General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Annfield Plain Pharmacy, 3 West Road, Annfield Plain, STANLEY, County Durham, DH9 7XA

Pharmacy reference: 1029497

Type of pharmacy: Community

Date of inspection: 06/09/2024

Pharmacy context

The pharmacy is in the village of Annfield Plain, in County Durham. It dispenses NHS prescriptions and sells over-the-counter medicines. The pharmacy offers services including the NHS New Medicines Service and the NHS Pharmacy First Service. And it offers seasonal vaccinations. The pharmacy team provides medicines in multi-compartment compliance packs to help some people in the community take their medicines at the right time. And the pharmacy delivers medicines to people's homes.

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 suitably identifies and manages risks with its services. It has written procedures relevant to its services and team members follow these to help them provide services safely. Pharmacy team members learn and improve from mistakes. They keep people's confidential information secure. And they know how to identify situations where vulnerable people need help. The pharmacy keeps the records required by law.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs) to help pharmacy team members manage risk with providing services. These included for dispensing, Responsible Pharmacist (RP) regulations and controlled drug (CD) management. These SOPs were held in an organised file so that team members could access them easily. There was also a reference page that made it clear which SOPs were applicable to the different roles within the team. This helped members of the team to work safely within their remit. All team members had read the SOPs and had signed to confirm they had understood them.

The pharmacy used its patient medication records system (PMR) to help support the clinical checks of prescriptions. The pharmacy team provided details of the abilities and limitations of using this technology. Team members received training prior to switching from the pharmacy's previous system. The RP on duty during the inspection was a locum pharmacist, who worked regularly at the pharmacy. They felt confident using the technology and described the regular system audits that took place to provide assurance that it was fit for purpose. The pharmacy team used the PMR's barcode scanning technology to support it in completing a series of safety checks during the assembly and accuracy checking process. The team demonstrated how the PMR flagged mistakes made during the dispensing process, including if a medicine was expiring soon or had expired. The PMR did not produce dispensing labels until a team member rectified the mistake. The team referred any medicines that did not scan and any queries they had during the dispensing process to the RP. Pharmacists routinely completed the final accuracy check of some medicines manually. These included CDs and medicines assembled in multi-compartment compliance packs.

The pharmacy team made regular records of near miss errors. These errors were mistakes identified before people received their medicines. Team members took responsibility for recording these errors themselves, as well as correcting the mistake once it had been highlighted. This meant they had the opportunity to reflect on what had happened. Some examples were seen of the recent monthly reports of these errors. The regular pharmacist completed these to analyse for any trends to produce learning points for the team. These were discussed with the team in informal meetings. The pharmacy also had a recorded procedure for managing dispensing errors. These were errors that were identified after the person had received their medicines. The most recent of these which team members were aware of was relating to the handing out of prescriptions. And the team were knowledgeable about the actions put in place to prevent this happening again in the future.

The pharmacy had a procedure for dealing with complaints. And it advertised this to people using its services, with a notice in the pharmacy retail area. The team aimed to resolve any complaints or

concerns locally. If they were unable to resolve the complaint, they escalated it to the area manager. The pharmacy had current professional indemnity insurance. The Responsible Pharmacist had their RP notice on display which meant people could see details of the pharmacist on duty. Team members knew what activities could and could not take place in the absence of the RP. And they knew what their own responsibilities were based on their role within the team.

The pharmacy kept its RP records electronically on an online platform. A sample of RP records checked during the inspection showed that the RPs were often recording their sign-out times for the end of the day earlier than the closing time of the pharmacy. The importance of maintaining accurate logs in legally required records was discussed with the RP and regular pharmacist, who agreed to ensure their entries were corrected before saving them. The pharmacy kept its private prescription records electronically within the dispensing system. A sample of these checked were compliant with requirements. The pharmacy team completed fortnightly checks of the running balance in the CD register against the physical stock. Random balance checks against the quantity of stock during the inspection were correct. The pharmacy kept a register of CDs returned by people, and there were recent records of these returns being destroyed.

Pharmacy team members understood what to do to keep people's personal information safe and they separated confidential waste from general waste, into a designated bin. A third-party company collected the confidential waste monthly for destruction. The pharmacy displayed a privacy notice in the retail area. And it advertised that it had a chaperone policy. The pharmacy had a procedure for the safeguarding of vulnerable people. A summary of this policy and a list of local contacts were displayed within the dispensary for quick reference. A team member shared an example of a situation where they'd had a concern for a vulnerable person and worked with the person's GP to help reduce the number of 'when required' medicines they had to manage for themselves.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together and within the scope of their competence. And they have opportunities to complete ongoing training so they can develop their knowledge. Pharmacy team members know how to raise concerns, if needed.

Inspector's evidence

At the time of the inspection, the RP was a locum pharmacist that worked regularly at the pharmacy. They were supported by a team who consisted of two qualified dispensers and a medicines counter assistant. Other team members who were not present during the inspection were a medicines counter assistant and three qualified dispensers, one of which was the pharmacy's manager. Although not on duty during the inspection, the regular pharmacist did attend the pharmacy and contributed to the inspection process. The team were observed to be managing the workload throughout the inspection. The competence and skill mix of the team appeared appropriate for the nature of the business and the services provided.

A delivery driver worked five days a week for the pharmacy. They had completed a recognised training course to help them effectively perform their role. Other team members completed various training which was directed by the pharmacy's head office. And they kept logs of the training which team members had completed. The regular pharmacist explained that the team members enrolled on recognised courses were given some protected time to facilitate their learning. The pharmacy had a summary of its 'Sale of Medicines' protocol displayed on a wall behind the medicines counter for quick reference, should the pharmacy team members need it. During the inspection, pharmacy team members asked appropriate questions when selling medicines over the counter and referred to the RP at appropriate times. They were confident challenging requests for over-the-counter medicines that they deemed inappropriate.

The pharmacy team members felt comfortable discussing when things went wrong openly with each other. They knew how to raise concerns. This would typically be done with the pharmacy manager, but they could also contact the area manager or superintendent pharmacist depending on the nature of the concern. A team member provided an example of contacting the area manager in relation to challenges the pharmacy had faced around the storage of their general waste while it was awaiting collection. The pharmacy had a whistleblowing policy and team members were aware of this. Although the pharmacy team was set targets relating to the delivery of services, the regular pharmacist explained that these were fair and meeting them was compatible with providing a safe service to the people who used the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are large, clean, secure, and provide a suitable environment for the services provided. And the pharmacy has a consultation room to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy was in a large premises. It consisted of good-sized retail and dispensary areas. The pharmacy had an overall appearance which was suitably professional. The retail area of the pharmacy was open plan and had seating for people to use when waiting. The pharmacy counter provided a barrier to prevent unauthorised access to the dispensary. All other staff-only areas of the pharmacy were accessed via the dispensary. The dispensary was elevated from the ground floor level of the retail area and was a good size for the workload being undertaken. There was a large island unit with additional bench space around the edge. And there was an area out the back of the dispensary, where multi-compartment compliance packs were assembled. Walkways were kept as clear as possible to minimise trip hazards. And there was sufficient storage space for stock, assembled medicines and medical devices. There was a window from the dispensary that overlooked the medicines counter and retail area. This supported the RP's supervision of medicines sales and queries, without compromising confidential materials within the dispensary. The lighting and temperature were suitable to work in and to provide healthcare services. The dispensary had a sink with access to hot and cold water for professional use and hand washing. There were staff and toilet facilities that were hygienic.

The pharmacy had a private consultation room which was accessed from the retail area. Access to this was secured by a keycode lock. The consultation room was large enough for two seats and a desk. And it was suitably constructed for the purpose they served. The pharmacy team kept the hygiene of the premises to an adequate standard, with team members completing cleaning tasks as required.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy sources its medicines from recognised suppliers. And it generally stores and manages them appropriately. Pharmacy team members complete regular checks to ensure medicines are suitable for supply. And they respond appropriately when they receive alerts about the safety of medicines. Team members appropriately manage the delivery of services safely and effectively. And they take opportunities to provide people with advice on higher-risk medications.

Inspector's evidence

The pharmacy had level access from the street. And the retail area had good clearance between aisles allowing for adequate access , for example for people using a wheelchair. The pharmacy provided a medicines delivery service during weekdays. The assembled bags of medicines for delivery were stored separately, and the driver scanned barcodes on each bag to enter them onto an online delivery application. This then organised their route and provided an audit trail for the deliveries made. Any deliveries for CDs had a corresponding delivery sheet completed. The driver returned any failed deliveries back to the pharmacy on the same day.

Some people had their medicines dispensed into multi-compartment compliance packs. Team members ordered people's prescriptions in advance of the compliance pack being due, which allowed enough time to receive the prescriptions back, order any necessary stock and deal with any queries. They also kept an audit trail of which ordered prescriptions had been received back to easily highlight if any were outstanding. The pharmacy used a record for each person that listed their current medication, dosage, and dose times. This was referred to throughout the dispensing and checking of the packs. From a sample of packs checked, the full dosage instructions, mandatory warnings, and medication descriptions were included. A team member explained patient information leaflets (PILs) were supplied for newly prescribed medicines. The importance of including a PIL with every supply of medicine was discussed during the inspection, and the team agreed to include these monthly.

The pharmacy team dispensed prescriptions using baskets, which kept prescriptions and their corresponding medicines separate from others. Different colour baskets were used to help the team prioritise work, so that the more urgent prescriptions were acted on first. The pharmacy maintained an audit trail of team members involved in the dispensing process via unique logins on the PMR system. During the inspection, all team members were observed to be working on their own login on the PMR. The team used stickers to highlight if a prescription contained a fridge item, to ensure correct storage temperatures were maintained. The team was observed using other similar stickers when dispensing for higher-risk medicines which highlighted that further advice and counselling was needed from the RP.

When the pharmacy could not entirely fulfil the complete quantity required on a prescription, team members created an electronic record of what was owed on the PMR system. And they gave people a note detailing what was owed. This meant the team had a record of what was outstanding to people and what stock was needed. The team checked outstanding owings as a regular task and were managing these well. The pharmacy had a procedure for checking expiry dates of medicines. Evidence was seen of medicines highlighted due to their expiry date approaching or because the shelf life was reduced after being opened. This activity was supplemented by the barcode scanning technology within

the PMR. The pharmacy kept unwanted medicines returned by people in segregated containers, while awaiting collection for disposal.

The pharmacy team showed a good understanding of the requirements of dispensing valproate for people who may become pregnant and of the recent safety alert updates involving other medicines with similar risks . The team dispensed prescriptions for these medicines in the manufacturer's original packs. The RP provided counselling on a range of higher-risk medicines when supplying them to people. They had a box of various written materials about such medicines, which they could supply to people to supplement these conversations. During the inspection, the RP demonstrated an intervention they had made earlier in the day relating to a prescription for an acne medication and the timing of it being dispensed.

The pharmacy obtained medicines from licensed wholesalers and specials manufacturers. It held medicines requiring cold storage in two medical fridges equipped with thermometers. Team members monitored and recorded the temperatures of the fridges daily. These records showed cold chain medicines were stored at appropriate temperatures. A check of the thermometer during the inspection showed temperatures were within the permitted range. Some food items were found in the fridge. A discussion highlighted the risk of cross contamination between food and medicines. And the team acted immediately to remove all non-medicinal items from the fridge. The pharmacy held its CDs in secure cabinets. It had a documented procedure for responding to drug safety alerts and manufacturer's recalls. It received these via email from the company's head office. And the team kept a log of the alerts received and any actions taken in response to these.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people’s private information.

Inspector's evidence

Pharmacy team members had access to a range of hard-copy reference materials and access to the internet for up-to-date information and further support tools. There was equipment available for the services provided which included an otoscope, a digital thermometer, and a blood pressure monitor with various sized cuffs. Electrical equipment was visibly free from wear and tear and appeared in good working order. The pharmacy had a range of clean triangles for counting medicines and CE marked measuring cylinders for liquid medicines preparation. The team used separate equipment when counting and measuring higher-risk medicines. They used personal protective equipment, such as disposable gloves when handling medicines and performing some other tasks.

The pharmacy's computers were password protected and access to people's records was restricted by the NHS smart card system. Computer screens were protected from unauthorised view and a cordless telephone was available for private conversations in quieter areas. The pharmacy stored completed prescriptions and assembled bags of medicines away from public reach in a restricted area.

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.