid medication and two fridges to hold medicines requiring storage at these temperatures. The pharmacy undertook testing of its electronic equipment and there was technical support for equipment such as the automated collection point. A recent problem with the door of the collection point was quickly fixed after the team reported it.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. Team members used cordless telephones to ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other private information in the dispensary which had restricted public access.

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.