General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newton Hall Pharmacy, 55 Carr House Drive, Framwellgate Moor, DURHAM, County Durham, DH1 5LT

Pharmacy reference: 1029428

Type of pharmacy: Community

Date of inspection: 30/11/2023

Pharmacy context

This is a community pharmacy that is situated in a parade of shops in Durham. Most of its activity is dispensing NHS prescriptions and selling medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to some people who need support taking their medicines correctly. Other services that the pharmacy provides are the Community Pharmacist Consultation Service, seasonal flu vaccinations and the New Medicines Service.

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 the risks associated with its services and manages them appropriately. The pharmacy team members follow written procedures and know their role in safeguarding the wellbeing of vulnerable people. They largely keep records in line with their legal requirements. When a dispensing mistake happens, team members respond well and discuss any learnings. The pharmacy team appropriately protects people's personal information.

Inspector's evidence

The pharmacy had Standard Operating Procedures (SOPs) which covered all the services that the team was providing. Training records were not available to show all team members had read the SOPs that were relevant to their role. The superintendent pharmacist (SI) explained that all team members had read them. The pharmacy had current indemnity insurance which included the provision of seasonal flu vaccinations.

The pharmacy team members were aware of the tasks that could and could not be carried out if the responsible pharmacist (RP) took a short leave of absence from the pharmacy. They were also aware of what to do if the RP did not arrive at the beginning of the day.

The pharmacy had a process to support the team with learning from mistakes that were identified during the final check by the pharmacist, also known as near misses. The pharmacist would ask the team member involved to identify the mistake and make a record on a near miss log after it had been corrected. The SI admitted that near misses were not being reviewed but a short discussion would take place with members of the team so they could raise awareness of common mistakes that happened. Team members could not provide any recent changes that had been implemented to help reduce the likelihood of common mistakes reoccurring. Any mistakes, identified after medicines had been handed out, dispensing errors, were recorded and filed securely; these were discussed with the team members to help reduce the risk of similar mistakes happening again.

The pharmacy's RP record and private prescription register were generally complete in line with requirements. But in some cases, the details of the prescriber within the private prescription register were missing. The RP record was stored on the pharmacy computer but the sign out times of the RP was missing from most of the entries. This may make it difficult to identify when the pharmacist's responsibilities had ended. Electronic CD registers had been filled in correctly and running balances were completed regularly. Running balances for three CDs were checked and found to match the physical quantities that were being held in the cabinet. CDs that were returned to the pharmacy were recorded in an electronic patient returns register and the entries were signed when the medicines were destroyed. The pharmacy supplied some unlicensed medicines to people, and it kept a record of these supplies.

The pharmacy had a process for managing complaints and the team were aware of the steps to follow if a complaint needed to be escalated. In the first instance, team members would try to resolve a complaint verbally but would refer to the SI if it required escalation. Team members were seen handling a patient complaint regarding the shortage of a medicine which resulted with a positive outcome. Confidentiality agreements for all team members were in place and the team was aware of

the importance of maintaining patient confidentiality. They were aware not to share people's private information. And they used a shredder to destroy confidential waste. Members of the pharmacy team were aware of the safeguarding procedure and what to do if they have any concerns to support the wellbeing of anyone vulnerable. Details of the local safeguarding contacts were easily accessible.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to effectively manage the workload. And they feel comfortable about raising any concerns and making suggestions to improve the way they work. The pharmacy adequately supports its team members who are undertaking training.

Inspector's evidence

The pharmacy team comprised of a superintendent pharmacist (SI), two trainee dispensing assistants, two qualified dispensing assistants and a delivery driver. There was also another qualified dispensing assistant who was on leave. The SI worked at the pharmacy on most days but also arranged for regular locums to support so that they could complete any managerial tasks.

Both trainees present said that adequate time was given to them to complete their training and the pharmacist provided them with support when needed. There was no ongoing training in place, but the SI explained that any new or changes to processes or guidance was verbally shared with members of the team. There were no appraisals or formal team meetings, but team members felt comfortable about feeding back any ideas or concerns to the pharmacist and superintendent pharmacist (SI). The pharmacy team started each day with a brief conversation to help them prioritise and manage the workload effectively. And they were seen working well together to serve people that entered the pharmacy to collect their medicines or receive a service. The pharmacy team had a process in place to cover for holidays and periods of absence to make sure the level of service it provided remained consistent.

The pharmacy team members were aware of the process to follow if they had multiple requests from the same person for medicines that were liable to abuse. And they knew the correct questions to ask when selling medicines over the counter. There was also an acknowledgement that some medicines, or cohorts of people, may require additional advice when buying medicines. Team members had adequate signposting information available in the form of leaflets to help them with their roles.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally keeps its premises clean and tidy. And it is large enough to support the level of workload that the pharmacy processes. People who need to have a private conversation can do so in a suitable consultation room.

Inspector's evidence

The pharmacy was generally clean and tidy. The fixtures and fittings were adequate and well maintained and cleaning was done by the pharmacy team members. The dispensary area was large enough to safely manage the workload. An appropriate temperature was maintained across the premises and the lighting was suitable to provide services safely. A sink with running hot and cold water was available for hand washing and making medicines that were required to be mixed before handing out.

A consultation room was available with good access for people to have a private conversation if needed. The room was tidy and clean which allowed the provision of the pharmacy services on offer. The premises were secured overnight.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from licensed sources and stores them appropriately. It highlights higher-risk medicines to team members to help them provide people with additional information about these medicines. And it takes the right action if medicines or devices are not safe to use. But it does not make a record of the actions taken so it may be difficult to resolve queries. It delivers medicines to some people in their own homes effectively and safely.

Inspector's evidence

The pharmacy had a manual door with a small step at the entrance which might make it difficult with someone using a wheelchair or a pram to access the pharmacy. However, team members explained that they assist people into the pharmacy or referred them to another local pharmacy in instances when they cannot provide a service.

The pharmacy offered a medicine delivery service to those who preferred to have the medicines sent to their home. The delivery service was completed by a delivery driver and an audit trail of successful deliveries were kept. Dispensing baskets were being used to separate different people's prescriptions and helped prioritise workload and identified when medicines needed to be delivered to people's homes. A dispensing audit trail was in place which included the use of 'dispensed-by' and 'checked-by' boxes to clearly identify who had done the dispensing and checking processes. Prescriptions for Schedule 2, 3, and 4 CDs were highlighted to help the pharmacy team members make sure they were not handed out beyond the prescription's legal validity. And they also highlighted prescriptions which required a fridge item to be added before being supplied to people. The pharmacy team explained that they use a variety of stickers to highlight any medicines that may require the pharmacist to counsel the patient or ask additional questions. The pharmacist was aware of the additional counselling about pregnancy prevention required with sodium valproate products and the steps to take for people in the at risk-group. This also included providing valproate containing medicines in its original container so that the patient warning card and patient information leaflet were provided with each supply.

The pharmacy supplied medicines in multi-compartment compliance packs to people that needed additional support with managing their medicines. Records were maintained to help make sure the packs were dispensed accurately each month and provided in a timely manner. A few packs were checked and found to contain an accurate description of the medication making it easier to identify the medicines that were being supplied. Once again, an audit trail of the team members involved in the dispensing and checking process were available. Patient information leaflets were being supplied with the packs, making it easier for people to access additional information if needed. Communication sheets were available for each patient that received the packs which the pharmacy team members used to record any changes initiated by the doctor or hospital.

The pharmacy used a range of licensed wholesalers and medicines were stored appropriately in the original packs. Access to prescription medicines and medicines awaiting collection was restricted. The expiry dates of medicines were checked each month by members of the team. But they did not make a record of completed checks so it may make it harder to identify which areas of the pharmacy have been checked and by who. However, team members recorded short-dated medicines in a diary under the month it was due to expire. They would then remove these from the shelf at the beginning of each

month if they had not been supplied. A selection of medicines stored on the shelves were checked, and none were found to be out of date. And liquid medicines had a date of opening written on them. The pharmacy had a suitable fridge available, which was within the appropriate temperature range for medicines that required cold storage. A daily record of the fridge temperatures was stored electronically. The pharmacy had a secure CD cabinet available to use. CDs that had been returned to the pharmacy were clearly marked and separated from stock CDs.

The pharmacy received alerts regarding defect medicines 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 all the necessary equipment that it needs to provide its services. And it uses its equipment in a way which helps protect people's personal information.

Inspector's evidence

The pharmacy used suitably calibrated and clean conical measures during the dispensing process. And its team members used separate counting triangles for medicines deemed higher risk when counting out medication. Resources such as the BNF were available in paper form, but the team also explained that they could access them online if needed. The pharmacy team members were aware of when the consultation room should be used to help protect the privacy of people that accessed the pharmacy services or require advice. Cordless phones were in use to help them have a private conversation if needed. Electrical equipment had not been tested for a few years but appeared to be in good working order. Pharmacy computers which held peoples medicine history were password protected and screens were not visible to people using the pharmacy.

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.