General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newhall Pharmacy, High Street, Newhall, Swadlincote, BURTON-ON-TRENT, Staffordshire, DE11 0HU

Pharmacy reference: 1036884

Type of pharmacy: Community

Date of inspection: 26/06/2024

Pharmacy context

This pharmacy is located in a residential area of Swadlincote, Burton-On-Trent. It dispenses prescriptions and sells medicines over the counter. The pharmacy provides a range of NHS services including the Pharmacy First Service, New Medicine Service, COVID-19 vaccination service and a supervised consumption service. It also supplies medicines in multi-compartment compliance packs to help people take their medicines correctly. And it offers a medicine delivery service 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 largely identifies and manages the risks associated with the services that it provides to help make sure they are safe and effective. Its team members discuss mistakes when they happen, but they do not always make a record so they may miss opportunities to identify common mistakes or trends. The pharmacy keeps the records that it needs to be law. And its team members take the correct steps to protect people's private information and keep vulnerable people safe.

Inspector's evidence

There was a set of electronic standard operating procedures which had last been reviewed in June and August 2024. Most team members had signed a training record to show they had read and accepted the SOPs. However, the delivery driver has not signed any of the procedures relating to their role. The responsible pharmacist (RP) explained that this was an oversight, and he would ask the driver to read and sign them. The SOPs did not detail who was responsible for each part of the process, this meant team members may not be fully aware of their responsibilities when completing tasks to help make sure they are done effectively. The RP provided an assurance that the SOPs would be updated to include the roles and responsibilities of team members. A current indemnity insurance certificate was available.

Mistakes that were identified during the final accuracy check, known as near misses, were usually recorded on an electronic near miss log. But the team members didn't always complete the log, and some near misses had not been recorded. The RP explained that mistakes were discussed with the team when they occurred, and action was taken to try and reduce similar mistakes from happening. For example, separators were used to help distinguish between different strength medicines containing the same active ingredient as this was a common mistake. Another example provided was the physical separation of ramipril tablets and capsules to help reduce the chance of the incorrect formulation being selected. There were no recent examples of mistakes that has been identified after a person has received their medicine, also known as a dispensing error. The RP explained they would record the mistake on an error form and investigate it so that team members could learn from the event. A written complaints procedure was available, but it was not on display to people using the pharmacy so they may not always know the correct way to raise a complaint or provide feedback.

The RP notice was on display and the RP log was completed in line with the requirements. Team members explained the activities that could and could not be completed in the absence of an RP. Controlled drugs (CD) registers were kept and maintained electronically and running balances were recorded. The RP explained that the balances were checked each month, but this was not evident from the record. Two running balances were checked against the physical stock held and matched. Private prescriptions records were held on the patient medication record (PMR), but the prescriber details were often missing or incorrect on the entries seen. So it may make it harder for the pharmacy to respond to any queries after the medicine had been supplied to the person. Records for the supply of unlicensed medicines were maintained and complied with the requirements.

Members of the team signed a confidentiality agreement when commencing their employment and a written procedure was in place to detail how private information should be protected. When questioned, team members were able to explain the steps they took to maintain patient confidentiality.

This included promptly moving confidential information from the retail area into the dispensary and shredding confidential waste. A SOP about safeguarding was available and the RP had completed level three training. Some team members had also completed training on safeguarding vulnerable people. They were aware of the steps to take if a concern was raised and the contact details for the local safeguarding leads was accessible.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. And its team members are comfortable about providing feedback to the pharmacist and senior management team. The pharmacy provides support to members of the team who are enrolled onto a training course to help make sure they develop the skills and knowledge they require for their role.

Inspector's evidence

The pharmacy team consisted of a regular pharmacist, who was also the manager, one pharmacy technician, one trainee pharmacy technician, one trainee dispensing assistant, one medicines counter assistant and one delivery driver. There were also two locum dispensers who were supporting the team on a regular basis. All team members were either qualified for their role or were enrolled on to an accredited training programme. When questioned, those undergoing training felt well supported by the regular pharmacist and the rest of the team. Members of the team completed ongoing training and the topics were usually in line with the NHS Pharmacy Quality Scheme.

Members of the team were aware of their roles to help manage the workload safely and effectively. The pharmacy team were seen working well together and they supported each other as people entered the pharmacy during busy periods. The medicines counter assistant explained the questions they would ask when selling pharmacy medicines. And they identified medicines that are liable to abuse. In such cases, they would refer to the pharmacist if they felt the sale was inappropriate or if repeated requests were made.

The pharmacy completed annual appraisals with its team members to discuss how they had performed over the year and to help identify any future training needs. Members of the team also felt comfortable raising concerns or providing feedback to the pharmacy manager. Team meetings were held informally as and when needed. Some targets were in place, but the RP explained that they did not feel pressurised to achieve these and they are able to use their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy and is a suitable place to provide healthcare services safely. It has a consultation room so that people can have a conversation in private with a member of the team.

Inspector's evidence

The pharmacy was clean and tidy. The dispensary was large enough for workload undertaken and cleaning was done on a daily basis. Work benches were clean and tidy which helped to make sure prescriptions were assembled safely. A clean sink was available to prepare medicines that required mixing before being supplied to people. The lighting and temperature of the pharmacy were adequately controlled and maintained.

Team facilities included a microwave, kettle and fridge, WC with wash hand basin and antibacterial hand wash. A consultation room was available for people to have a private conversation or receive a pharmacy service. It was clean and tidy which helped maintain a professional appearance. It was large enough for the services that the pharmacy offered.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people and are provided in a safe and effective manner. It sources and stores medicines appropriately and carries out checks to help make sure that they are kept in good condition and safe to supply to people.

Inspector's evidence

The pharmacy had step free access with automatic doors leading into the retail area which was clean, tidy and clutter free. The opening hours of the pharmacy was displayed on the entrance door. Two temporary structures had been created during the pandemic so that people could receive COVID-19 vaccinations. They were situated next to the consultation room and were clearly signposted.

The pharmacy provided a range of NHS services including seasonal flu and COVID-19 vaccinations, New Medicine Service, Discharge Medicines Service and the Pharmacy First service. Signed copies the patient group directions (PGDs) were available, and the team had printed out the protocols for each condition that was being treated under the Pharmacy First service for reference. The RP had completed suitable training to provide the service. A medicine delivery service was offered to people that could not access the pharmacy. Deliveries were completed by a single driver, and they kept a record of completed deliveries. A note was left if people were not available to accept a medicine delivery.

The main workload was dispensing NHS prescriptions. Prescriptions were placed into baskets to prevent them getting mixed up. Team members initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels to help identify who was involved in both processes if a query arose. Medicines were accuracy checked by the pharmacist. Medicines that required special storage conditions, such as fridge items or CDs, were highlighted on prescription bags using stickers. The pharmacist also attached stickers to medicine bags if they needed to provide additional advice to people. This served as a reminder to team members. The use of CD stickers also prompted members of team to check the prescription validity at the time of supply. Prescriptions for higher-risk medicines were marked and the pharmacist provided additional counselling advice to people when they presented to collect their medicines. This was to help make sure the medicine was safe and used as intended by the prescriber. Education materials were provided to people taking valproate containing medicine to highlight the risks. And the pharmacist was aware of the requirement to supply people with original packs so that the warning card and patient information leaflet was supplied each time.

The pharmacy supplied some medicines in multi-compartment compliance packs to people. An electronic record was maintained for each person receiving a compliance pack which detailed the medicines they were routinely supplied with. This allowed team members to identify any discrepancies when new prescriptions were issued. Any changes to medicines were confirmed with the person's doctor and a record was made on the patient medication record (PMR) to create an audit trail. Patient information leaflets were supplied with the compliance packs so that people could access additional information about their medicines. But the descriptions of the medicines were not included so people may find it hard to identify their medicines in the event of a query. The risk of this was discussed and the RP provided an assurance that it would be rectified.

The pharmacy obtained its medicines from licensed sources, and it stored them securely to prevent

unauthorised access. Its team members checked the expiry dates of medicines regularly but did not make a record. This may make it harder to identify which areas of the pharmacy had been checked and by who in the event of an issue or query. Medicines that were short dated were highlighted with a red sticker and a record was made in a book under the month it was due to expire, so that team members could remove these from the shelf. Obsolete stock was separated to help reduce the risk of unsafe medicines being supplied to people. Medicines with special storage requirements were stored appropriately. CDs were stored across two cabinets with date-expired stock and patient returns clearly marked and separated. Medicines that required cold storage conditions were stored in two fridges. The fridge temperate of both fridges was seen to be in range and the pharmacy kept a daily record of the temperatures. The pharmacy received alerts regarding defect medicines by email. An electronic record of the alerts was retained, and the action taken was recorded.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely and maintains them appropriately. It is uses them in a way to help protect privacy.

Inspector's evidence

The pharmacy team used the internet to access websites for up-to-date information, for example, the BNF. Any problems with equipment were reported to the senior management team. All electrical equipment appeared to be in working order.

There was a selection of clean liquid measures with British Standard and Crown marks. The pharmacy had clean equipment for counting loose tablets and capsules, including tablet triangles. Suitable equipment was available to use when the pharmacist provided the NHS Pharmacy First service. And the RP was aware of the calibration requirements.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. Cordless telephones were available and were used to hold private conversations with people when needed.

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.