General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newtons Pharmacy, 1028-1030 Anlaby High Road, HULL, North Humberside, HU4 7RA

Pharmacy reference: 1032051

Type of pharmacy: Community

Date of inspection: 10/03/2020

Pharmacy context

The pharmacy is amongst a small parade of shops in a suburb of Hull. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies some medicines in multi-compartment compliance packs to help some people take their medicines. And it delivers medication to people's homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy doesn't have a complete set of standard operating procedures (SOPs) for the team to follow. And the SOPs have not been reviewed for quite a number of years. Several SOPs do not reflect how the pharmacy operates and some do not cover legal requirements such as the Responsible Pharmacist (RP) Regulations. Not all the team members have signed the SOP signature sheets to confirm they have read the SOPs. And some SOPs such as the one for delivering medicines to people's homes are not followed by all team members.
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 not all met**

Summary findings

The pharmacy identifies some of the risks associated with its services. But it hasn't a full set of up-to-date written procedures available for the team to follow. Several of these procedures do not reflect how the pharmacy operates and some do not cover legal requirements. The pharmacy team members correct mistakes when they happen. And they discuss what happened and act to prevent future mistakes. But they don’t always record or review these errors. So, they do not have the information to identify patterns and help reduce similar mistakes in the future. People using the pharmacy can raise concerns and provide feedback. Team members have training, guidance and experience to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The team members keep the records they need to by law.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. Some SOPs had review dates due in 2007. Others had review dates due in 2014. But the pharmacy hadn't completed any reviews. So, several SOPs did not reflect current practice such as the use of the electronic CD register. SOPs covering the requirements of the Responsible Pharmacist legislation could not be found. Not all team members had signed the SOPs signature sheets to show they had read the SOPs and would follow them. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy did not keep records of these near miss errors. The pharmacy team had a system to record dispensing incidents. These were errors identified after the person had received their medicines. But an error reported by a person a few days earlier had not been recorded. The pharmacy did not print off the dispensing incident reports and there were none available to look at. On occasions the Superintendent Pharmacist (SI) dispensed and checked the prescriptions without involving one of the dispensers on duty. A recent dispensing error involving the supply of the wrong medicine had been from a prescription that the SI had dispensed and checked. The pharmacist discussed dispensing incidents with the team to identify how to prevent the error happening again. The pharmacist highlighted to the team the risk of errors with new formulations of inhalers. The team members had separated meloxicam 15mg and mirtazapine 15mg after identifying the two medicines were involved in errors. And they had ordered a different brand of levothyroxine 50mcg after spotting that the three different strengths from the same manufacturers had similar packaging. The pharmacy team placed large yellow stickers on bags holding completed prescriptions to highlight to each other that there was another person with the same name or a similar name. This prompted the team to double check the person’s details when handing over the medicine. The team introduced this after finding some patients with the same name or a similar name. These people lived near each other so the team identified that the extra check of the postcode may not spot if the prescription was for the correct person.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. But it did not have a leaflet or other information source such as a poster to provide people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the

pharmacy. The pharmacy published these on the NHS.uk website. And it provided people with a comments card to provide feedback.

The pharmacy had electronic controlled drug (CD) registers, a sample looked at found that they met legal requirements. The system captured the current stock balance for each register and prompted the pharmacist when a stock check was due. This helped to spot errors such as missed entries. The system highlighted CDs that were out-of-date. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy did not display details on the confidential data kept and how it complied with legal requirements. The team separated confidential waste for shredding onsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team responded appropriately when safeguarding concerns arose. The delivery driver reported to the team any concerns they had about people they delivered medicines to. And the team passed on the concern to the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. The team members support each other in their day-to-day work. They discuss and share ideas and they introduce processes to improve their efficiency in the way they work. The pharmacy provides the team members with some opportunities to develop their knowledge. But team members don't receive formal feedback on their performance. So, they may miss the opportunity to reflect and identify training needs to help the safe and effective delivery of services.

Inspector's evidence

The Superintendent Pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of four part-time dispensers, four part-time medicines counter assistants and two part-time delivery drivers. At the time of the inspection the Superintendent Pharmacist, three dispensers and one of the medicines counter assistants were on duty. Many of the team had worked together for around 25 years and were well known to people in the local community who used the pharmacy. The pharmacy provided extra training through modules provided by an external organisation. And some team members attended evening training events.

The pharmacy did not provide formal performance reviews for the team. So, they did not have a chance to receive feedback and discuss development needs. The team received in the moment informal feedback. Team members could suggest changes to processes or new ideas of working. The team had changed the storage of completed prescriptions for fridge medicines. After checking the fridge medicines the team placed them in to the fridge but they were only put in to bags at the point of supply. So, a second check of these medicines could take place. The pharmacy had no targets for its pharmacy services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean and tidy. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink. The team generally kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a sound proof consultation room. The team used this for private conversations with people. The premises were secure and the pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides services that support people's health needs and it manages its services appropriately. The pharmacy team takes care when dispensing medicines in to multi-compartment compliance packs to help people take their medication. The team keeps records of the deliveries it makes to people at home. But the delivery driver doesn't always obtain signatures from people for the receipt of their medicines. So, the pharmacy team doesn't have a robust audit trail and cannot always evidence the safe delivery of people's medicines. The pharmacy obtains its medicines from reputable sources and it mostly stores them correctly. But the pharmacist does not always promptly contact the relevant organisations when people report problems with their medicines.

Inspector's evidence

People accessed the pharmacy via two entrances. One entrance had an automatic door and an external ramp was installed. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy team had completed checks to identify people who met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found one person who met the criteria and was on a PPP. The pharmacist directed people receiving valproate to the information card embedded within the medicine packaging.

The pharmacy provided multi-compartment compliance packs to help around 30 people take their medicines. When an initial request for the service was made the pharmacist assessed the suitability of the service for the person. And liaised with the person's GP. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions one week before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. The team checked received prescriptions against the person's electronic medication record (PMR). And queried any changes with the GP team. The team used a small section of the main dispensary to dispense the packs. The team members were asked to not disturb the dispenser when they were dispensing the medicines in to the packs. The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets. The pharmacy sometimes received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items.

The team members provided a repeat prescription ordering service. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The local GP surgery was changing the ordering system so the person had to order their own prescription with the GP surgery, not through the pharmacy. The pharmacy team spent time with people explaining why this was happening. And the options available to order their repeat prescriptions such as an NHS App. The pharmacist had downloaded the NHS App so he could show people how it worked. And to answer any questions from people about using the App. The team advised people to order their prescriptions seven days before they ran out of their medicines. The team were putting a list together of people that would struggle to order their own prescriptions. So, they could ask the GP team if the pharmacy could continue to order on behalf of these people. The team marked the bags containing the completed prescriptions with a blue dot. This prompted the team to

inform the person about the changes when handing their medicines over.

The pharmacy received a large volume of electronic prescriptions (EPS). The team regularly downloaded the prescriptions throughout the day. One of the dispensers labelled the prescriptions and another dispenser picked the medicine and labelled the medicine. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. But the pharmacy didn't get a signature from the person receiving the medication. So, the pharmacy didn't have a full audit trail or proof of delivery for all prescriptions. The standard operating procedure included this as a requirement.

The pharmacy team checked the expiry dates on stock. The team placed coloured dots on medicines with a short expiry date. No out-of-date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had a computer upgrade to meet the requirements of the Falsified Medicines Directive (FMD). But the pharmacy had no scanning equipment to help the team meet FMD requirements. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record. The pharmacy had recently received concerns from some people about the packaging for one medicine. People reported that it was very difficult to remove the tablet from the packaging. The pharmacist had yet to report this to the manufacturer and the MHRA.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and to protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. The pharmacy had a fridge to store medicines kept at these temperatures. The fridge had a glass door. This enabled the team to view stock in the fridge without prolong opening of the door.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.