General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Douglas Pharmacy, 17 Ashburton Road, Gosforth, NEWCASTLE UPON TYNE, Tyne and Wear, NE3 4XN

**Pharmacy reference:** 1037506

**Type of pharmacy:** Community

**Date of inspection:** 10/06/2024

## Pharmacy context

This is a pharmacy in Gosforth, Newcastle. Its main activities are dispensing NHS prescriptions and providing some people with their medicines in multi-compartment compliance packs. It provides NHS services such as Pharmacy First and private services including travel vaccinations.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** Improvement Action Plan

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's written procedures help guide team members to provide services safely and effectively. Team members record details of mistakes and discuss actions to take to help prevent the same mistake from occurring again. They keep the records required by law and they take appropriate steps to keep people's private information secure. They have the necessary training to know how to respond to concerns about the welfare of vulnerable people.

### Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were accessed by team members electronically. These included SOPs about the responsible pharmacist (RP), controlled drug (CD) management and handing out prescriptions to people. The SOPs had an annotation to show when they had been read by team members and were marked as "approved" on the date the team member had originally read them. A sample of SOPs seen showed that team members had read the SOPs in the last two years. Team members were asked to re-read a selection of SOPs weekly by the superintendent pharmacist (SI). But the last SI documented review of the SOPs seen was 2021.

The pharmacy recorded mistakes identified and rectified during the dispensing process, known as near misses. The RP who identified the mistake recorded the details about the mistake and discussed it with the person responsible. A sample of near miss records captured the details of who was involved in the mistake and what was dispensed in error. But learnings from the near misses were not captured which may mean that opportunities to learn from the mistake may be missed. There were several examples of alert stickers on the shelves where medicines were kept. These prompted team members to check quantities and the medicines selected when dispensing. And recently, team members had annotated some of the shelves with the names of the medicines to be stored there, but these did not always correspond to the medicines stored there. The RP and trainee pharmacist had completed a monthly safety review for May and April respectively. These highlighted actions team members were to take to help improve patient safety in the following month. The pharmacy recorded errors that were identified after the person had received their medicines, known as dispensing incidents. The RP recorded the details of the incident on the NHS website Learning from Patient Safety Incidents (LFPSE). A previous report showed that the pharmacy was to separate the different forms of a medicine from each other to prevent the mistake happening again. But these were still stored next to each other which may mean that team members had not maintained the actions put in place to prevent the error occurring again. The pharmacy had a complaints procedure which was detailed on their website. Team members asked people to email their complaint to the pharmacy's email address and it was passed to the SI for resolution.

The pharmacy had current professional indemnity insurance. Team members were aware of what activities could not take place 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 electronically and included the details of the RP on duty, but it did not always indicate what time the RP's duty ended. The pharmacy recorded the receipt and supply of its CDs. A sample of records showed that the entries met legal requirements. Team members checked the physical stock levels of medicines matched those in the CD register on a weekly basis. The pharmacy recorded the receipt of CDs returned by people who no longer needed them and the destruction of these was up to date. Team members

provided an example of a certificate of conformity for an unlicensed medicine, and it included full details of the supply which provided an audit trail. Further examples of certificates were not seen during the inspection as team members were unaware of their storage location. The pharmacy kept complete records of medicines supplied against private prescriptions and retained corresponding prescriptions.

Team members knew to keep people's private information secure and confidential information was kept in staff-only areas. And they ensured that confidential information in the dispensary was not visible for people leaving the consultation room adjacent to the dispensary. The pharmacy kept confidential waste separately for destruction by a third-party company. Team members had received safeguarding training relevant to their roles from recognised training providers. They gave examples of signs that would concern them about vulnerable adults and children, and they knew what action to take if they encountered these. The pharmacy displayed a chaperone policy at the consultation room for people accessing the pharmacy's services.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has suitably skilled team members to help manage the workload. It supports team members in training to complete their qualification training courses and to develop their skills and knowledge. Team members feel comfortable having open and honest conversations and they know how to suitably respond to repeated requests for medicines liable to misuse.

### Inspector's evidence

At the time of the inspection the RP was a locum pharmacist, who had been working in the pharmacy over a period of a few weeks. They were supported by a trainee pharmacy technician, a dispenser and a pharmacy student who was a medicines counter assistant. Other team members not working included a dispenser who was training to become a pharmacy technician, a trainee pharmacist, and two delivery drivers. One of the trainee pharmacy technicians was completing a month's training in a local hospital as part of their course. Team members completing accredited qualification training received learning time in order to progress through their course and they received regular reviews with their training provider as part of their training. Other team members were given weekly direction by the SI to review SOPs. And they were given a module related to healthcare by one of the trainee pharmacy technicians on a monthly basis, with the last training about travel health advice. The pharmacist was trained to give people covid vaccinations.

Team members were observed supporting each other to manage the workload and support each other with queries. Annual leave was planned in advance and team members from other pharmacies in the company supported periods of absence where necessary. The SI pharmacist had regular meetings with team members to discuss the pharmacy's performance and areas of focus. Team members felt able to have open and honest conversations with the SI. Team members were set targets and ensured they applied them reasonably so that people accessing the pharmacy's services benefitted from them. Performance reviews had taken place for some team members.

Team members were observed asking appropriate questions when responding to requests for over-the-counter medicines. They knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. They felt comfortable to have supportive conversations with people or referred to the pharmacist, who would assist the person by giving further help and advice.

## Principle 3 - Premises ✔ Standards met

### Summary findings

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

### Inspector's evidence

The pharmacy was comprised of a retail area to the front and small dispensary to the side. The dispensary was very small, but team members managed the space well and had sufficient space to complete tasks. Team members kept the benches generally free from clutter and there were no trip hazards. The pharmacist's checking area was situated within the main dispensary, and they were able to intervene in conversations at the medicines counter if necessary. There was a very small separate area at the rear of the pharmacy where multi-compartment compliance packs were assembled. And a room adjacent to this area provided a waiting area for those attending the vaccination clinic. A surgical curtain separated these spaces, so any activities or patient identifiable information could not be seen. The rear waiting area had a sink which provided hot and cold water. And separate toilet facilities provided hot and cold water for hand washing. The temperature was comfortable throughout and lighting provided good visibility. Team members completed cleaning activities according to a rota to ensure the work areas of the pharmacy were hygienically cleaned.

The pharmacy had a consultation room which was situated between the rear waiting area and the front dispensary. It had a desk, chairs and computer. There were two lockable doors to the consultation room which lead into the front dispensary and rear waiting area respectively. People attending the vaccination clinic entered via the pharmacy's back door and team members accompanied them to the front door after the vaccination was completed in the consultation room.

## Principle 4 - Services ✔ Standards met

### Summary findings

Overall, the pharmacy suitably manages its services. Team members respond appropriately when they receive alerts about the safety of medicines. And they complete some checks to ensure medicines are suitable to supply. But sometimes they do not identify and highlight medicines that are out of date or expiring. Team members generally provide medicines dispensed into multi-compartment compliance packs safely but some team members are unsure how to use the pharmacy systems effectively to help delivery the service effectively.

### Inspector's evidence

The pharmacy had stepped access to both the front and rear entrances to the premises. The rear entrance had a grab bar fitted to assist some people who may have difficulty with the step. The front entrance had an electronic chime fitted so team members could help people if they had difficulty accessing the pharmacy.

Team members used baskets to keep people's prescriptions and medicines together to prevent them becoming mixed up. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Team members highlighted the inclusion of a fridge line or CD and had laminated cards to attach to prescriptions for higher-risk medicines such as methotrexate and valproate. Team members were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate and knew to not cover the warning information on packs when dispensing. And they were aware of recently updated legislation to dispense valproate in original packs. Team members were observed making suitable checks when handing out medicines to people to ensure they were handed to the correct person. They gave people an owing slip which was a record of any medicine that could not be supplied.

The pharmacy provided a covid vaccination clinic. Team members worked together to deliver the service. This included offering the service to eligible people, booking appointments on the electronic record and accompanying people safely past the dispensary following their vaccination. Team members received informal training from the SI on the service. And they felt comfortable performing these tasks and speaking to people about the vaccine and their health relating to it. The RP had completed the necessary competence declarations to administer the vaccine and attended an online refresher course to help maintain their competence. Records of the service were made on an online platform, and this notified the GP that a person had received the vaccine. The pharmacy provided the service during a specified time slot so that team members could safely manage other work. The pharmacy also provided a travel vaccination service via patient group directions. This was provided by the SI, and they recorded details of the consultation and vaccines given.

The pharmacy provided some people with their medicines in multi-compartment compliance packs. The pharmacy ordered prescriptions in advance to give time to resolve any queries with the medicines. They checked the orders against the person's medication record sheet. Each person had a medication record sheet, which detailed the medicines taken and when. An example of a person's medication record sheet had many annotations and changes made on the sheet, which made it difficult to read and may increase the risk of mistakes being made. Team members confirmed these were being updated to clearer typed records. People were provided with a printed backing sheet as a record of the medicines

in the pack. A change to a person's backing sheet had been handwritten because not all team members understood the process for correctly labelling the prescription and producing the backing sheet. Similarly, a sample of completed packs seen showed that the record sheets were dated for September, which may make it confusing for people to know which pack they were to use, especially those who received four packs at a time. Team members provided patient information leaflets so people had the correct information about their medicines.

Medicines were stored on shelves, in cupboards and in drawers. These medicines were stored untidily in some parts and were mixed up with each other which may increase the risk of an incorrect selection. A selection of amber bottles containing stock were discovered on the shelves by the inspector. These bottles either had no label, or had labels attached with insufficient information as to the medicine contained. This was similar to a previous visit in which the importance of suitable storage and labelling requirements were discussed. These were removed for disposal during the inspection. The pharmacy had a system in place to check the expiry dates of its stock. Team members used a date-checking matrix which divided the pharmacy's stock into different sections which was signed by the team member completing the section. Team members knew to highlight stock that was going out of date in the coming months for use first. A random selection of medicines found examples of out-of-date medicines and medicines that were short dated but were not highlighted including some adrenaline used in the provision of vaccination services. This was removed during the inspection and the importance of checking all areas where medicines were kept was highlighted. The pharmacist confirmed they spot checked the expiry dates of medicines when completing the final accuracy check. Team members kept medicines requiring cold storage in a large fridge with a glass door. The temperature of the fridge on the day of the inspection showed it was operating between two and eight degrees Celsius.

Team members accessed drug safety alerts and manufacturers recalls via an online portal on their supplier's website which were received via email. They marked these alerts as complete on the online portal which provided an audit trail. And it allowed for the quick identification of any outstanding actions. Medicines returned by people were kept separately for uplift by a third-party company.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

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

### Inspector's evidence

The pharmacy had access to paper and electronic copies of the British National Formulary (BNF) and British National Formulary for children (BNFc). It had two blood pressure monitors and an ambulatory blood pressure monitor (ABPM) which were used in the NHS hypertension case finding service and an otoscope used in the NHS Pharmacy First service. The ABPM had been given to a person to monitor their blood pressure and team members demonstrated a good understanding of the device and provided appropriate advice to a person using it. The pharmacy kept emergency medicines so that they were available if needed after giving people vaccinations. The pharmacy had a range of crown-stamped measuring cylinders which were marked to show which were for liquid medicines and which were for water.

The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines awaiting collection in a way that prevented unauthorised access to people's private information. Confidential information was secured on computers using NHS smartcards and passwords. And computer screens were not visible to the public.

## 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. |