General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: A.D. Phillips, 21a Church Road, Trimdon Village, TRIMDON STATION, County Durham, TS29 6PY

Pharmacy reference: 1029498

Type of pharmacy: Community

Date of inspection: 11/10/2023

Pharmacy context

This community pharmacy is in Trimdon Village, County Durham. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. The pharmacy provides a seasonal flu and COVID vaccination service. And it supplies a range of medicines to people for the treatment of minor ailments and illnesses. The pharmacy delivers some medicines to people's homes.

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 risk appropriately. It keeps people's confidential information secure. And it advertises how people can feedback about its services. The pharmacy generally keeps the records it must by law. Pharmacy team members know how to recognise and respond to safeguarding concerns to help protect vulnerable people. And they engage in regular conversations and learning to help reduce risk following mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). They covered responsible pharmacist (RP) requirements, controlled drug (CD) management and pharmacy services. The most recent version of most SOPs was due for review in December 2024. But some SOPs, such as those for the delivery service were overdue for review. And there was a clear written instruction on a separate sheet confirming the SOPs remained relevant and should continue to be followed. The pharmacy had implemented a specific SOP to support the team in managing the risks associated with the supply of specific higher-risk medicines following the last inspection of the pharmacy in February 2023. The superintendent pharmacist (SI) provided details of the ongoing checks they undertook to support the safe supply of these medicines. Pharmacy team members signed training records confirming they had read and understood the SOPs. And they had a good understanding of their roles and responsibilities. They were aware of what tasks could not be completed should the responsible pharmacist (RP) take absence from the pharmacy.

The pharmacy had processes for managing mistakes made and identified during the dispensing process. Pharmacy team members were encouraged to look again at their work following a mistake being identified. They then worked to correct the mistake and generally recorded the mistake on a near miss record. Team members felt that most near misses were recorded to support learning. And records seen included the actions the team had taken to reduce risk. For example, rearranged stock on the dispensary shelves. The pharmacy had an incident reporting process for when a dispensing mistake happened, and the medicine was handed out. This included reporting mistakes to a senior pharmacist within the ownership group. The SI, who was the RP on duty, reflected on action taken to separate two medicines with similar names on the dispensary shelves following a dispensing incident. And they provided evidence of incident reporting.

The pharmacy advertised how people could provide feedback about its services. It also displayed polite notices informing people of its zero-tolerance approach to verbal abuse directed at its team members. Team members had a clear understanding of how to manage feedback and they aimed for local resolution of concerns wherever possible. They offered people details of the pharmacy's head office team if they wished to escalate feedback. The team explained that most feedback in recent months had been due to delays in obtaining stock. This was outside of the pharmacy team's direct control. The pharmacy had information governance procedures to support its team members in managing confidential information with care. It held personal identifiable information in the staff-only area of the premises. Confidential waste was separated, and this was disposed of securely.

The SI had completed safeguarding learning through the Centre for Pharmacy Postgraduate Education.

They had also completed other learning to support them in having difficult conversations with vulnerable people. Other team members had read procedures and knew how to recognise and report a safeguarding concern. Contact information for local safeguarding teams was accessible. The SI provided details of several safeguarding concerns the team had managed when people reached out to the pharmacy for support. The SI was aware of safety initiatives designed to support people experiencing domestic abuse in accessing a safe space. A discussion with team members provided a learning opportunity about common code words associated with these safety initiatives.

The pharmacy had current indemnity insurance. The RP notice was changed as the inspection began to reflect the correct details of the RP on duty. RPs signed into the RP record as required but they did not regularly sign-out of the record. A sample of private prescription records seen complied with legal requirements. The pharmacy maintained running balances in its controlled drug (CD) register and completed balance checks of physical stock against the register periodically. A random physical balance check conducted during the inspection complied with the running balance in the register. The team recorded patient-returned CDs in a separate register at the point of receipt. It generally completed records for the supply of unlicensed medicines at the time of dispensing. But records for several recently dispensed unlicensed medicines required completion.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a small, dedicated team of people to safely manage its workload. It supports its team members in developing their skills and knowledge through ongoing learning relevant to their role and the pharmacy services they deliver. Pharmacy team members work well together, they regularly share learning through conversation. And they are confident in providing feedback about the pharmacy. They know how to raise a professional concern if needed.

Inspector's evidence

The SI was supported by two qualified dispensers and a delivery driver. Another trainee dispenser also worked at the pharmacy. Workload was generally up to date with the exception of the mornings workload which was assembled and waiting to be checked. The SI had been running a vaccination clinic in the morning and explained normally they would have a second pharmacist present. But on this occasion did not due to unplanned absence. The outstanding workload seen was manageable and team members commented that it was unusual circumstances. The pharmacy did not have any targets associated with its services.

One dispenser was enrolled on a pharmacy technician training course. They felt supported with their learning but did not receive protected learning time at work. The trainee dispenser was enrolled on a GPhC accredited training course. And all team members undertook relevant learning to support them in their roles. For example, reading SOPs and updating themselves on NHS service specifications as services changed. A team member provided an example of how they used learning associated with the Pharmacy First minor ailment service to support face-to-face consultations with the person with the minor ailment.

Team members engaged with each other through regular conversations during the working day. The company had a secure messaging group that was used to share wider information such as stock queries. The pharmacy had a whistleblowing policy and team members were confident in sharing feedback with each other and with the SI. They were currently going through a period of uncertainty at work due to the business being up for sale. They felt the SI was supportive. And they shared examples of how their feedback informed working practices. For example, the pharmacy had improved the audit trail for managing the medicines it owed to people following a team members idea. Team members knew how to raise and escalate concerns at work if a needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is adequately clean and secure. It is suitable for the services provided. And it has facilities to allow people to have a private conversation with a member of the pharmacy team.

Inspector's evidence

The pharmacy was secure and maintained to an adequate standard. The premises were old and there was some structural wear and tear. The SI provided assurance that the wear and tear to the building was monitored with structural reviews taking place periodically. Working areas were clean with other areas such as staff facilities requiring some attention. Team members had access to sinks equipped with antibacterial hand wash and towels. Heating and ventilation arrangements were sufficient.

The public area was open plan with medicines held behind the medicine counter. Access to a private consultation room was available from the public area. A separate staff entrance into the room was provided from behind the medicine counter. The room was fitted with a portable sink and equipment and documents to support services were readily accessible within the room. People were seen to be directed to the room when they required a private conversation with the pharmacist. The dispensary was accessed through a doorway behind the medicine counter. It was small but team members managed workflow adequately within the space provided. A centre island within the room was full of stacked baskets waiting to be accuracy checked. Team members explained that this was an exception due to no additional cover being available to support the mornings vaccination service. A storeroom and staff facilities led off the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

People benefit from the range of accessible services the pharmacy provides. The pharmacy obtains its medicines from licensed sources. And it stores its medicines appropriately. Team members provide advice and relevant information to help people take their medicines safely. And they carry out regular checks to ensure medicines remain safe to supply to people.

Inspector's evidence

The pharmacy was accessed through a door, up a small step from street level. It displayed valuable information for people to see, such as its opening times and details of the services it provided. Pharmacy team members had good knowledge of the local area and explained how they would signpost people to other pharmacies or healthcare services if they required a service or medicine the pharmacy could not provide. The pharmacy was committed to providing services that would benefit the local community. It had reviewed the way it managed bookings for its COVID-19 vaccination service to make the service more accessible to local people. On the day of inspection, the SI had arranged to attend a local school to provide a vaccination service to staff. A service specification was available along with the necessary equipment to enable the SI to provide the service safely. The service was arranged during the pharmacy's lunch hour when it was closed which meant it had no negative impact to people needing to access other pharmacy services.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. The SI took the opportunity to speak to people requesting advice. The pharmacy team was vigilant about repeat requests for over-the-counter medicines subject to abuse, misuse, and overuse. The SI explained how they referred people to their GP if they required ongoing pain relief. The pharmacy team was aware of the requirements of the valproate Pregnancy Prevention Programme. And they knew about very recent changes to the Human Medicines Regulation about the need to supply valproate in original packs. Either the RP or a team member, acting under the RP's direction, counselled people on the safe use of their medicines. But the team did not general record these types of intervention on the patient medication record to help support continual care.

The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form. The SI signed their initials in the 'checked by' boxes on medicine labels. But other team members did not always sign the 'dispensed by' box on medicine labels. This meant it may be more difficult to know who had been involved in the dispensing process should a query arise. The pharmacy kept a record of the medicines it owed to people, and team members used the original prescription when dispensing owed medicines. The pharmacy kept an audit trail of the medicine deliveries it made to people's homes. Pharmacy team members had access to current information to support them in delivering the pharmacy's services safely. For example, patient group directions for flu and COVID vaccinations and the most recent service specification for the minor ailments service. The minor ailment service was popular and team members provided an oversight of how the service was managed.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. The process for ordering and receiving stock currently required additional steps which at times had increased the

timescale for obtaining stock. It meant that the number of owed medicines had increased. This situation was due to circumstances outside of the team's control. The pharmacy stored medicines in an orderly manner, and within their original packaging, on shelves throughout the pharmacy. It held its CDs in secure cabinets, and it held medicines requiring cold storage in suitable fridges. These were equipped with thermometers and data trackers. The team monitored the temperature of both fridges, but it did not always record the checks that it made. Team members completed regular date checking tasks, they highlighted medicines with short expiry dates to prompt additional checks during the dispensing process. A random check of dispensary stock found no out-of-date medicines. The pharmacy had appropriate medicine waste receptacles and sharps bins available. The pharmacy received medicine alerts through email and the team acted in a timely manner to check the alerts it received.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Overall, the pharmacy has the equipment it requires to provide its services. Pharmacy team members use this equipment appropriately and in a way which protects people's privacy.

Inspector's evidence

Information on computer monitors was suitably protected from unauthorised view. The pharmacy stored bags of assembled medicines behind the medicine counter with care taken to ensure people's information on bag labels could not be read from the public area. Pharmacy team members used a cordless telephone handset. This allowed them to move out of earshot of the public area when discussing confidential information over the telephone. They had access to written reference resources as well as the internet. And they used NHS smartcards and passwords when accessing people's medication records.

The pharmacy had a range of clean counting and measuring equipment for liquids, tablets, and capsules. It had identified separate measures for use with higher-risk medicines to reduce any risk of cross-contamination. Equipment to support the pharmacy's consultation services was readily available. But a check of the equipment held within the consultation room identified that it was not checked as often as it should be as some expired adrenaline ampoules were found. The SI accepted this should be checked prior to undertaking vaccination services and acted immediately to replace the adrenaline. They acknowledged the need to adopt regular checks of equipment held in the consultation room moving forward.

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.