General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Stanley Pharmacy, 79 Front Street, STANLEY, County Durham, DH9 0TB

Pharmacy reference: 1029493

Type of pharmacy: Community

Date of inspection: 07/06/2024

Pharmacy context

This is a busy town centre pharmacy on the main pedestrianised street running through Stanley in County Durham. It dispenses people's prescriptions, sells over-the-counter medicines and offers health advice. It provides a very wide selection of other health-related services such as the NHS Pharmacy First service and an anticoagulant clinic. It delivers people's prescriptions if they can't visit the pharmacy in person. The pharmacy also supplies some medicines in multi-compartment compliance aids to people who may find it difficult to manage their medicines.

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	1.1	Good practice	Members of the pharmacy team are given annual refreshers on their SOPs in between the regular reviews, and also complete quizzes to make sure they understand them. They also make suggestions to include in the SOPs.
		1.2	Good practice	The pharmacy superintendent has close oversight of incident records and they ensure everyone involved is fully informed on how the matter is being resolved. Records of incidents are regularly reviewed and discussed with all team members to avoid the same mistakes happening again.
		1.8	Good practice	There is a clear culture of safeguarding the safety and wellbeing of children and vulnerable adults. The pharmacy can provide examples of when its team members have identified someone potentially at risk and has taken action resulting in positive outcomes.
2. Staff	Good practice	2.1	Good practice	The pharmacy is well staffed so that team members can complete their tasks safely and in the required timescale. The staffing levels and skill mix are regularly reviewed and adjusted when there has been a significant change in workload.
		2.2	Good practice	Planned learning and development is actively encouraged, and relevant useful learning opportunities are provided for the team to access. Most team members are fully trained and experienced and seen to be supporting those with less experience.
		2.3	Good practice	Pharmacy professionals re supported with their revalidation through regular peer group meetings and discussions.
		2.4	Good practice	There is evidence of effective team working, to achieve common goals. This is particularly evident since the recent closure of another local pharmacy. Team members are enthusiastic about their role

Principle	Principle finding	Exception standard reference	Notable practice	Why
				and understand how they can meet the needs of their local community.
		2.5	Good practice	There is active engagement with staff, who are able to provide feedback and share their own ideas through a 360-degree feedback programme.
3. Premises	Standards met	3.2	Good practice	The pharmacy makes very good use of both its consultation rooms, with a second pharmacist dedicated to providing the wide range of service available from the pharmacy.
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy reaches out to the local community to provide the services needed, some in their own homes if necessary. The pharmacy and its team have identified local needs and added new services to meet them, as they become available.
		4.2	Good practice	The pharmacy has dedicated a large room, away from distractions, entirely for assembling multi-compartment compliance aids. It also carries out audits of people taking high-risk medicines to make sure they are given the counselling they may need.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy provides its team members with clear written instructions on how to carry out their tasks safely and effectively. It is good at ensuring they understand how to carry out those tasks. It makes sure they are clear about their roles and responsibilities. And they work to professional standards, identifying and managing risks effectively. The pharmacy regularly reviews the mistakes its team members make and takes appropriate action to reduce the chances of similar mistakes happening again. It also communicates effectively with all involved so that everyone knows what is being done. It keeps all the records that it should, making sure they are easily accessible. Its team members have a good understanding of their role in helping protect vulnerable people. The pharmacy manages and protects confidential information well and tells people how their private information will be used.

Inspector's evidence

There were up-to-date Standard Operating Procedures (SOPs) in place to help the pharmacy's team members complete their tasks safely and effectively. They had last been reviewed in September 2021 and were currently under review. The superintendent pharmacist (SI) subsequently confirmed that they were being obtained from an external provider who was currently tailoring them to meet the specific needs of the pharmacy. Team members were able to input into the SOPs, for example by developing an A4 laminated bright yellow prompt sheet to highlight any changes to multi-compartment compliance aids. There was a master signature sheet with a matrix where all team members had signed to show that they had read and understood each of the SOPs. The SI explained how she had appointed one of the foundation trainee pharmacists to lead on the SOPs. They arranged an annual refresher for all staff on the SOPs in between the formal reviews. They also ran quizzes to check that team members fully understood the SOPs.

There were daily near-miss record sheets at each workstation so that team members could easily record the mistakes they made, how they may have happened and what they had learned. Although many of the entries didn't include much detail on the learnings, both the responsible pharmacist (RP) and one of the technicians independently explained how they discussed the mistakes with the individual(s) concerned to ensure they learned from their mistakes. The technician also added that they had brief meetings to discuss them with the team as well. The SI regularly reviewed errors and near misses, identifying any patterns or trends, and then updating all team members at regular quarterly meetings. Errors which were only identified after they had left the premises were always reported immediately to the SI who ensured that the errors were corrected straight away, that a full explanation and apology was given, the GP informed and that the incident was reported through the NHS Learning from Patient Safety Events Service (LFPSE) website. Staff were aware of 'Look Alike Sound Alike' (LASA) drugs and took extra care to make sure they weren't mixed up.

Staff were able to describe what action they would take in the absence of the responsible pharmacist (RP), and they explained what they could and could not do. They outlined their roles within the pharmacy and where responsibility lay for different activities. Their job descriptions also set out their roles and responsibilities. All dispensing labels were signed by two people to indicate who had dispensed the item and who had checked it. The RP notice was correct and clearly displayed for people to see. All the entries examined in the electronic RP record correctly recorded the date and time the RP's responsibilities commenced, but some were missing the time at which they ceased. Upon

reflection the RP considered how they could implement a reminder at the end of their shifts. Creating an automatic on-screen reminder was also discussed.

People could give their feedback about the pharmacy's services, usually verbally. Team members knew who to contact for assistance so they could maintain the pharmacy's services in the event of an unforeseen emergency. The SI explained how they had drawn up a business continuity plan as part of the service specification for the anticoagulant service. There was a certificate of professional indemnity and public liability insurance which was valid until the end of May 2025.

Private prescription records were kept electronically and those checked were mostly complete other than some missing the required prescriber details. Following a brief discussion, the team understood the need to include these details. The online Controlled Drug (CD) registers were all in order. Individual stock balances were checked when each entry was made at the end of the day. A full check was carried out on the third Thursday of each month when the local surgeries were closed. The online records included a full audit trail of any alterations so that it was clear who had amended the record, when and why. Stock balances of those CDs selected at random were checked and found to correspond with their respective entries in the CD register.

There was an online record for recording controlled drugs (CDs) returned by people who no longer needed them. Those entries examined were all in order, with some still awaiting safe destruction. They were kept in a clearly segregated part of the CD cabinet, separate from stock available for dispensing. There was a folder for keeping records of unlicensed medicines (specials). Those certificates of conformity examined all contained the required information, including the prescriber details.

All staff were able to demonstrate an understanding of data protection and they had signed confidentiality agreements. They were able to provide examples of how they protected people's confidentiality, for example not disclosing personal information over the phone or not leaving patient-sensitive information lying about for people to see. Completed prescriptions in the prescription retrieval system were not easily visible to people waiting at the counter. Confidential waste was kept separate from general waste, collected in sacks and securely disposed of offsite.

There were safeguarding procedures in place for both adults and children. And contact details of the local safeguarding agencies were available in the consultation rooms. The SI and the regular pharmacist had both completed Level 3 safeguarding training, mainly on account of the home visits they carried out for vulnerable people. They ensured that none of those visits were carried out unaccompanied. The other registrants working at the pharmacy were all trained to level 2 and all other team members to level 1. They were well aware of the signs which may suggest a potential safeguarding concern and described some successful interventions they had made. The pharmacy actively promoted its consultation rooms as a safe space for vulnerable people.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy has plenty of staff to manage its workload safely and effectively. Pharmacy team members are well-trained and have a clear understanding of their roles and responsibilities. They communicate effectively and make sure they all stay up to date. The pharmacy gives them plenty of support with their professional development. They work well together and can make suggestions to improve safety where appropriate.

Inspector's evidence

There were two pharmacists on duty throughout the inspection, and the superintendent pharmacist was also present for most of that time. There were two Accuracy Checking Technicians (ACTs), one of whom managed the compliance aid service from the dispensary upstairs. There were two Medicines Counter Assistants (MCAs), a pharmacy student and several dispensing assistants on duty. The pharmacy also had two foundation trainee pharmacists, neither of whom were present as they were preparing for their registration assessment. The SI explained that they regularly reviewed their staffing levels, and staff mix. They were currently recruiting an additional full-time dispensing assistant to help manage the significant increase in workload generated by the recent closure of a nearby pharmacy. In the meantime, the existing staff were flexing their hours to maintain their service and ensure their work was completed on time. And they had increased the second pharmacist's hours from three days a week to every day. The team was also well supported by the SI who frequently visited the pharmacy.

There were certificates in the consultation room showing the courses completed by team members. Everyone had either completed the required accredited training or was in the process of doing so. The SI explained that there were five separate Whatsapp groups which she used to keep people up to date with current developments and to maintain clear communications across all their pharmacy teams. Team members also described some of the training modules they had completed as required by the Pharmacy Quality Scheme (PQS). The SI also described a 360-degree appraisal process they carried out each quarter to assess what had been done over that quarter, and how well. This process involved all staff. There were also one-to-one meetings with staff where they could input into the process. All staff had recently attended training on services for people who used drugs, with presentations from people with lived experience of using drugs. They also covered a recent coroner's report and the learnings taken from that.

The SI held a separate quarterly meeting for the twelve pharmacists employed across the group, where they discussed current topics and provided peer-to-peer support for their revalidation. Recent topics included the COVID-19 vaccination service and the Pharmacy First service. All the pharmacists were to undergo Independent Prescriber (IP) training, phased over a period of time, with the SI acting as their Designated Prescribing Practitioner (DPP).

Staff were seen asking appropriate questions when responding to requests or selling medicines. They demonstrated a clear understanding of medicines liable to misuse and would speak to the pharmacist if they had any concerns about individual requests. They also recognised when the same people made repeated requests and would refer them to the pharmacist.

All team members appeared open and comfortable with discussing any concerns and supported each

other. Those questioned knew who they could speak to if they had any concerns and were aware of the pharmacy's whistleblowing policy. There were some targets, or expectations in place, but they were managed sensibly and didn't influence the registrants' professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a secure and professional environment for people to receive its services. The team keeps them clean and tidy, presenting a suitably professional image. The pharmacy makes effective use of its entire premises, completing different types of work in different rooms. The premises include two private rooms which they make good use of for their services and for private conversations.

Inspector's evidence

The pharmacy's premises were spacious, clean and tidy, presenting a professional image inside. The retail area was well organised with a clear layout and plenty of space for people to wait. There was a large screen displaying animations or videos to highlight the services available. The main dispensary had three computer workstations arranged so everyone could work with sufficient space around them. The dispensary sink was clean and equipped with hot and cold running water. There was also a dispensing robot that was no longer in use. The room it occupied was still used as storage for medicines.

There was a second dispensary at the back of the premises on the ground floor, where items due out for delivery were checked. This had a central island workbench, and two computer workstations. There was additional space between the two downstairs dispensaries for storing bags, cartons and some over-the-counter (OTC) stock. There was another large dispensary upstairs which was used for assembling multi-compartment compliance aids. There were two islands in the middle of the room with further workbenches and storage around the walls. There was another computer workstation here as well. There was also an office, staff rest room and toilets which were all well maintained, clean and tidy.

The temperature in the pharmacy was maintained at a comfortable level and was suitable for the storage of medicines. Worksurfaces and floors were clean, and shelves were cleaned during the date checking process.

There were two consultation rooms available for confidential conversations and the provision of many of the pharmacy's services. Conversations inside the room could not be heard from outside. The doors were kept closed when the rooms were not in use. There were lockable storage cupboards with no confidential material visible. The computers were password protected so that only authorised personnel could access them.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, and people with a range of needs can easily access them. It shows a good understanding of local health needs and adapts its services to suit, including delivering some of its services in people's homes if they can't get to the pharmacy. The pharmacy sources, stores and manages its medicines safely, and so makes sure that all the medicines it supplies are fit for purpose. It identifies people supplied with high-risk medicines so that they can be given extra information they may need to take their medicines safely. It responds well to drug alerts or product recalls to make sure that people only get medicines or devices which are safe for them to take.

Inspector's evidence

The pharmacy provided a range of services which it highlighted using notices in the windows and a large video screen displaying health related videos and animations. The pharmacies services were also spread by word of mouth in the local area as it had a long-standing reputation for providing a wide range of services. There was step-free access into the pharmacy directly from the pedestrianised street.

There were controls in place to help reduce the risk of errors, such as using baskets to keep individual prescriptions separate. There was a procedure for the team to follow when prescriptions could not be fulfilled in their entirety. One of the pharmacists explained the process and how they kept track of them. Completed prescriptions awaiting collection were marked to indicate if further intervention was required when handing them out, such as additional counselling from the pharmacist, or if there were additional items in the fridge. Prescriptions for CDs were highlighted so that team members would know to look in the CD cupboard. And to make sure they wouldn't be handed out after their 28-day expiry. The SI explained how the foundation trainees had been given responsibility for reconciling all CD movements at the end of each day. This was carried out under the supervision of a pharmacist. They checked the expiry dates of all uncollected CD prescriptions on the patient medication record (PMR) system at the end of each week, flagging them and removing any that had expired. The SI explained that they checked all the bagged prescriptions on their retrieval shelves at the end of each month, removing any that had remained uncollected for six months.

Multi-compartment compliance packs were assembled in a large dispensary, on the first floor away from distractions. The compliance pack service was managed by one of the ACTs who explained how the process worked and how she made sure everyone was following the correct procedures. There was a 'patient medication profile' for each person receiving their medicines in compliance aids. This document contained details of each medicine, the dose, the time of day they should take each item, along with notes of any changes to their medication. If there was a change, team members placed an A4 laminated bright yellow card in the basket to draw the pharmacist's attention to the change. If there were any mid-cycle changes, then the driver would be sent out to collect the old compliance aid and deliver a replacement so the change could be put in place as soon as possible. There was a large whiteboard used for noting when people had been admitted to hospital so that they would know to avoid attempting any deliveries. The ACT kept a matrix which she used to track each person's compliance aid through the process and to ensure they were completed on time. She checked that the dispensing assistants had selected the correct medicines (reading the prescription and not the label) before they were placed in a compliance aid. Compliance aids for care homes were labelled with product descriptions and Patient Information Leaflets (PILs) were provided. But many of the compliance

aids for people still living in their own homes did not include those descriptions unless they had specifically requested them. The need to include product descriptions was discussed with a view to finding a practical solution while assembling several hundred of them each week.

The second dispensary on the ground floor was used for completing any owings and managing the delivery service. The pharmacy used its own drivers to deliver medicines to those who couldn't visit the pharmacy in person. They had delivery sheets for each day, which they used to record each successful delivery. Any failed deliveries were brought back to the pharmacy for redelivery. There were large tote boxes where each day's delivery was put once it had been checked. There were shelves for the compliance packs awaiting delivery, again organised by the due day.

Team members were aware of the risks involved in dispensing valproates to people who could become pregnant, and the need to check whether they had long-term contraception in place. The SI confirmed that they were also aware of the recently updated requirement to dispense valproates in the manufacturer's original packaging, and to avoid covering any of the warnings with their dispensing label. The foundation trainees completed an audit on this each year. All interventions were recorded on the PMR system.

The pharmacy had been providing an anticoagulant service for many years. This involved checking people's INR and then ensuring they were taking the correct dose of their warfarin. The GPs generally issued prescriptions for all strengths of the warfarin so the dose could then be adjusted without further intervention from the GP. If people needed vitamin K then the SI could write a prescription if necessary.

Medicines, including unlicensed specials, were obtained from recognised licensed pharmaceutical wholesalers. Fridge temperatures were recorded daily and seen to be within the correct temperature range. All medicines were kept in manufacturers' original packs, and open containers of liquid medicines were annotated with the date of opening. Pharmacy medicines were displayed behind the medicines counter to avoid unauthorised access or self-selection. There was a matrix for recording when staff had completed date checks of their stock on the third Thursday of every month. Everyone had their own assigned section to look after and they ranked each item red, amber or green depending on how many months were left on its shelf life. They also kept a list of the shortest dated items.

Unwanted medicines returned by people were screened in a clear plastic tray to ensure that any CDs were appropriately recorded by the pharmacist, and that there were no sharps present. There was a section within the electronic CD register to record all returned CDs and when they had been safely destroyed within the pharmacy. The pharmacy received drug alerts and recalls from the MHRA, which were annotated to show any action taken.

The pharmacy provided the hypertension case-finding service where people within the specified age range were asked if they would be interested. The pharmacy kept the necessary records and signposted people to their GP if necessary.

The pharmacy offered a COVID-19 vaccination service, which included some home visits. Records for the service were kept on the 'PharmOutcomes' online platform.

The recently introduced Pharmacy First service was going very well. The SI explained that they received many referrals from local GPs as a result of the close working relationships they had built up over many years. The SI explained that there were approximately one third more GP referrals in the northeast compared with the national average. They had also ensured that the GPs were familiar with the gateway criteria for the service, so they received very few inappropriate referrals. If someone didn't

meet the gateway criteria, then the pharmacist still carried out the consultation and then provided the GP with the details so they could decide whether to issue a prescription or not. The aim being to ensure people received the treatment they needed without having to go back to the NHS111 service or their GP. The SI could also write a prescription if she felt it was within her scope of practice and competence. There was a file with details of each of the seven conditions covered by the service. It also included the gateway criteria, the treatment pathways and the necessary patient group directions (PGDs). There was also a set of A5 laminated prompt cards with an overview of the service, a summary of key points for each of the conditions, and a QR code which people could scan to access the information for themselves. This was easily available for all team members to refer to when people asked about the service.

The pharmacy had just introduced an alcohol identification and brief advice service. The pharmacy was also currently carrying out a patient advice audit to demonstrate the 'social goodwill' generated by the pharmacy. In one day alone they had completed 90 entries for the audit.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has suitable facilities for the services it provides, and it makes sure that they are properly maintained. It also ensures that people's private information is kept safe and secure.

Inspector's evidence

The pharmacy had a set of crown-stamped conical measures and suitable equipment for counting loose tablets and capsules. All the necessary equipment was available for the Pharmacy's services, including a blood pressure monitor and an otoscope. The consultation rooms were spacious and well used for many of the pharmacy's services.

All computer screens were positioned so that they were not visible to the public and were password protected. NHS smartcards were in use, and team members were using their own NHS smartcards. The pharmacy made use of online reference sources such as the electronic medicines compendium and the BNF online.

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.