General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sneinton Road Pharmacy, 113 Sneinton Road, NOTTINGHAM, Nottinghamshire, NG2 4QL

Pharmacy reference: 1035737

Type of pharmacy: Community

Date of inspection: 21/03/2024

Pharmacy context

This community pharmacy is located on a main road in a residential area. Most people who use the pharmacy are from the local area and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines. And it provides a flu vaccination service and some other NHS funded services including the Pharmacy First Service and needle syringe provision. It supplies some medicines in multi-compartment compliance aid packs to help people take their medicines at the right time.

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 generally manages risks, and it acts to improve patient safety. It keeps most of its records up to date, so it can show it is providing services safely. The pharmacy team members keep people's private information safe and understand how to help to protect children and vulnerable adults.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. The SOPs had not been changed when the new owners took over around six months ago. The responsible pharmacist (RP) explained that she and the rest of the pharmacy team had worked at the pharmacy before the change of ownership and were continuing to follow the original SOPs. The pharmacist superintendent (SI) had confirmed to the RP that he would be preparing new SOPs in the near future. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their roles. The name of the RP was displayed as required by the RP regulations.

The pharmacy team reported dispensing errors electronically. Learning points were identified and actions taken to help avoid re-occurrences were recorded. For example, following an error involving cyclizine and colchicine, the two medicines were moved apart, and alert labels were placed in front of them to highlight that they were look-alike and sound-alike drugs (LASAs), so extra care would be taken when selecting these. All the team members had been made aware of the error and the RP had recorded the error on the National Reporting and Learning System (NRLS). Near miss errors were recorded on a log and discussed within the team at the time the error was identified. The RP said she didn’t always carry out formal reviews of the near miss log, so there was a risk that the pharmacy team might miss out on additional learning opportunities. The RP said she would re-introduce a monthly review which is what had been done under the previous owner.

The RP explained that she would deal with any complaints but was waiting for a new complaint policy from the new owners. There was nothing on display advising people how to raise a concern or leave feedback. Professional indemnity insurance arrangements were in place. Private prescription records and the controlled drug (CD) registers were appropriately maintained. Records of CD running balances were kept and these were checked weekly. One CD balance was checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately. The RP had forgotten to sign into the RP record for the previous day, and the morning of the inspection. Otherwise, the RP record appeared to be in order and the RP completed the missing entries during the inspection. Members of the pharmacy team had read SOPs and received training on information governance (IG) which included confidentiality. Confidential waste was collected in a designated place and shredded. A dispenser correctly described the difference between confidential and general waste. Assembled prescriptions and paperwork containing patient confidential information were stored appropriately so that people’s details could not be seen by members of the public. A privacy statement was on display, in line with the General Data Protection Regulation (GDPR).

All members of the pharmacy team had completed level 2 training on safeguarding. The RP had requested this as the pharmacy had a large number of vulnerable people, and she had ensured there was relevant safeguarding information in the supervised medication and needle syringe provision area.

For example, leaflets outlining the signs and symptoms of abuse, and a poster offering support with domestic abuse. A dispenser explained she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. The pharmacy had a chaperone policy, and this was highlighted to people. The pharmacy team were aware of the 'ask for ANI' initiative, where pharmacies were providing a safe space for victims of domestic abuse.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members work well together, and they have the right training and qualifications for the jobs they do. Team members are comfortable providing feedback to their manager and they receive informal feedback about their own performance.

Inspector's evidence

The RP, an NVQ3 qualified dispenser and an NVQ2 equivalent dispenser were on duty at the time of the inspection. Team members qualification certificates were on display in the consultation room. The RP was the regular pharmacist. The SI visited at least once each week and was going to become the regular pharmacist in the near future. The staffing level was adequate for the volume of work during the inspection and the team members were observed working collaboratively with each other and people who visited the pharmacy. Planned absences were organised so that no more than one person was away at a time. Absences were covered by re-arranging the staff hours or using locum dispensers.

Members of the pharmacy team carrying out the services had completed appropriate training. Team members completed some ongoing training to ensure their knowledge was up to date, such as on the new Pharmacy First service. But there wasn’t a structured programme, and the pharmacy team did not have regular protected training time. The RP confirmed that she had completed all the relevant training for the Pharmacy First service and had received face-to-face training in use of the otoscope and ear examination. Team members received feedback informally about their performance and development. Issues were discussed within the team as they arose. A dispenser said she felt there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the RP about any concerns she might have. She said she felt comfortable admitting errors and always tried to learn from her mistakes. The RP was empowered to exercise her professional judgement and could comply with her own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because she felt it was inappropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for people to receive healthcare services. It has a private consultation room so people can receive services in private and have confidential conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy premises, including the shop front and facia, were clean and in a good state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with one chair. The temperature and lighting were adequately controlled. The pharmacy had been fitted out to a high standard, and the fixtures and fittings were in good order. There was an office area, a small stockroom and an area dedicated to the preparation and storage of compliance aid packs at the rear of the main dispensary. Staff facilities included a tea-room with a small kitchen area, and a WC, with a wash hand basin and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks. The consultation room was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. This room was used when carrying out services and when customers needed a private area to talk. A separate area of the counter was screened and used by people receiving supervised medication and needle syringe provision.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are generally well managed and easy for people to access. The pharmacy team members are helpful and give healthcare advice and support to people. The pharmacy gets its medicines from licensed suppliers, and it carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

There was a slight step up to the front door of the pharmacy, but it was possible for customers to enter with prams and wheelchair users with assistance. There was a power assisted double door at the entrance and the pharmacy had a portable ramp which could be used if necessary. There was a hearing loop and a sign showing this. Some of the services provided by the pharmacy were advertised in the window, along with the opening hours. There was a range of healthcare information including leaflets on mental health and sexual health, and posters advertising local activities, such as a 'mental health coffee morning.' The pharmacy team was clear what services were offered and where to signpost people to a service not offered. A folder was available containing relevant signposting information which could be used to inform people of services and support available elsewhere. The pharmacy offered the Pharmacy First service and there was a large display with guidance for pharmacy team members on each of the seven conditions and their main clinical exclusions. The RP said she had shared this information with the local GP practices, but they were still getting quite a few unsuitable referrals, such as people with chesty coughs requiring antibiotics. There were patient checklists which people were asked to complete whilst waiting for a consultation. The RP then took the person into the consultation room, went through the checklist, and completed the consultation if they were suitable for treatment.

There was a home delivery service with associated audit trail. Deliveries were usually carried out by the SI. He made a record to confirm the delivery had been successful, but he did not record the name of the recipient or obtain a signature from them. This might cause a delay if there was a problem or query about the service. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was adequate in the dispensary and the workflow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat, and tidy. Dispensed by and checked by boxes were generally initialled on the medication labels to provide an audit trail. Initials were missing from assembled methadone solution, so it was not clear who had assembled and checked it. Single tablets of buprenorphine, which were to be taken under supervision, were not always placed in suitable containers with a medication label. The RP said she would remind the pharmacy team to label all medicines and initial the medications labels so there was a better audit trail. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. 'Pharmacist' stickers were used to highlight when counselling was required and high-risk medicines

such as valproate were targeted for extra checks and counselling. The team were aware of the requirements for a Pregnancy Prevention Programme (PPP) to be in place and that people who were prescribed valproate should have annual reviews with a specialist. The RP said that the pharmacy did not currently have any patients in the at-risk group but said the valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling. The RP was aware of the requirements for original pack dispensing for valproate.

Multi-compartment compliance aid packs were reasonably well managed with an audit trail for communications with GPs and changes to medication. But, four weeks of packs were assembled from the first weekly prescription of the month, and the remaining three packs were not labelled until the three subsequent prescriptions were received. The dispenser said the packs were checked carefully against the prescriptions when they arrived to see if there had been any changes from the first one, and explained it was to give the pharmacy more time to assemble the packs. The RP agreed that this was risky procedure, and it was not strictly in line with the SOPs. She said she would review this procedure and discuss it with the SI. Medicine descriptions were usually included on the labelling sheets to enable identification of the individual medicines. Packaging leaflets were included so people were able to easily access additional information about their medicines. Disposable equipment was used. An assessment was made by the pharmacist as to the appropriateness of a pack or if other adjustments might be more appropriate to their needs, before agreeing to supply it in a pack.

A dispenser explained what questions she asked when making a medicine sale and was clear which medicines could be sold in the presence and absence of a pharmacist. She understood what action to take if she suspected a customer might be misusing medicines such as a codeine containing product.

CDs were stored in two CD cabinets which were securely fixed to the wall. The keys were under the control of the RP during the day and stored securely overnight. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored in glass cabinets in the retail area, so there was a risk of unauthorised access. One of the dispensers said people were never left unattended in the pharmacy and somebody would go to assist anyone attempting to open the cabinets, to reduce this risk.

Recognised licensed wholesalers were used to obtain stock medicines and appropriate records were maintained for medicines ordered from ‘Specials.’ Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out, but this was not always recorded, so some parts of the pharmacy might get missed. Short -dated stock was highlighted using stickers. Expired and unwanted medicines were segregated and placed in designated bins. Alerts and recalls were received via email messages. These were read and acted on by a member of the pharmacy team. A copy was retained in the pharmacy with a record of the action taken so the team were able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe, and they use it in a way that protects privacy.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date reference sources. The RP said she usually used an App on her mobile phone to access the electronic British National Formulary (BNF) and BNF for children. There was a clean medical fridge for storing medicines. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested. There was suitable blood pressure testing equipment. New ambulatory equipment had been requested as the original one which was provided had been difficult to use. An otoscope was available for use in the Pharmacy First service. There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were marked and used for methadone solution. Meth-a-measure automated equipment was also used to measure methadone solution. It was cleaned and calibrated every time it was used. The pharmacy had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.