General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Leadgate Pharmacy, George Ewen House, Watling Street, Leadgate, CONSETT, County Durham, DH8 6DP

Pharmacy reference: 1029397

Type of pharmacy: Community

Date of inspection: 30/11/2023

Pharmacy context

This pharmacy is in Leadgate, Consett. It dispenses NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them take their medicines at the right time. The pharmacy provides some NHS services such as the New Medicine Service and the Community Pharmacy Consultation Service.

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 has written procedures to help its team provide services in a safe and effective manner. Members of the team record their mistakes so that they can learn from them. They largely keep the records they need to by law. They keep people's information safe and are aware of the actions to take to help protect the wellbeing of vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which covered the services that it provided. Its team members had read the SOPs and they signed each one to show this. The SOPs detailed which team members it was directed at based on their roles. And members of the team appeared to be knowledgeable about their roles and when to seek advice from the pharmacist.

The pharmacy maintained a record of near misses on a near miss log. This is when a mistake is identified upon completion of an accuracy check in the pharmacy. The mistake was highlighted to the team member involved and they were required to identify the mistake as part of the learning process. They would then correct the mistake and make a record on the near miss log. Team members explained near misses were reviewed each month and the findings were shared verbally so that they could learn from the mistakes that had occurred. Members of the team instilled changes following a review of the near misses to help reduce the reoccurrence of common mistakes. An example of this was the physical separation of metformin modified release tablets from its normal release formulation. The pharmacy had a process in place for recording and reporting dispensing errors. This is when a dispensing mistake occurs but is not identified before the medicine is supplied to people. A dispensing error report was completed on the pharmacy computer and shared with the shared with the superintendent pharmacist (SI).

The pharmacy largely maintained the records it needed to by law. Records for controlled drugs were kept electronically on the pharmacy computer. The running balances of CDs were recorded and checked against the physical stock regularly. But liquid CD formulations were not checked as frequently which means any discrepancies may not be identified in a timely manner. Members of the team made a separate record of patient-returned CDs and signed the record when destruction of these medicines had been completed. A random sample of the recorded balances were checked against the physical CD stock and found to be correct. The pharmacy dispensed private prescriptions and made a record in a prescription register. But the date of dispensing was missing from the entries. Responsible pharmacist (RP) records were kept but on some occasions the sign out time was missing which means that it may be difficult to identify when the pharmacist's responsibilities had ended. Team members were aware of the tasks they could not complete in the absence of a pharmacist. The pharmacy kept records of unlicensed medicines that were supplied to people.

The pharmacy had professional indemnity insurance in place which covered the services it provided. And it advertised how people could raise a complaint or provide feedback. Its team members explained they would try and resolve any complaints verbally but would escalate the complaint to head office when this was not possible.

Pharmacy team members were aware of how to keep people's information safe. They used the

consultation room to have private conversations with people and separated confidential waste for secure disposal. Documents that contained people's information were kept secure from unauthorised access. The pharmacy had an SOP about safeguarding vulnerable people which its team members had read. When questioned, team members were able to explain the signs to look out for which may indicate a safeguarding issue. This included physical signs of abuse such as bruising or behaviour changes that may indicate abuse. The details of the local safeguarding contacts were readily available if a concern needed to be raised.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to safely provide its services. It provides support to members of the team who are on training courses. Members of the team feel comfortable to raise concerns and provide feedback.

Inspector's evidence

The pharmacy team consisted of a dispenser who worked as an accuracy checker (ACD), a qualified dispenser, two trainee dispensers and a delivery driver. All team members were qualified, or enrolled on to a suitable training course, for the roles they fulfilled. The regular pharmacy manager had recently left so the pharmacy was using regular locum pharmacists.

Members of the team were aware of their roles to help manage the workload safely and effectively. One team member explained their job was to label prescriptions and assemble medicines for people that received multi-compartment compliance packs. Another team member was helping assemble prescriptions for people that were waiting in the pharmacy to be supplied their medicines. Team members explained the questions they would ask when selling pharmacy medicines. And they identified medicines that are liable to misuse. In such cases, they would refer to the pharmacist if they felt the sale was inappropriate or if repeated requests were made.

The pharmacy team were seen working well together and they supported each other as people entered the pharmacy during busy periods. There were enough trained team members and were seen managing the workload safely. The pharmacy completed annual appraisals with its team members to discuss how they had performed and to help identify any future training needs. Members of the team also felt comfortable raising concerns or providing feedback to the pharmacy manager. Regular team meetings were held so that members of the team could identify if any support was needed to help manage the workload.

Training was provided by a recognised third-party provider and support was given by the area manager. The trainee dispensers were given protected learning time to complete their learning and they felt well supported by the rest of the pharmacy team. Members of the team completed regular training and the topics that were covered were based on the NHS Pharmacy Quality Scheme.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services that the pharmacy provides. And it has a consultation room available for people to have private conversations.

Inspector's evidence

The pharmacy was clean and organise. It had adequate lighting and maintained as suitable ambient temperature to provide services in a safe manner. Its team members cleaned the pharmacy daily. The pharmacy had adequate bench space to safely assemble prescriptions and a separate area was created upstairs to assemble and store multi-compartment compliance packs. A sink with hot and cold water was available. It was clean and suitable to prepare medicines that required mixing before being supplied to people.

A consultation room was available for people to have a private conversation or receive a pharmacy service. It was clean and tidy which helped maintain a professional appearance. It was large enough for the services that the pharmacy offered. The dispensary area was behind the front counter and unauthorised access was restricted. Suitable staff facilities were available which included a small kitchen area, washroom and rest area. The pharmacy was secured when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers services that are easily accessible and provides them safely. It obtains its medicines from licensed sources and generally stores them appropriately. Its team members provide advice to people when supplying higher-risk medicines to help make sure they are used correctly.

Inspector's evidence

The pharmacy had a step leading to the entrance. A ramp was available for people with a wheelchair or pushchair. The entrance was wide and led into the retail area of the pharmacy. The opening hours of the pharmacy were displayed on the entrance door. A range of health information leaflets were situated in the retail area for people to access if they required additional health related information.

The pharmacy provided some NHS services including the New Medicine Service and the Community Pharmacy Consultation Service. But its main workload was dispensing NHS prescriptions. Prescriptions were placed into baskets to prevent them getting mixed up. And different coloured baskets were used to help prioritise the workload and help make it easier to identify medicines that needed to be delivered to people's homes. Team members initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels to help identify who was involved in both processes if a query arose. Medicines were accuracy checked by the pharmacist or ACD. The pharmacist completed a clinical check of prescriptions and annotated the prescription with ’cc’ before the ACD completed an accuracy check. This helped the ACD to identify which prescriptions had been clinically checked and they explained that they would not accuracy check any prescriptions if this annotation was missing. An SOP was available for accuracy checking and had been read by the ACD.

Medicines that required special storage conditions, such as fridge items or CDs, were highlighted on prescription bags using stickers so that they could be added before the medicines were supplied. The pharmacist also attached stickers to medicine bags if they needed to provide additional advice to people. This served as a reminder to team members. CD stickers were also used to prompt members of the team to check the prescription for a schedule 2 or 3 CD was still valid at the time of supply.

The pharmacy supplied some people with medicines in multi-compartment compliance packs. It made a record of the medicines that people were supplied with in the multi-compartment compliance packs. And it used the records to check any changes that the prescriber had made. Copies of discharge letters for people leaving hospital were stored so that an audit trail of any changes was maintained. The prescriptions were ordered by the pharmacy team and checked against each person’s record to make sure their medicines had been prescribed correctly. The pharmacist clinically checked the prescriptions before the packs were labelled and assembled. The pharmacist or ACD then completed an accuracy check to make sure medicines had been dispensed correctly. Completed packs had the appropriate warning labels printed on them. The description of the medicines supplied were included to make it easier for people to identify the individual medicines. And patient information leaflets were supplied each month so people could access additional information about their medicines.

Education materials were provided to people taking valproate containing medicine to highlight the risks. And the pharmacist was aware of the requirement to supply people with original packs so that the warning card and patient information leaflet was supplied each time.

A medicine delivery service was offered to people who could not get to the pharmacy. Deliveries were completed by a delivery driver, and they kept an electronic record of completed deliveries. A note was left if people were not available to accept a medicine delivery.

The pharmacy obtained its medicines from licensed sources, and it stored them securely to prevent unauthorised access. But some pharmacy medicines were found in the retail area available for self-selection. The medicines were removed and stored behind the counter when it was identified to a member of the team. Its team members checked the expiry dates of medicines regularly but did not make a record. This may make it harder to identify which areas of the pharmacy had been checked and by who. Medicines that were short dated were highlighted with a red sticker. Liquid medicines that had been opened had the date of opening written on the packaging to help team members make sure they were safe to supply to people. The expiry dates of some medicines were checked, and a few were found to be expired. These were removed from the shelf and separated for destruction. Medicines with special storage requirements were stored appropriately. CDs were stored in a secure cabinet and date-expired stock and patient returns were clearly marked and separated. Medicines that required cold storage conditions were stored in a suitable fridge. The temperature of the fridge was seen to be in the required range and the pharmacy kept a daily record of the temperatures.

The pharmacy received alerts regarding defect medicines from head office by email. Its team members checked the pharmacy for any affected stock but did not make a record of the actions taken. This may make it harder for them to respond to any queries following a safety alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to safely provide its services. And its team members use the equipment appropriately to provide services in an effective manner.

Inspector's evidence

The pharmacy had a selection of clean calibrated glass measures to help its team members measure liquid medicines. And it clearly marked measures that were used for higher risk medicines to prevent cross-contamination. Clean counting equipment was also available for tablets and capsules. Electrical equipment was in good working order. The pharmacist explained they use the internet to access resources such as the British National Formulary (BNF).

The pharmacy had three computer systems installed which held people's clinical records. The screens were not visible to members of the public and the computers were password protected to prevent unauthorised access. Members of the team used cordless phones so they could have conversations without being overheard by people.

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.