General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Berwick Hills Centre, Ormesby Road, MIDDLESBROUGH, Cleveland, TS3 7RP

Pharmacy reference: 1029961

Type of pharmacy: Community

Date of inspection: 08/10/2024

Pharmacy context

The pharmacy is part of a local shopping and community centre complex in Middlesbrough. It changed ownership in November 2023. The pharmacy's main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing NHS consultations to people. These include the Pharmacy First service, New Medicine Service, and blood pressure checks. It offers people the option to collect their medicines through an automated collection point situated to the side of the premises. And the pharmacy offers a medicine delivery service to people.

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 suitably identifies and manages the risks for providing its services. It keeps people's confidential information secure, and it generally keeps the records it must by law. Its team members understand how to manage feedback from people visiting the pharmacy. And they know how to recognise, and report concerns to help keep vulnerable people safe. They act honestly and openly by recording the mistakes they make during the dispensing process. And they regularly share learning and act to reduce the risk of repeat mistakes occurring.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. The pharmacy's superintendent pharmacist's team reviewed these on a two-year rolling cycle. SOPs were updated and new SOPs introduced to support changes to pharmacy services between formal review dates. Team members had access to the SOPs, but they had not all completed formal learning to confirm their understanding of all of the SOPs relevant to their role. The pharmacy's area operations manager provided monitoring records to support the team in addressing gaps in its learning. Team members were knowledgeable about the tasks they undertook and demonstrated how they completed tasks safely. For example, by making appropriate checks with people when handing out assembled medicines. A team member discussed what tasks could not take place if the responsible pharmacist (RP) took absence from the pharmacy.

The pharmacy had processes for managing mistakes made and identified during the dispensing process, known as near misses. A team member demonstrated how they would report a near miss. They corrected their own mistakes following feedback from the RP. And all team members were encouraged to reflect on their own mistakes by recording them. The team followed a similar process for recording mistakes identified following the supply of a medicine to a person, known as a dispensing incident. The pharmacy manager led a monthly patient safety review with the team to help identify learning and risk reduction actions following mistakes. Team members demonstrated actions they had taken to reduce risk following these reviews. For example, moving similar sounding medicines in the dispensary and highlighting medicines with similar names on the dispensary shelves to prompt additional care. The team also stored some medicines in transparent plastic boxes on the dispensary shelves to keep them organised and prevent the risk of a picking error occurring.

Pharmacy team members had a good understanding of how to manage feedback and concerns. They explained how they aimed for local resolution of concerns wherever possible. And they knew how to provide information to people to support them in escalating their concern to the pharmacy's head office. Team members had engaged in learning about safeguarding vulnerable people. A team member discussed the types of concerns they may identify and how they would report these concerns directly to the team leader and RP. The team understood how to support somebody asking directly for access to a safe space but not all team were aware of code phrases promoted by domestic violence safety initiatives designed to support people in requesting access to a safe space.

The pharmacy held personal identifiable information securely in staff-only areas of the premises and on password-protected computers. Team members completed mandatory learning to support them in

managing confidential information. They segregated confidential waste when working and the pharmacy disposed of this securely. The pharmacy had current professional indemnity insurance. The RP notice displayed the correct details of the RP on duty. The RP record was generally kept in order but there were occasional gaps in the record where a RP had not signed out when ceasing their role. A sample of the pharmacy's private prescription register, and specials records found the records were generally made in accordance requirements. But the date of dispensing was not always recorded alongside the date of prescribing within the private prescription register. The pharmacy kept its controlled drug (CD) register electronically. It kept records of running balances for all CDs and it undertook regular full balance checks of physical stock against the register balances. Physical balance checks of CDs conducted during the inspection matched the running balances in the register. The team recorded patient-returned CDs in a separate part of the electronic register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the appropriate knowledge and skills to provide its services effectively. Pharmacy team members are supportive of each other, and they work together well. They engage in regular conversations together to help minimise risk. And they understand how to raise concerns at work.

Inspector's evidence

The RP on duty was a locum pharmacist, they had very recently accepted a role to work as the regular pharmacist and was due to commence this role in the next few weeks. Three dispensers and a trainee dispenser were also on duty, one of the dispensers was the pharmacy's team leader and completed management tasks as part of their role. The pharmacy also employed another dispenser and a medicine counter assistant. A company-employed delivery driver normally provided the medicine delivery service. But a team member explained an agency driver was currently being used due to absence within the delivery team. The pharmacy had some targets for the services it provided, and team members were encouraged to promote pharmacy services to people during conversations with them. The RP had not been provided with any specific targets to meet whilst working. Workload was up to date and team members were observed working together well to complete tasks and they communicated effectively with each other.

Team members completed learning to support them in their roles, such as learning how to take people's blood pressure. The team leader had completed vaccination training to support the delivery of the seasonal flu vaccination service. Team members did not receive protected learning time at work to support them in completing regular learning and they felt that this was sometimes a barrier to completing learning such as SOP assessments to confirm their knowledge of the SOPs. The trainee dispenser reported that their course was going well, and they were suitably supported in their role. Team members engaged in regular briefings at work to discuss information, such as details of the patient safety review. And they were encouraged to share their ideas or any concerns they had during these briefings. They also knew how they could raise concerns in confidence at work, including how to escalate a concern if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It offers a suitable environment for delivering healthcare services. People using the pharmacy can speak with a member of the pharmacy team in private.

Inspector's evidence

The pharmacy was clean and spacious. It was secure from unauthorised access and was generally maintained to a good standard. But some areas of the carpeted floor both in the dispensary and public area were heavily worn with the adhesive layer of the carpet tiles exposed in some areas. Team members explained they had reported this issue. The pharmacy had two private consultation areas leading off the public area. One area led to a room with a hatch into a space just off the dispensary. The second area was a consultation room fitted with a table and chairs. Lighting was adequate throughout the premises. And air conditioning helped control the temperature in the pharmacy year-round. Team members had access to appropriate hand washing facilities.

The dispensary was large and team members used the workspace effectively with dedicated areas for different workflows. Workbenches were clear of clutter and floors were free from trip hazards. A sink in the dispensary was primarily used for preparing liquid medicines. A door leading from the back of the dispensary led to staff facilities, including a break room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and ensures they are accessible for people. It obtains its medicines from reputable sources. And it stores them safely and securely. Team members make regular checks to ensure medicines remain safe to supply to people. And they provide relevant information to people to help them take their medicines safely.

Inspector's evidence

People accessed the pharmacy from street level. It advertised its opening hours and details of the services it provided. People had the option to collect their medicine from an automated collection point. The pharmacy obtained consent before supplying medicines in this way and had processes to monitor the collections from the machine. It used a text messaging service to inform people of their personal code in order for them to collect their medication. Pharmacists were responsible for assessing whether a medicine was suitable for collection from the collection point. The RP demonstrated the process for identifying medicines suitable for collection in this way. And they provided examples of how they applied their professional judgement when making these decisions. Team members discussed how they would telephone a person if a medicine were not considered suitable for collection via the collection point and provided examples of what medicines would not be suitable. For example, medicines requiring cold storage.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying these behind the medicine counter. The RP was able to supervise the activity taking place in the public area from the dispensary. Team members discussed how they managed repeat requests for some P medicines which were liable to abuse. And the RP was confident in refusing sales which were not deemed appropriate. Team members understood how to signpost people to alternative pharmacies or healthcare providers when needed. A team member was observed dispensing valproate, they discussed legal changes made in 2023 which required the medicine to be dispensed in the manufacturer's original packaging. And they had an awareness of the requirements of the pregnancy prevention programme (PPP). The RP provided examples of counselling when handing out higher-risk medicines, including those included within medicine-related PPPs. They discussed a recent drug safety update requiring pharmacists to provide counselling to men taking valproate. But the team did not regularly record these types of interventions on people's medication records to support continual care.

Pharmacy team members had information available to them to support the safe delivery of consultation services. They had access to the national protocol and patient group direction (PGD) for the flu vaccination service. The team leader and RP were aware of their own roles and responsibilities when providing the vaccination service through the national protocol. For example, during the inspection the RP completed a clinical intervention and sought further information to ensure the vaccine was safe to provide to a person with a specific medical condition. PGDs to support the Pharmacy First service were readily available, and these were signed by the RP. The RP was observed completing consultation records following a person accessing the service. Team members transcribed information from prescriptions to the pharmacy's automated dispensing machine, used to dispense a liquid medicine. The pharmacist then completed clinical checks of prescriptions and accuracy checks of the data entered. The RP was observed making appropriate checks when supplying medicines for

people on an opioid treatment program. This included obtaining written authority when a police officer attended to collect medicine on behalf of a person. It effectively monitored the supply of these medicines and communicated with prescribers and people's key workers when needed.

Pharmacy team members used baskets throughout the dispensing process to help keep all items for each prescription together. They took ownership of their work by signing their initials on dispensing labels to confirm their involvement in the dispensing process. The pharmacy retained prescriptions for the medicines it owed to people when the full quantity of a medicine could not be supplied. It kept prescriptions for CDs separately to help prompt additional checks when dispensing these medicines. And the team demonstrated how it made regular checks of owed medicines and informed GP surgeries of long-term stock supply issues to help inform prescribing decisions. The pharmacy kept records of the medicine deliveries it made to people. This helped the team to resolve any queries received about the service.

The pharmacy sent prescription information to the company's offsite dispensing hub pharmacy which dispensed some medicines on behalf of the company's community pharmacies. Team members were positive about using this service and explained how it supported an effective workflow. They identified prescription data that was not suitable for sending to the dispensing hub pharmacy. For example, prescriptions for medicines required urgently. The process involved pharmacists completing data accuracy and clinical checks of prescriptions prior to transmitting data to the hub pharmacy. Some prescriptions were part-dispensed locally and part-dispensed by the offsite dispensing hub pharmacy. A team member demonstrated the safe process for managing these prescriptions which involved barcode technology to support the team in ensuring it handed out all medicines for a prescription when people attended to collect them.

The pharmacy obtained its medicines from licensed wholesalers and a licensed specials manufacturer. It stored medicines in their original packaging and in an orderly manner. The pharmacy stored its CD medicines safely in secure cabinets. Medicine storage inside the cabinets was neat with out-of-date medicines and patient-returned medicines clearly separated and identifiable. A large pharmaceutical fridge held medicines requiring cold storage. The team checked and recorded the operating temperature range of the fridge each working day. These records showed the fridge was operating within the required temperature range of two and eight degrees Celsius.

Team members documented the completion of regular stock management checks, including checking the expiry dates of medicines. They used stickers to identify short-dated medicines. And they recorded the opening date on bottles of liquid medicines to help ensure they remained safe to supply. Random checks of stock in the dispensary found no out-of-date medicines. The pharmacy had medicine waste receptacles available to support it in disposing of expired medicines and patient returns safely. The team received details of drug alerts and medicine recalls electronically. They checked these alerts regularly and made a record of the action taken in response to the alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities required for providing its services. It maintains its equipment appropriately. And its team members use the equipment and facilities in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members had access to a range of reference resources, they could access the most recent version of these reference resources through a digital subscription service provided by the company. Pharmacy team members accessed people's medication records on password-protected computers using NHS smartcards. Information on computer monitors was suitably protected from unauthorised view. The pharmacy stored bags of assembled medicines on shelves to the side of the dispensary. This area was neat and tidy with a separate section used to store bags containing new medicines. This helped to ensure people received the advice and support required when commencing on a new medicine. The storage arrangements protected information on bag labels from public view.

The pharmacy had a range of crown-stamped measures with separate measures used when dispensing higher-risk medicines. Counting equipment for tablets and capsules was also available. Equipment to support consultation services such as blood pressure machines, an otoscope and thermometer were readily available in the consultation room. Consumables used with this equipment, such as individual use earpieces for the otoscope were also readily available. The pharmacy kept its anaphylaxis supplies in a safe location. Team members could access this equipment quickly, should it be needed. The pharmacy checked its equipment regularly. For example, electrical equipment was annotated to show it had been safety checked in June 2024 and team members calibrated the automated dispensing machine daily. And the machine was covered by a service contract.

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.