General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, Temple Grove, Burgess Hill, West Sussex, RH15 9XN

Pharmacy reference: 9011988

Type of pharmacy: Community

Date of inspection: 25/07/2023

Pharmacy context

This NHS community pharmacy is located next door to a convenience store and a GP surgery in a residential area of Burgess Hill. 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. And its team can check a person's blood pressure.

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 manages its risks appropriately. It has written instructions to help its team members work safely. 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 review the mistakes they make 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

The pharmacy had written instructions for its team to follow if it needed to close due to an emergency. This told its team members what they should do to make sure people could access the care they needed if the pharmacy was closed. 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. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles 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. Their roles and responsibilities were described within the SOPs. And the pharmacy displayed a notice that told people who the responsible pharmacist (RP) was at that time.

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 processes to deal with the dispensing mistakes that were found before reaching a person (near misses) and those which weren't (dispensing errors). Members of the pharmacy team discussed and recorded the mistakes they made. They reviewed their mistakes from time to time to learn from them, spot any patterns and help them stop the same sort of things happening again. And, for example, they strengthened their dispensing process and highlighted the different types of medicines used to treat epilepsy following an incident when the wrong one was dispensed.

People have left online reviews about their experiences of using the pharmacy and its services. The pharmacy had a complaints procedure. It had a notice which asked people to share their views and make suggestions about how the pharmacy could do things better. And, for example, the pharmacy team tried to keep a person's preferred make of a prescription medicine in stock 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 computerised controlled drug (CD) register. But the stock levels recorded in this register weren't checked as often as the SOPs asked them to be. And more than one section was used to record transactions of the same drug. The pharmacy kept records to show which pharmacist was the RP and when. And these were mostly in order. The pharmacy generally kept adequate records for the supplies of the unlicensed medicinal products it made. The pharmacy team was required to record the emergency supplies it made and the private prescriptions it supplied on its computer. But the reason for making a supply of a prescription-only medicine to a person in an emergency wasn't always recorded properly. And the details of the prescriber and the date the prescription was issued were incorrect in some of the private prescription records seen.

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 ✔ Standards met

Summary findings

The pharmacy has enough people in its team to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. And they work well together and use their judgement to make decisions about what is right for the people they care for. The pharmacy team is comfortable about giving feedback to help the pharmacy do things better. And it knows how to raise a concern if it has one.

Inspector's evidence

The pharmacy team consisted of a pharmacist manager, a pharmacy technician, a dispensing assistant, two trainee dispensing assistants, a trainee medicines counter assistant and a delivery driver. The pharmacy depended upon its team, colleagues from other branches or locum pharmacists to cover absences.

The people working at the pharmacy during the inspection included a locum pharmacist (the RP), the pharmacy technician and the trainee dispensing assistants. The pharmacy was busy during the inspection. But its team was up to date with its workload.

Members of the pharmacy team helped each other make sure people were seen to as quickly as possible and prescriptions were dispensed safely. And they didn't feel the incentives or targets set for the pharmacy stopped them from making decisions that kept people safe.

The RP 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. And 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.

People working at the pharmacy needed to complete mandatory training during their employment. And they were required to do accredited training relevant to their roles after completing a probationary period. Team members discussed their performance and development needs with their manager when they could. They could share learning from the mistakes they made and were kept up to date during unplanned team meetings. They were encouraged to complete training. But they were often too busy doing all the other things they needed to do while they were at work so, they chose to train in their own time.

Members of the pharmacy team knew who they should raise a concern with if they had one. They were comfortable about making suggestions on how to improve the pharmacy and its services. And, for example, the layout of the dispensary was changed following their feedback.

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, clean and tidy. 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. But it sometimes had difficulty storing large prescriptions and bulky items when it was busy.

The pharmacy 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 has working practices that are generally safe and effective. It gets its medicines from reputable sources. It mostly stores them appropriately and securely. And its team is friendly and helps people access the services they need. Members of the pharmacy team 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 didn't have an automated door. But its entrance was level with the outside pavement. And members of the pharmacy team helped people who couldn't open the door easily, such as someone with a pushchair or a wheelchair, access the building. The pharmacy had a notice that told people when it was open. And it had a small seating area people could use if they wanted to wait in the pharmacy.

The pharmacy team asked people who were prescribed new medicines if they wanted to speak to the pharmacist about their medication. The pharmacy dealt with CPCS referrals. People benefited from the CPCS 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. 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. And it kept a written record to show when it delivered someone their medicines. But an electronic delivery record was soon to be introduced. This meant it would have a better audit trail to show the right medicine had been delivered to the right person. The pharmacy provided winter flu jabs. And its team had already started to prepare for the upcoming season.

The pharmacy used a disposable and tamper-evident system for people who received their medicines in compliance packs. And its team assessed whether a person needed a compliance pack. The pharmacy kept an audit trail of the person who had assembled and checked each prescription. It provided a brief description of each medicine contained within the compliance packs. And patient information leaflets were usually supplied. So, people had the information they needed to make sure they took 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. It used reminder stickers to alert the team when these items needed to be added or if extra counselling was needed. And 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. And it kept most of its medicines and medical devices within their original manufacturer's packaging. Members of the pharmacy team didn't always mark the containers of liquid medicines with the date they opened them. They checked the expiry dates of medicines as they dispensed them and at regular intervals which they were required to record to show they had done so. And they marked products which were soon to expire.

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 recorded the destruction of the CDs that people returned to it. And it kept these and out-of-date CDs separate from in-date stock.

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 pharmaceutical waste bin. But the pharmacy didn't have an appropriate waste bin for the hazardous waste people brought back to it.

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 and returned pholcodine-containing cough and cold medicines following the receipt of an MHRA medicines recall. One of the team members described the actions they took when they received an MHRA medicines recall. But the pharmacy didn't always keep a record of the actions it took in response to a 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 data 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 usually 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 monitor they used needed to be recalibrated from time to time.

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 tried to remember to store their NHS smartcards securely when they weren't using them or 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.