General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 15 Station Road, Seghill, CRAMLINGTON, Northumberland, NE23 7SE

Pharmacy reference: 1035847

Type of pharmacy: Community

Date of inspection: 16/10/2019

Pharmacy context

This is a small community pharmacy in a residential area of Cramlington, Northumberland. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it provides services including home delivery, seasonal flu vaccinations and medicines use reviews (MURs). It also supplies medicines in multi-compartment compliance packs to people living in their own 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 identifies and manages many of the risks associated with the services it provides to people. And it has a set of up-to-date written procedures for the team members to follow to help them deliver the services safely. It keeps the records it must have by law. And it keeps people's private information secure. It acts on the feedback it receives from people who use the pharmacy to improve services. The team members discuss and record most of the mistakes they make when dispensing. And they implement changes to minimise the risk of similar mistakes happening in the future. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had a small retail area which led to a small dispensary. The pharmacy counter prevented access from the retail area to the dispensary. There was an established work flow with separate areas for dispensing and checking. The pharmacy had a set of standard operating procedures (SOPs). And these were held electronically. They included ones for responsible pharmacist regulations and dispensing. The superintendent pharmacist's team reviewed each SOP every two years on a monthly rolling cycle. This ensured that they were up-to-date. The pharmacy defined the roles of the pharmacy team members in each SOP. The superintendent pharmacist's team sent new and updated SOPs to the team via the eExpert training programme. The team members completed a short quiz once they had read the SOP. They needed to pass the quiz and the manager had to be satisfied that the team member understood its contents.

The pharmacy recorded near miss errors made while dispensing onto a paper near miss log. And records were seen for previous months. It was noted that the error rate had halved in the last few months. The manager advised that she was aware that some members of the pharmacy were not recording all their errors. And she thought that this was because the pharmacy was busy so there was lack of time to do this. Some of the errors recorded also lacked detail. For example, they did not record the learning points or the reason the errors had occurred. And so, they may have missed out on some learning opportunities. The manager completed an analysis of the errors that had been recorded each month. This was to identify any trends or patterns. And the findings were discussed with the team when most of the team members. Recent discussions had taken place about the similarity of inhalers, and the overcrowding of the pharmacy shelves. The manager was trying to reduce stock levels. There was a new ordering system to assist with this. The pharmacy used the Datix system to record details of dispensing incidents which had reached the patient. The pharmacy had had the same type of error twice in the last few months. People had been supplied with someone else's medicines at hand out. A root cause analysis had been done to get to the bottom of why this was happening. The manager observed members of the pharmacy team handing out completed prescriptions. And identified where the weakness in the system was. Some members of the team were asking people to confirm their address but were looking at the prescription, not the bag. And were selecting a bag next to the one required. The system was changed as a result of this. Now prescriptions were attached to the bags in the retrieval area. So now the bag label and the prescription are checked before handing out. The pharmacy detailed its complaints procedure in the pharmacy information leaflet on display. And people were signposted to the procedure if they were unhappy with the service they received. The manager

described the complaints procedure and how she would escalate the complaint if she was unable to deal with it to the persons satisfaction. The pharmacy welcomed feedback from people. And it collected the feedback from people for annual patient satisfaction survey. There was also a mystery shopper. And they had highlighted that people were not being acknowledged and welcomed when entering the pharmacy. The pharmacy team had discussed this, and they now make a conscious effort to acknowledge everyone entering the pharmacy.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team were aware of the need to keep people's personal information confidential. They had all undertaken general data protection regulation (GDPR) training. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. A privacy policy was on display for people to read in the retail area. The pharmacy team used a cordless telephone so that they could move away from areas in the pharmacy where they may be overheard. This helped to protect people's private information. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a third-party contractor. The team members had up-to-date guidance on safeguarding the welfare of vulnerable adults and children available to them. The manager had completed formal training via CPPE up to level two. The other team members had completed training via the eExpert online training system. The pharmacy had a chaperone policy on display close to the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload. The pharmacy team members complete regular training to keep their knowledge and skills up to date. And they have appraisals to discuss their performance and training needs. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise concerns when necessary.

Inspector's evidence

At the time of the inspection there was the responsible pharmacist (RP) who was the manager, one technician, two pharmacy assistants and one trainee. The pharmacy manager organised the team rotas in advance to ensure enough support was available during the pharmacy's busiest times. They were seen managing the workload well during the inspection. Team members worked authorised overtime to cover absences and holidays. The pharmacy was able to ask for some relief support. The superintendent had introduced a procedure to allow pharmacy team members to contact the SI directly if an area manager was not responding to a request for support when the branch was struggling.

The team members were able to access the online training system, eExpert, to help them keep their knowledge and skills up to date. They received training modules to complete, usually monthly. Many of the modules were mandatory. The team members were also able to voluntarily choose a module if they felt the need to learn about a specific healthcare related topic, or needed help carrying out a certain process. The team members did not receive set time during the day to allow them to complete the modules. Pharmacy team members completed some training when the pharmacy was quiet, but this was rare and so some training was done in their own time. Team members had been given an additional 2.5 hours pay to complete eExpert training for the new analyst system. Each team member had completed all of the modules that were mandatory. The manager had monitored the team to ensure all were up to date with their training. The pharmacy had an annual appraisal process. The appraisals were an opportunity for the team members to discuss their roles and any areas they wanted to improve in.

The team had informal meetings and discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. The team members felt comfortable to give feedback or raise concerns with the manager, to help improve the pharmacy's services. For example, a team member had suggested not sending delivery prescriptions to the hub because it was causing too much confusion in the pharmacy and for the patient. This was working well. There was a whistleblowing policy, and the team were aware of it. The team was set various targets to achieve. These included the number of prescription items they dispensed and the number of services they provided. The team members were currently meeting the targets. The manager thought they achieved these by working together as a team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean, tidy and professional in appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was generally tidy and well organised during the inspection. Floor spaces were kept clear to minimise the risk of trips and falls. There was a clean sink in the dispensary with hot and cold running water. There was a small , but adequately sized soundproofed consultation room accessed from the retail area. The room was smart and professional in appearance and was signposted by a sign on the door. The room was kept locked when not in use, and the team did not leave people in the room unattended. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. The services are generally well managed. It stores, sources and manages its medicines safely. And it identifies and manages most risks adequately. The pharmacy gets its medicines from reputable suppliers. It responds appropriately to drug alerts and product recalls. And it makes sure that its medicines and devices are safe to use. The pharmacy may not always give advice to people who get higher-risk medicines. And when they do they don't always record it. So, it may not be able to refer to this information in the future if it needs to.

Inspector's evidence

The pharmacy had access from the street into the pharmacy through an automatic entrance door. And so, people with wheelchairs could enter the pharmacy. The pharmacy could supply people with large print dispensing labels if needed. There was a hearing loop to help people with a hearing impairment in the consultation room. The pharmacy advertised its services and opening hours on the door, and on the pharmacy's website. There were several healthcare related leaflets available for people to select and take away with them. The team members regularly used various stickers as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. Baskets were available to hold prescriptions and medicines. This helped the team stop people's prescriptions from getting mixed up. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. And so, there was an audit trail that could be used to solve any queries.

The pharmacy had recently introduced a new system for dispensing many of the prescriptions it received, at the company's offsite dispensing hub. The system was designed to reduce the team's dispensing workload and allow the team members more time to offer services such as medicine use reviews. Team members had received comprehensive training before the process went live. The team firstly assessed whether a prescription was suitable to be dispensed at the hub. Any prescriptions that were for CDs or fridge items were not sent. The team also avoided sending prescriptions for more urgent items such as antibiotics. Once it was established that a prescription was suitable to be sent to the hub, the data was entered. And then the pharmacist completed an accuracy and clinical check. The details of the prescription were then sent electronically to the hub. It took around two days for prescriptions to be processed and the medicines to be received from the hub. The team marked all prescriptions that were sent to the hub and stored them in a separate box to prevent them being mixed up with other prescriptions. The pharmacy received the medicines that had been dispensed at the hub in sealed bags. The bags were then coupled with the relevant prescription. And then scanned on the shelves in the prescription retrieval area, ready for collection. The pharmacy had completed a quality assurance audit of the first 300 prescriptions that were dispensed and returned to the pharmacy via the

hub. The pharmacy was currently sending about 30% of their prescriptions to the hub. The team thought that the procedure was not currently saving any time. But it was envisaged that the procedure would eventually save time when the process was embedded.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used “therapy” stickers attached to people’s medication bags to remind them that the bag contained a high-risk medicine. The team member handing out the medication asked to see the yellow book with the INR results and dose of warfarin. The team did not routinely record the details of conversations with people. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. Two eligible patients were identified. Both were on the prevention programme. And had received advice which was recorded on their records.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The medicines in the dispensary were generally stored tidily. Some shelves were overstocked. Team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a random check of several items in two areas in the pharmacy. And the team members used alert stickers to help identify medicines that were expiring within the next 12 months. For example, Rosuvastatin 20mg was marked as out of date in February 2020. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. For example, morphine liquid was marked as opened on 4 October 2019.The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The team were not currently scanning products as required under the Falsified Medicines Directive (FMD). But they were undertaking manual checks of tamper evident seals on packs. The team had received training on how to follow the directive. They did not have working scanners in place. The team was unsure of when they were to start following the directive. The pharmacy obtained medicines from reputable sources such as AAH, alliance and NDC. And invoices were retained. Drug alerts were received via the company Merlin system. These are actioned and recorded on the Merlin system. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the electronic medicine's compendium. They could also access the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. The team members used tweezers to help dispense multi-compartmental compliance packs. Both Labcold fridges used to store medicines were of an appropriate size. And the medicines inside were organised in an orderly manner. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private. The electrical equipment looked to be in good working order.

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.