General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Allendale Pharmacy, 3 Shield Street, Allendale, HEXHAM, Northumberland, NE47 9BP

Pharmacy reference: 1035856

Type of pharmacy: Community

Date of inspection: 02/09/2024

Pharmacy context

This is a pharmacy in the village of Allendale in Hexham. Its main activity is dispensing NHS prescriptions. It provides some people with their medicines in multi-compartment compliance packs to help them take their medicine safely and effectively. It provides a range of services including NHS Pharmacy First. And it offers a delivery service, taking medicines to people in their 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's written procedures help team members to manage risk and provide services safely and effectively. Team members record mistakes made during the dispensing process to help learn from them and they take steps to help prevent the same mistake from happening again. They keep the records required by law and mostly complete these correctly. They keep people's private information secure. And they suitably respond to concerns for the welfare for vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. They included SOPs about the responsible pharmacist (RP), controlled drug (CD) management and dispensing activities. A sample of SOPs seen showed they had been reviewed by the superintendent (SI) pharmacist in May 2022. And the SI had begun the process of reviewing the SOPs at the time of the inspection. Team members had signed to say they understood and would comply with the SOPs. The SOP for the delivery service did not allow for team members to deliver people's medicines through their letterbox, but the pharmacy was doing this on occasion if necessary. The SI intended to review the SOP to reflect the pharmacy's practice.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. The person who made the mistake recorded the details about it when it was identified. The pharmacist reviewed the near miss data to identify what the most common mistakes were. And they discussed with team members actions that could be taken to help prevent the same mistake from occurring. For example, candesartan and doxazosin were separated from each other on the shelves to help prevent future medicine selection errors. Team members did not routinely capture learning points on the near miss log which may mean that opportunities to learn from the mistake may be missed. The pharmacy had a process for recording mistakes that were not identified until after person had received their medicines, known as dispensing errors. The pharmacy had not had any dispensing errors since the SI had taken ownership two years previously. The pharmacy had a separate record book for recording dispensing errors in. And the SI had a blank copy of an NHS community pharmacy medication safety incident report form, which could also be completed electronically. The pharmacy had a complaints policy which involved initially attempting to resolve complaints informally. The SI worked in the pharmacy as one of the resident pharmacists, so was frequently available to resolve any complaints or concerns. The pharmacy received feedback online on social media, and this was seen to be positive. The pharmacy had recently received positive feedback after installing a defibrillator outside the pharmacy for people to use in an emergency.

The pharmacy had current professional indemnity insurance. Team members were aware of the tasks that could and could not be completed in the absence of the RP. The RP notice was prominently displayed in the retail area and reflected the correct details of the RP on duty. The RP record was completed correctly. The pharmacy recorded the receipt and supply of its CDs on paper. A sample of records seen showed they were mostly completed correctly, with the address of the suppling wholesaler not captured. Team members had last checked the physical stock levels of medicines matched those in the CD register in August 2024, June 2024 and January 2024. The RP completed stock checks when a CD record was made when receiving or supplying CDs. The pharmacy recorded details of CD medicines returned by people who longer needed them at the point of receipt. And they were destroyed by the SI and another team member witnessed the destruction. The pharmacy kept

certificates of conformity for unlicensed medicines known as “specials” and details of who the medicines were supplied to, which provided an audit trail. It kept electronic records for the supply of medicines against private prescriptions and kept associated prescriptions.

Team members were aware of their responsibility to keep people’s private information secure. The pharmacy separated confidential waste which was shredded on site. Team members were also aware of their responsibility to safeguard vulnerable adults and children. They knew to refer any concerns to the pharmacist in the first instance who would refer to the person’s GP or local safeguarding contacts. The driver was also aware of their responsibility to refer any concern they had about people they were delivering to back to the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough competent team members to help manage the workload and provide services safely. Those in training are appropriately supervised by the pharmacists to ensure they are supported in their training. Team members generally respond to requests for the sales of medicines well to support people with their healthcare needs.

Inspector's evidence

The RP at the time of the inspection was one of the resident pharmacists and the SI. They worked part-time in the pharmacy alongside another resident pharmacist and between them they covered the pharmacy's opening hours. The SI was supported by two trainee dispensers and a pharmacy services apprentice. And a trained dispenser arrived to begin their shift during the inspection. Team members who were not present during the inspection included a trainee dispenser and two delivery drivers. The trainee dispensers were in the process of completing accredited training for their roles, either through a training provider or through an apprenticeship. The SI acted as tutor for the trainee dispensers, and they had frequent discussions about their progress or if they needed help with their learning. The trainee's received protected learning time to help progress through their courses in a timely manner, and they were able to complete additional training at home if needed. The SI completed performance reviews with team members every three to six months. The SI had completed face to face training to be able to deliver the NHS Pharmacy First service.

Team members were observed to work well together and were managing the workload. They felt comfortable to raise professional concerns with the SI or the other resident pharmacist if necessary. Annual leave was planned in advance where possible and part-time team members could increase their hours to support periods of absence. The SI planned rotas in advance so that people knew when they were working. And the two pharmacists covered each other's absences.

Team members asked people questions in line with their experience when selling medicines over the counter to ensure they were receiving appropriate care, and some asked more thorough questions than others. Team members referred to the pharmacist or other more experienced team members for assistance if they were unsure. They knew to be vigilant for repeated requests for medicines liable for misuse, for example codeine containing medicines. They referred any such requests to the pharmacists who would have supportive conversations with the person.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services it provides. It has appropriate facilities for people requiring privacy when accessing services.

Inspector's evidence

The pharmacy was comprised of a spacious front retail area and dispensary behind this. The medicines counter acted as a barrier to prevent unauthorised access to the dispensary. To the rear of the dispensary was a corridor which led to secure external doors. The pharmacy's dispensary was small but there was sufficient space for team members to move about freely. And there were different bench spaces for the completion of different tasks, including dispensing routine prescriptions and multi-compartment compliance packs. The pharmacist's checking bench was situated centrally so they were able to supervise the dispensary. There was a small connecting space between the medicines counter and dispensary, and although team members were unable to see people being served at the counter, they were still able to hear conversations. The dispensary had a sink with hot and cold water. And toilet facilities were clean and had separate hand washing facilities. Lighting provided good visibility throughout and the temperature was comfortable.

The pharmacy had a lockable consultation room where people could have private conversations with team members or access services from the pharmacist. The room had a desk, chairs and a computer for consultations to be complete comfortably. It had a sink although it was not in use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services appropriately. Team members complete checks on medicines to ensure they remain fit for supply. They provide people with the relevant information to take their medicines safely. They have a suitable process for responding to alerts about the safety of medicines.

Inspector's evidence

The pharmacy had level access from the street to help provide ease of access to those using wheelchairs or with prams. Team members provided people with visual difficulties with large print labels, and they sign posted people to other pharmacies for services they did not offer. The pharmacy displayed its opening hours and services in the front windows. And it had various healthcare leaflets for people to read or take away.

Team members used baskets to keep people's prescriptions and medicines together and reduce the risk of them becoming mixed up. They used stickers to highlight the inclusion of a fridge item or CD in a prescription and used "speak to pharmacist" stickers to highlight that the pharmacist wanted to speak to someone when they collected their prescription. Team members signed dispensing labels so there was an audit trail of who had dispensed and who had checked the medicines. Team members were aware of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate and the recent update about dispensing valproate in the manufacturer's original pack. Team members asked appropriate questions when handing out medicines to people to ensure they were given to the correct person.

The pharmacy provided the NHS Pharmacy First service. The service was underpinned by patient group directions and the pharmacist had a flow chart provided by the local pharmaceutical committee which helped with the pharmacist's decision making about treatment. And it included inclusion and exclusion criteria for the pharmacist to assess a person's suitability to be treated under the service. The pharmacy provided a service whereby some people collected their medicines weekly to support them with substance misuse. The medicines were prepared in advance of them being required by people. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. The pharmacy ordered the prescriptions ahead of them being required so that any queries about a person's medication could be resolved before they were required. Each person had a medication record sheet which detailed the medicines and administration times. Team members ensured that medicines selected for a person's compliance pack were checked by another team member before the packs were dispensed. They recorded changes to a person's medication received from the GP so there was a record of the change. Prescriptions for CDs were sent by the GP surgery weekly. Team members prepared other medicines in the pack and added the CDs weekly once the prescriptions were received. They provided people with descriptions of the medicines in the packs and provided patient information leaflets, so people had all the information about their medicines. The pharmacy provided a delivery service to people in their homes. The drivers used a sheet with people's labels on as a record of the deliveries to be made. And they ticked the sheet once a delivery was complete. The drivers prioritised fridge items when delivering to people. The drivers generally returned medicines that were unable to be delivered back to the pharmacy. Due to the rural nature of the pharmacy, a very small number of people had an arrangement for their deliveries to be

left in special location, such as a parcel box. Fridge items or CDs were never left in this way.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were stored behind the medicines counter which ensured the sales of these medicines were supervised by the pharmacist. Team members completed checks on the expiry date of medicines every two months and records showed this was up to date. Medicines that were expiring in the next six months were highlighted for use first. Team members kept a list of the medicines that were expiring. A random selection of ten medicines found none past their expiry date. Team members checked the expiry date of medicines when putting the stock order to shelf and when dispensing and checking medicines. The pharmacy had a fridge for medicines requiring cold storage. Team members recorded the temperatures daily and records showed it was operating between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls via email. They had a process for responding to the notifications which was to print, action and retain the alerts if they had any affected stock. The SI confirmed they had no alerts which had affected the pharmacy's stock in the past two years and as such had no actioned alerts to provide during the inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to electronic versions of the British National Formulary (BNF), British National Formulary for children (BNFc) and National Institute for Health and Care excellence guidelines. It had equipment used in the provision of the NHS Pharmacy First service including otoscopes, tongue depressors, a thermometer and blood pressure monitor. It had crown stamped measuring cylinders which were marked to identify which were for water and which were for liquid medicines.

The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines awaiting collection in the dispensary so that people's private information was secured. Confidential information was secured on computers using passwords. And they were positioned in a way that meant only authorised people could see the information on the screens.

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.