General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Day Lewis Pharmacy, Unit J Ravenswood District Centre, 42 Hening Avenue, Ipswich, Suffolk, IP3 9QJ

Pharmacy reference: 9012344

Type of pharmacy: Community

Date of inspection: 18/11/2024

Pharmacy context

The pharmacy is in a shopping precinct in a largely residential area. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service, seasonal flu vaccinations and the NHS Hypertension Case Finding service. The pharmacy supplies medicines in multi-compartment compliance packs to some people who live in their own homes and need this support. And it provides substance misuse medications to a small number of people. The pharmacy has an automated prescription collection point.

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	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 to help provide them safely. It learns from mistakes that happen during the dispensing process to help make its services safer. And people can provide feedback about the pharmacy's services. The pharmacy keeps most of its records up to date and accurate. And it protects people's personal information well. Team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Team members had signed to show that they had read, understood, and agreed to follow them. The SOPs were available electronically and team members had to pass a test to show that they had understood them. Team members' roles and responsibilities were specified in the SOPs. Team members explained that the pharmacy would remain closed if the pharmacist had not turned up in the morning. They knew which tasks should only be undertaken if there was a responsible pharmacist (RP) signed in. And they knew that they shouldn't hand out dispensed items or sell pharmacy-only medicines if the pharmacist was not in the pharmacy.

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. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. 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. The pharmacy stamped 'LASA' (look alike or sound alike) on prescriptions for medicines with similar names or similar packaging.

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 medicines had been supplied to a person from the automated collection point. The pharmacist said that the wrong barcode label had been attached to the bag. Team members had been reminded to check both bag labels against the prescription when placing the bagged item in the collection point. And the pharmacist confirmed that there had not been any incidents of this type since.

The pharmacy had current professional indemnity insurance. The correct RP notice was clearly displayed, and the RP record was completed correctly. The private prescription records were largely completed correctly, but the prescriber's details were not always recorded. And the nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The importance of maintaining complete records about private prescriptions and was discussed with the team. CD registers examined were filled in correctly, and the CD running balances were checked at regular intervals. And any 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.

People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. Confidential waste removed by a specialist waste contractor, computers were password

protected and 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.

The pharmacist said that there had not been any recent complaints. The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. The pharmacy would attempt to address any complaints and inform the pharmacy's head office.

Most members had completed training about protecting vulnerable people. The delivery driver had recently started working at the pharmacy and said that he had not done any yet. He was aware of signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist explained about a recent occasion where the delivery driver had made him aware of a potential safeguarding concern. He had contacted the person and the person's GP so ensure that they received support if needed. 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. They are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can raise concerns to do with the pharmacy and they can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one pharmacist, one ACT, three trained dispensers and one trained medicines counter assistant (MCA) working during the inspection. Holidays were staggered to ensure that there were enough staff to provide cover and there were contingency arrangements for pharmacist cover if needed. Team members worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was seen to be up to date with its dispensing.

The MCA appeared confident when speaking with people. She explained that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care. She asked people relevant questions to establish whether the medicines were suitable for the person they were intended for. And she was aware of the restrictions on sales of medicines containing pseudoephedrine.

Team members had access to an online learning portal. They could complete training at the pharmacy during quieter times or they could access it at home if they preferred. The pharmacist was aware of the continuing professional development requirement for professional revalidation. He had completed declarations of competence and consultation skills for the services offered and had done the associated training.

Team members explained that there were informal huddles each morning to allocate tasks and discuss any issues. Information from the pharmacy's head office was also passed on to team members during these. And the pharmacy used a messaging app to share information.

Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And they had yearly performance reviews. One of the dispensers said that the pharmacy provided feedback about locum pharmacists to its head office, and this was considered when allocating pharmacists. The pharmacist felt able to make professional decisions.

Targets were set for the New Medicine Service (NMS), the Pharmacy First service, contraception service and the Hypertension Case Finding service. The pharmacist said that there was a certain amount of pressure to achieve the targets, but he would not let it affect his professional judgement. And the pharmacy provided these services for the benefit of the people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured against unauthorised access. Pharmacy-only medicines were kept behind the counter or in clear plastic drawers in the shop area. The drawers had ‘please ask for assistance’ on. There was a clear view of the medicines counter from the dispensary and 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. And the pharmacy was bright, clean, and tidy throughout which presented a professional image.

There was seating in the shop area for people waiting for services. The consultation room was accessible to wheelchair users and was accessible 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 not used for storing pharmacy items. There were separate hand washing facilities available. There were some open pharmaceutical waste bins kept in the toilet area which made it harder for the pharmacy to show that these medicines were being kept securely. The pharmacist said that the pharmacy would only keep sealed bins in this area in future.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. And people with a range of needs can access the pharmacy's services. The pharmacy responds appropriately to drug alerts and product recalls, so that people get medicines and medical devices that are safe to use. And it gets its medicines from licensed wholesalers and stores them properly. People who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

There was step-free access into the pharmacy through a wide entrance. 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. And the induction hearing loop appeared to be in good working order.

Workspace in the dispensary was free from clutter. There was an organised 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. Team members initialled dispensing labels when they dispensed and checked each item to show who had completed these tasks. And the pharmacist initialled prescriptions he had clinically checked. This helped the accuracy checking technician (ACT) know which prescriptions she could check. She knew that she should not check medicines if she had been involved with dispensing them and she should not check Schedule 2 controlled drugs (CDs).

There were signed in-date patient group directions available for the relevant services offered. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being handed out when the prescription was no longer valid. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. And the opportunity for the pharmacy to check that the person was having relevant blood tests done at appropriate intervals was limited. The pharmacist said that 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 said that they would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacy dispensed these medicines in their original packaging.

Dispensing stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Items due to expire within the next six months were highlighted. There were no date-expired items found in with dispensing stock during a spot check and medicines were kept in their original packaging. The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office. The pharmacist 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.

The fridge was suitable for storing medicines and was not overstocked. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. CDs were stored in accordance with

legal requirements and denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

The pharmacist explained that uncollected prescriptions were checked regularly, and people were sent a text message reminder if they had not collected their items after around three months. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. People were sent regular text message reminders if their medicines were in the automated collection point. Part-dispensed prescriptions were checked daily. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

The pharmacy supplied medicines in multi-compartment compliance packs to some people. A suitability assessment was completed by the pharmacy to identify which medicines were needed to be dispensed into the packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. And prescriptions for 'when required' medicines were not routinely requested. One of the dispensers explained that people usually contacted the pharmacy if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it 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 meant people were provided with up-to-date information about their medicines.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible, and these were recorded on a hand-held electronic device. 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 pharmacy could track the delivery driver and inform people if they asked about their delivery.

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

Up-to-date reference sources were available online. The pharmacist said that the blood pressure monitor had been in use for less than one year and 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 if needed.

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

The pharmacy's collection point could be accessed remotely by the provider if needed. The pharmacist explained that there had been some recent issues with the pharmacy's internet which meant that the machine was not working properly. He said that these issues had been reported to the pharmacy's head office and been resolved.

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.