General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Nursey Park Primary Care Centre, Nursery Park Road, ASHINGTON, Northumberland, NE63 0HP

Pharmacy reference: 1035817

Type of pharmacy: Community

Date of inspection: 17/02/2023

Pharmacy context

The pharmacy is in a residential area in Ashington. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide services to people, including the NHS New Medicines Service (NMS). They provide medicines to some people in multi-compartment compliance packs. And they deliver 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 adequately identifies and manages risks to its services. And it has the written procedures it needs relevant to its services. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. Team members record and discuss the mistakes they make to learn from them. But they don't always capture enough key information in these records to help aid future reflection and learning.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage the risks to its services. These were available electronically, although they could not be accessed during the inspection because of IT technical difficulties that were out of the team's control. The superintendent pharmacist's (SI) office reviewed the procedures every two years on a monthly rolling cycle. It sent new and updated procedures to pharmacy team members via the company's online training system. Pharmacy team members read the procedures, and they completed a test after reading each one. If they passed the test, they could complete the sign off process as having read and understood it. The pharmacy defined the roles of pharmacy team members in each SOP, and tasks were further defined by frequent discussions amongst pharmacy team members throughout the day. The pharmacy was currently operating with locum pharmacists three days a week. It had a locum briefing pack available, which included key information about how the pharmacy operated, who the key personnel were, the team roles and levels of qualification and the key daily tasks that needed to be completed. Team members gave the pack to new locum pharmacists when they arrived.

The pharmacy provided advice and support to people about newly prescribed medicines, via the NHS New Medicines Service (NMS). The service provided people with regular advice and support about their new medicines during the first month of treatment. And this helped the pharmacy to counsel people about how to take their medicines effectively, answer people's queries about their medicines, and help them to manage any side effects they experienced. The pharmacy had an SOP in place to help team members manage the risks with the service, and team members had been properly trained. The pharmacy team members did not know if the pharmacy had assessed the risks of providing the service when it started, or on an ongoing basis. And there was no documented risk assessment available on the pharmacy for team members to refer to.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made when dispensing. There were documented procedures to help them do this effectively. They discussed their errors and why they might have happened. And they used this information to make some changes to help prevent the same or similar mistakes from happening again. One example of changes they had made was separating look-alike and sound-alike (LASA) medicines on the shelves, such as similarly packaged gliclazide and furosemide, to help prevent the wrong medicines being selected. Pharmacy team members did not always capture much information about why the mistakes had been made or the changes to prevent a recurrence to help aid future learning. But they gave their assurance that these details were always discussed. The pharmacy manager analysed the data collected every month to look for patterns. They recorded their analysis. And pharmacy team members discussed the patterns found at a monthly patient safety briefing. The pharmacy had a system in place to manage and record dispensing errors, which were errors identified after the person had received their medicines. But the

pharmacy was experiencing IT difficulties during the inspection and was unable to access any previous records. So, the quality of error reporting could not be assessed.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. Pharmacy team members explained feedback was usually collected verbally from people. Any complaints were immediately referred to the pharmacist to handle. The pharmacy had a practice leaflet available, which included information for people about how to provide the pharmacy with feedback.

The pharmacy had up-to-date professional indemnity insurance in place. It kept accurate controlled drug (CD) registers electronically, with running balances in all registers. Pharmacy team members audited these registers against the physical stock quantity every week. The pharmacy kept and maintained a register of CDs returned by people for destruction. But team members did not always capture full information in the destruction register about who had destroyed CDs and who had witnessed the destructions. The pharmacy maintained a responsible pharmacist record, which was complete and up to date. The pharmacist displayed their responsible pharmacist notice. Pharmacy team members monitored and recorded fridge temperatures daily. They kept accurate private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bins, which were periodically emptied by a waste disposal contractor for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information. Pharmacy team members had signed to confirm they had understood the procedure. Pharmacy team members explained how important it was to protect people's privacy and how they would protect confidentiality. They completed mandatory confidentiality and information security training each year. A pharmacy team member gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would refer their concerns to the pharmacist. The pharmacy had procedures for dealing with concerns about children and vulnerable adults. Pharmacy team members completed mandatory safeguarding training every year. And team members completed training to different levels according to their qualifications and responsibilities.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide. They complete appropriate training to keep their knowledge up to date. They effectively discuss and implement changes to improve their services and make the pharmacy safer. And they feel comfortable raising concerns with the right people if necessary.

Inspector's evidence

During the inspection, the pharmacy team members present were a locum pharmacist and two qualified dispensers. And they were observed to manage the workload well. Team members completed mandatory e-learning modules regularly. Their latest modules included training on safeguarding and sepsis. They also regularly read new and revised standard operating procedures (SOPs) via the company's online training platform. And were required to pass a short test after reading each SOP to confirm their understanding. Team members were able to complete their training during working hours. The pharmacy had an appraisal process in place for pharmacy team members. But team members had not received an appraisal with their manager in at least two years. They explained how they would raise any training needs informally with their manager, who would support them by providing training and signposting to appropriate resources.

A team member explained how they would raise professional concerns with the pharmacy manager, the area manager, or the regional manager if necessary. They felt comfortable raising concerns. And making suggestions to help improve the pharmacy's ways of working. They were confident that their concerns and suggestions would be considered, and changes would be made where they were needed. Team members had recently changed the way they managed repeat dispensing (RD) prescriptions. They had previously processed prescriptions weekly but changed to a daily processing system to help them better manage their workload. They explained their changes had worked well and had helped them to make sure people's prescriptions were prepared on time. The pharmacy had a whistleblowing policy. Pharmacy team members knew how to access the procedure. They communicated openly during the inspection. Team members were asked to achieve targets in various areas of the business, for example the number of prescription items dispensed, and the number of NMS consultations provided. Team members explained they felt comfortable achieving the targets set. They explained their strategies for achieving their targets safely. And explained they were comfortable to have conversations with their area manager if they did not achieve their targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it provides. And it has a consultation room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a private consultation room, which was clearly signposted, and pharmacy team members used the room to have private conversations with people. There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a staff toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy kept its heating and lighting to acceptable levels. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are accessible to people, including people using wheelchairs. The pharmacy uses the systems it has in place, including the available technology, to help provide its services safely and effectively. These include processes to help ensure people's medicines are suitable for them. And that they receive appropriate advice. It sources its medicines appropriately. And it stores and manages its medicines properly.

Inspector's evidence

The pharmacy had level access from the street through a power-assisted door. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And provide large-print labels and instruction sheets to help people with a visual impairment.

The pharmacy had a good proportion of its prescriptions dispensed at the company's off-site dispensing hub, where medicines were picked and assembled by a dispensing robot. Pharmacy team members explained that prescriptions were assessed to establish whether they were suitable to be sent to the hub. They continued to dispense prescriptions for urgent acute items, such as antibiotics, for medicines stored in the fridge and for prescriptions for unusual quantities of medicines. They used the hub most commonly for people's regular repeat medication. Pharmacy team members annotated on the electronic prescription token which items were being sent to the hub and which items were for the team to dispense. The pharmacist logged on to the system and performed a clinical and accuracy check of each prescription. Once the pharmacist was satisfied, they released the prescription which was then sent to the hub for assembly. The pharmacy received the medicines in sealed packages from the hub. Pharmacy team members married up the bags with the relevant prescriptions and any medicines that had already been prepared in the pharmacy. And the bags were added to the prescription retrieval shelves ready for collection or delivery. Pharmacy team members said they sometimes had difficulties managing prescriptions that were rejected by the hub system at the last minute. This meant they needed to dispense the prescription locally instead. But often, they did not have the required medicines in stock, which created further delay while the pharmacy ordered the right medicines. They explained the situation did not happen often. But it would help if they were provided with more notice if they needed to complete the prescriptions locally instead.

Pharmacy team members attached labels to bags of dispensed medicines that contained a unique barcode. When they were ready to store a completed prescription bag, they scanned the barcode using a hand-held device. The information on the device was linked to the electronic patient medication records system. Pharmacy team members chose a location to store the bag. And they scanned the barcode attached to the location and placed the bag on the shelf. When people came to collect their medicines, pharmacy team members entered their details into the hand-held device. The device then told them where the bags were stored. Pharmacy team members marked the bag as collected and a record was made of the time and date of collection. They explained that the system helped to prevent bags kept in different locations being missed and the patients leaving without all their prescriptions. For example, if part of their prescription was being stored in the fridge or the controlled drugs cabinet as well as on a shelf. Pharmacy team members also explained that the system helped them to identify if a patient had forgotten to collect a prescription previously.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if they were at risk. They checked if the person was aware of the risks if they became pregnant while taking the medicine. And whether they were on a pregnancy prevention programme and using effective contraception. The pharmacy had stock of some information materials to give to people to help them manage the risks of taking valproate. Pharmacy team members were currently undertaking an audit of people who received valproate from the pharmacy. And this would help to ensure that the right people had received the appropriate information and counselling.

The pharmacy supplied medicines for some people in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Team members included descriptions on the packs of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month. Pharmacy team members documented any changes to medicines provided in packs on the person's master record sheet, which was a record of all their medicines and the times of administration. They also recorded this on their electronic patient medication record (PMR). The pharmacy delivered medicines to people via a delivery driver, who also delivered medicines for other local stores. The pharmacy used an electronic system to manage and record deliveries and it uploaded information to the driver's handheld device. Pharmacy team members highlighted bags containing controlled drugs (CDs) on the driver's device and on the prescription bag. The delivery driver left a card through the letterbox if someone was not at home when they delivered, asking them to contact the pharmacy. And they returned the medicines to the pharmacy.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored the minimum and maximum temperatures in the pharmacy's fridge each day and recorded their findings. The temperature records seen were within acceptable limits. Team members recorded weekly checks of medicine expiry dates. They completed checks in various areas of the pharmacy on a rolling cycle. This meant they checked all medicines every three months. Pharmacy team members highlighted and recorded any short-dated items up to six months before their expiry and recorded these items on a monthly stock expiry list. They removed expiring items during the month before their expiry. Pharmacy team members responded to any alerts or recalls they received about medicines from manufacturers and other agencies. They removed any affected medicines from the shelves, and they recorded the actions they had taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people’s confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had suitable containers available to collect and segregate its confidential waste. It kept its password-protected computer terminals and bags of medicines waiting to be collected in the secure areas of the pharmacy, away from public view and where people's private information was protected.

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.