

Registered pharmacy inspection report

Pharmacy Name: Bensham Pharmacy, 181 Coatsworth Road,
GATESHEAD, Tyne and Wear, NE8 1SQ

Pharmacy reference: 1037453

Type of pharmacy: Community

Date of inspection: 20/07/2023

Pharmacy context

This pharmacy is in a suburb of Gateshead. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies several people with their medicines in multi-compartment compliance packs to help them take their medicines properly. And it delivers medicines to many people's homes. The pharmacy offers other NHS services including the NHS Community Pharmacist Consultation Service (CPCS) and a smoking cessation service. It also provides a private ear wax removal service.

Overall inspection outcome

✓ **Standards met**

Required Action: None

Follow this link to [find out what the inspections possible outcomes mean](#)

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 suitably identifies and manages the risks associated with all its services. It has up-to-date written procedures that the pharmacy team follows. It completes the records it needs to by law and it protects people's private information properly. The pharmacy encourages people to provide feedback on its services and team members suitably reply to comments raised by people. They respond correctly when errors occur and they take appropriate action to prevent future mistakes.

Inspector's evidence

To support the safe and effective delivery of its services the pharmacy had a range of up-to-date standard operating procedures (SOPs). The SOPs included one for the electronic patient medication record (PMR) system, which used bar code scanning technology and supported the accuracy check of dispensed medication. Team members had read the SOPs and signed the signature sheets to show they understood and would follow the SOPs. They demonstrated a clear understanding of their roles and worked within the scope of their role.

The Superintendent Pharmacist (SI) regularly monitored the team's compliance with the SOPs. For example, the SOP covering the use of the PMR system required the team to scan the barcode on one pack at a time to generate a label. The labelling and dispensing of this pack were completed before the next pack was selected and the barcode scanned. The SI regularly observed team members dispensing prescriptions with several items prescribed to ensure they followed this procedure. A dedicated SOP was in place for the private ear wax removing service. The SI had completed governance checks on the company providing the equipment for the service. And they had used these checks along with the training provided by the company to assess the risks of providing the service. However, a full risk assessment linked to the pharmacy's role in providing the service had not been documented.

Team members followed the SOPs when alerted to errors they made when dispensing prescriptions, known as near misses. After being asked to identify and correct their errors the team member recorded their error. The details captured enabled the SI, when completing a monthly review of the records, to identify trends. The SI shared the outcome of the review with team members who discussed the actions to take to prevent errors from reoccurring. A recent review highlighted to the team the importance of double checking with a colleague the controlled drugs they'd dispensed. A procedure was in place for managing errors that were identified after the person received their medicines, known as dispensing incidents. This included recording the dispensing incident and making all team members aware of the incident. The SI reported the use of bar code technology in the PMR had significantly reduced the number of picking errors.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. The team monitored a social media platform for feedback and responded to comments left on the platform. People were also provided with a QR code to take them directly to the platform.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers generally met legal requirements. Appropriate records were kept of CDs returned by people for destruction. However, the pharmacy used an electronic word document as the RP record, but it was not protected so entries could

be amended or removed. The log was printed off once completed. Team members had completed training about the General Data Protection Regulation (GDPR) and they separated confidential waste for shredding offsite. Information on how the pharmacy protected people's private information was displayed in the retail area for people to read and take away.

Team members had received safeguarding training relevant to their role and understood their responsibilities to protect children and vulnerable adults. They were aware of the Ask for ANI (action needed immediately) initiative but had not had an occasion when a person presented at the pharmacy asking about it. This was an initiative to support people experiencing domestic abuse that required access to a safe space. A poster in the window clearly showed the pharmacy's participation. The delivery driver reported concerns back to the team who took appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they are good at supporting each other in their day-to-day work. They discuss ideas to enhance the safe delivery of the pharmacy's services. Team members have opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

The SI worked full-time at the pharmacy with locum pharmacist support when required. And they were assisted by a full-time accuracy checking technician (ACT). Other team members included two full-time dispensers, one who had qualified as a pharmacist in Spain and was waiting to start the GPhC Overseas Pharmacists' Assessment Programme (OSPAP). Another full-time dispenser mostly worked in the role of medicines counter assistant (MCA). A delivery driver who had been in post several years worked with the team along with a full-time team member who provided administration support. At the time of the inspection all team members except one of the dispensers were on duty.

Team members worked very well together and supported each other. They each had specific roles such as the dispensing of medicines in multi-compartment compliance packs. However, all team members were trained on how to undertake key tasks. This ensured the tasks were completed especially at times when team numbers were reduced such as planned and unplanned absence.

The SI had completed training provided by the company that supplied the equipment for the ear wax removal service. This included a trainer from the company attending the pharmacy to observe the SI use the equipment. The MCA supported the smoking cessation service and undertook annual training which included advice to give to people about the use of e-cigarettes. Additional training for team members to keep their knowledge up to date was centred around that required for the NHS Pharmacy Quality Scheme such as infection prevention and control. Team members received informal feedback on their performance and could discuss opportunities to further develop their knowledge and skills. The SI had asked the ACT if they would train to be a vaccinator to support the seasonal flu vaccination service.

The SI used a notice board to highlight areas where team members performed well. And areas they needed to focus on to improve the safe delivery of the pharmacy's services. Team meetings were regularly held and team members were encouraged to give feedback and suggest new ways of working. They recently discussed the safest way to store and mark partially used packs of medicines to help prevent incorrect quantities from being supplied.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services it provides. It has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy premises were kept tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, with hot and cold water available along with hand sanitising gel. Heating and lighting were kept to an acceptable level in the dispensary and retail areas. In response to the COVID-19 pandemic the pharmacy had installed a clear plastic screen on the pharmacy counter.

The dispensary provided sufficient bench space for the team members to work from. They kept the floor spaces clear to reduce the risk of trip hazards. There was a defined professional area and items for sale in this area were healthcare related. The pharmacy had a well-equipped, soundproof consultation room that the team used for private conversations with people and when providing some of the pharmacy's services. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy actively promotes the services it provides to help people meet their healthcare needs. Team members manage the pharmacy services well to help make sure people receive medicines when they need them. And they use technology to support them to deliver the pharmacy services safely and effectively. Team members store medicines properly and they complete regular checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

Access to the pharmacy was via a small step with handrails located either side of the door. There were healthcare information leaflets for people to read and to take away. And team members provided people with information on how to access other healthcare services when required. Information on significant dates in the year for the team to be aware of was displayed, such as Easter weekend and Eid al-Fitr. Team members asked appropriate questions when selling over-the-counter (OTC) medicines and they monitored people's request for OTC medicines to ensure the supplies were suitable for the person. This sometimes involved a referral to the pharmacist who intervened in the sale to ensure the appropriate medicine was supplied. And to provide the person with advice such as making an appointment to see a GP. The team had installed a bell on the counter so the MCA could ask for support when the pharmacy became busy. The computer on the pharmacy counter had access to the PMR so when a person presented the team member could check what stage the dispensing of their prescription was at.

The smoking cessation service provided by the pharmacy was popular and had recently been audited by the local council who were pleased with the service. Team members promoted the service by placing information cards with people's prescribed medicines. They also promoted the NHS Hypertension Case Finding service and a notice next to the dispensary computer reminded them of the criteria for inviting people to attend for the service. So, they could attach a sticker to the dispensed prescription to prompt them to invite the person to attend when handing over their medication. The pharmacy supplied medicine to some people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. And they were bagged separately and stored securely.

Following comments raised by several people about accessing ear wax removal services the SI researched how to provide the service which began in May 2023. The SI had undertaken governance checks on the company providing the equipment before starting the service. And completed training provided by the company. A certificate highlighting the completion of the training was displayed in the consultation room for people to refer to. Team members had promoted the service in the local community through the distribution of information leaflets and raising awareness with organisations such as the Citizens Advice Bureau and local medical centres. The pharmacy recorded the consultation including the person's signature confirming consent to receive the service on a secure platform provided by the company. People received photographs of the inside of their ear before and after the wax was removed along with an information leaflet about the service.

The pharmacy provided multi-compartment compliance packs to help many people take their medicines. One team member managed this service but other team members had been trained to

provide support. A room to the rear of the dispensary, away from any distractions, was used for dispensing and checking the packs. To manage the workload the team started the dispensing process several days before supply to allow time to deal with issues such as the ordering of stock. Each person had a record listing their current medication and dose times which team members referred to during the dispensing and checking of the packs. The GP teams emailed the pharmacy to advise of changes to a person's medication or when a new medicine was added. They recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. So, people could identify the medicines in the packs and had information about their medicines. The ACT mostly checked the packs and stored the completed packs in boxes labelled with the person's name.

Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided. A regular review of people prescribed valproate was undertaken to identify anyone who may meet the PPP criteria. The team reported no-one prescribed valproate met the criteria. Information about other higher-risk medicines was displayed for team members to refer to.

Team members used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The bar code technology embedded within the PMR was used to complete an accuracy check of the dispensed medicines as part of the bagging process. This process was only used for complete original packs of medication. When required, the pharmacist doing the clinical check at the start of the process could amend the system to enable the accuracy check to be completed by the pharmacist or ACT. For example, when CDs were prescribed or the quantity of medication prescribed was less than the original pack. Team members had unique log-in numbers related to their role. The SI's log-in number gave them full access to the system whilst the dispensers' log-in numbers provided less access. For example, they could not access the clinical check of the system so prescriptions were not dispensed until the pharmacist had completed their clinical check. The team members unique log-in numbers provided a record of who had been involved in each step of the process. A bag label embedded with a unique bar code was generated and scanned by the team when placing the medication in the collection area and the delivery section. This also generated a text message to the person advising them their prescription was ready to collect. Team members scanned the bar code when the prescription was handed to the person. This enabled a record to be kept detailing the date and time of supply which they could refer to when queries arose. The team also kept a separate record of the delivery of medicines to people. Fridge stickers were placed on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item.

The pharmacy obtained medication from several reputable sources and the team members followed the pharmacy's SOPs to ensure medicines were safe to supply. They regularly checked the expiry dates on medicines and kept a record of this activity. Medicines with a short expiry date were marked to prompt team members to check the medicine was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening so team members could assess if the medicines were still safe to use. Fridge temperatures were checked and recorded each day and a sample of these records found the temperatures were within the correct range. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it has appropriate systems in place to ensure its equipment is fit for purpose. The pharmacy uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And two fridges for holding medicines requiring storage at this temperature. The fridges had glass doors that enabled the team to view stock without prolong opening of the door. Technical support was provided by the company supplying the equipment for the ear wax removal service. The SI had reported issues with the equipment and after a telephone call to establish the cause of the problem a replacement was promptly sent. IT support was available for the PMR system and team members commented that any issues were promptly responded to.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The team positioned the computer on the pharmacy counter in a way to prevent disclosure of confidential information. Team members used cordless telephones to help ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other confidential information in the dispensary which had restricted public access.

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. |