General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medicentre (Newcastle) Ltd, 43a St Georges Terrace, Jesmond, NEWCASTLE UPON TYNE, Tyne and Wear, NE2 2SX

Pharmacy reference: 1037546

Type of pharmacy: Community

Date of inspection: 27/01/2023

Pharmacy context

This pharmacy is in Jesmond, Newcastle. In addition to dispensing NHS and private prescriptions, the pharmacy provides a range of services including providing supplies of emergency hormonal contraception and flu vaccinations. The pharmacy is associated with a third party online private prescribing service. It dispenses private prescriptions for people who access services through the website, and it arranges delivery of medicines to their homes.

Overall inspection outcome

Standards not all met

Required Action: Statutory Enforcement

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 not all met	1.1	Standard not met	The pharmacy does not adequately identify and manage the risks associated with dispensing of prescriptions for an associated online prescribing service. It does not a have risk assessment for the service. And the team does not have procedures and prescribing policies to refer to ensure that the supply of medicines is safe.
		1.2	Standard not met	The pharmacy does not review the safety and quality of the service it provides for the associated private prescribing service. It does not have a system to identify and record mistakes associated with the dispensing for this service. And so team members do not have the opportunity to learn from any mistakes. The pharmacy does not complete audits to provide assurances that the service is safe.
		1.6	Standard not met	The pharmacy does not maintain suitable private prescription records for the prescriptions it dispenses from the online prescribing service.
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 not all met	4.2	Standard not met	The pharmacy does not have enough safeguards in place for the dispensing of prescriptions from the online prescribing service. So it cannot be sure people always receive medicines that are suitable for their health needs. It supplies medicines to people without obtaining sufficient information or making appropriate checks. And the pharmacy is not able provide assurance that the online prescribing service it works with is operating safely and responsibly.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy mostly manages the risks with providing its services. But it does not adequately identify and manage the risks associated with dispensing for the online private prescribing service that it works with. And it does not have a suitable process to identify and record mistakes associated with this service. So team members do not have the opportunity to learn from mistakes to help reduce risks of mistakes in the future. The pharmacy does not make the necessary records of dispensing for this service. Team members keep people's private information secure. And they know how to help safeguard vulnerable people in the local community.

Inspector's evidence

The pharmacy dispensed both NHS and private prescriptions. It had standard operating procedures (SOPs) for its NHS services. Team members had read and signed SOPs relevant to their roles. The pharmacy was working with an unregulated third-party prescribing service, where people accessed services through the third-party website. The superintendent (SI) had access to some operational procedures for this service, but these had not been shared with the pharmacy team members. And they had not been implemented into their ways of working. The pharmacy had not completed a risk assessment prior to commencing working with the unregulated prescribing service or since. The SI had checked that the prescribers for this service were doctors who were registered with the GMC, but had not made independent checks whether the service was registered with the Care Quality Commission (CQC) or with Health Improvement Scotland (HIS). The third party website allowed people to select a medicine before starting a consultation, which made the service appear transactional and may increase the risk of people receiving medicines that were not suitable for them. The pharmacy had not assessed the risk of working with a prescribing service working in this way. The team didn't have access to prescribing policies and clinical guidelines that the prescribers used. So, this made it more difficult to assess if the medicines were clinically suitable and safe to supply. And there was no policy for a minimum interval between repeat supplies. Information received indicated multiple Ventolin inhalers had been dispensed to people with no evidence of any interventions or checks made.

The pharmacy had a system for recording near misses and dispensing errors for the NHS services it provided. The pharmacy team demonstrated how near misses were recorded on an electronic system by scanning the QR code on the wall and entering the details. The responsible pharmacist (RP) picked up near miss errors made by team members during the dispensing process. They informed the dispenser of the error and asked them to rectify the mistake. Team members recorded their own errors electronically. The computer generated a range of useful graphs from the errors recorded and the pharmacist discussed these with the team. This procedure did not apply to the online private dispensing service, as the prescriptions were dispensed on a different system. No records of near miss errors or errors identified after people received their medicines were seen for these prescriptions and pharmacy team members weren't aware of the process to follow. The telephone number on the dispensing labels was not that of the pharmacy so any queries were directed to that number. There was no system in place for the pharmacy team to be made aware of any errors and so they were unable to mitigate future risks. The pharmacy had not completed audits relating to its dispensing for the online prescribing service to verify the safety and quality of the service being provided. For example, the pharmacy hadn't audited the supplies of multiple inhalers made to people over a short period of time or queried the

appropriateness of any of these supplies.

The correct RP notice was displayed. The pharmacy displayed a current professional indemnity insurance certificate. The SI confirmed that he had spoken to the professional indemnity insurance provider and the policy included dispensing for the online prescribing service. It had a complaints procedure and complaints about NHS services were dealt with by the SI. He reported that people were generally happy with the service they received. The SI was unsure if they had a procedure specifically for dealing with concerns raised about the online prescribing service they dispensed for and was unaware of any complaints made. In any event the SI reported that the pharmacy would direct any queries to the third-party prescribing service.

The pharmacy had a procedure for recording private prescriptions supplied to people on the pharmacy's Patient Medication Record (PMR) system, but it did not follow the same procedure for recording prescriptions received from the online prescribing service. There were some records of what had been labelled and supplied on the system owned by the online prescribing service, but this was not a complete private prescription record. And these records were held separate from the pharmacy's private prescription records. The prescriptions for this service, were stored in totes in the basement and were in no kind of order and without reference numbers. So, if there was a query about a prescription it would not have been possible to retrieve it in a timely manner.

A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. Pharmacy records demonstrated that CD balances were audited regularly. A balance check of three CDs in the CD cabinet matched with the balances in the register. The team recorded CDs returned by people for destruction. A sample of records for the receipt and supply of unlicensed products demonstrated that the team kept certificates of conformity with people's details included. The SI advised that team members had completed General Data Protection Regulations (GDPR) training and retained training records for team members in the GDPR training folder, which couldn't be located on the day. The pharmacy team separated confidential waste before shredding.

The pharmacy had safeguarding procedures and guidance for the team to follow. The RP had electronic access to local safeguarding contact details. And described an occasion when they had acted when a serious safeguarding concern had been raised. The pharmacy didn't have a separate policy for recognising or dealing with safeguarding issues relating people dispensed medicines through the on-line service.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough team members to manage the current workload and the services that it provides. Team members mostly receive the appropriate training for the roles in which they are working.

Inspector's evidence

The SI covered most of the pharmacy opening hours with the help of a second pharmacist two days a week. On the day of the inspection a pharmacist, three dispensary assistants, one trainee dispensary assistant, two counter assistants and two trainee counter assistants supported the SI. The pharmacy team were seen managing the workload on the day.

The pharmacy team members discussed tasks that needed to be completed. And they discussed any near miss errors as they occurred. The SI gave in the moment feedback. Team members found the SI approachable, and they felt comfortable sharing ideas to improve the pharmacy's services. They advised that the SI had made positive changes since the pharmacy had changed hands. These included introducing baskets to keep prescriptions together when dispensing to reduce risk of errors. The pharmacy team knew to speak to the SI if they had any concerns. Team members did some ongoing training by reading training material provided by manufacturers of medicines. The SI supported the trainees with their qualification course work. The pharmacy team hadn't completed training relating to the online prescribing service. The pharmacy had targets for services, but team members didn't feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable and provide a safe and secure environment for people to receive healthcare. And they are adequately maintained. The pharmacy has a good-sized soundproofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was in a suitable state of repair. The dispensary was small but well laid out and the team made best use of the space available. There was appropriate lighting throughout and the temperature was suitable for the storage of medicines and it had air conditioning. There was some clutter on the benches, but the pharmacy was generally tidy.

The pharmacy stocked a range of healthcare-based products and pharmacy only medicines were restricted from self-selection. There was a good-sized consultation room accessible from the retail area for people to have private and confidential discussions. The pharmacy had handwashing facilities with hot and cold running water in the dispensary, the consultation room and in the rest areas.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy delivers most of its services safely and effectively. But it doesn't have enough safeguards in place to ensure the dispensing service it provides for the online prescribing service is safe. And it doesn't have a complete audit trail for the delivery of these medicines. The pharmacy obtains its medicines from recognised sources, and it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had a step free access from the pavement. The pharmacy had removed some bollards from the front of the pharmacy to make it easier for people to access the pharmacy. There was free short stay parking available outside. The pharmacy provided a delivery service for people with NHS prescriptions. The driver had a delivery sheet, but he didn't obtain people's signatures to confirm receipt. This also applied to CDs. People using the online prescribing service accessed their medicines via a 48-hour tracked postal service. The pharmacy had a postal tracking reference number but the address on the pre-printed postage label for any queries and returns was not that of the pharmacy. This meant the pharmacy was unable to verify whether medicines it supplied always reached the patient safely. And it could not demonstrate that any returned medicines were securely handled.

People using the online prescribing service had on a few occasions telephoned the pharmacy about medication that they had received. The pharmacy referred any issues to the third-party prescribing service. The pharmacy received prescriptions from the online prescribing service via email. The team was not informed of how many prescriptions would be received each day, so this could make it difficult to plan for any unexpected increases in workload. The prescriptions were received as a PDF attachment which the pharmacy team printed out. The SI was unsure how the prescribers accessed the system and generated prescriptions, so the pharmacy hadn't sought assurance of the validity of these electronic prescriptions or whether they could be duplicated. Prescriptions were received with pre-printed postage and dispensing labels which included the drug name, the dosage instructions and the details including the registration number and a signature of the prescriber. These were printed as part of the dispensing process. A standard number of pre-printed labels were issued, regardless of the quantity of medicine being supplied, which could increase the risk of errors. The pharmacy team had access to limited information on the system, but the pharmacy team didn't refer to this when dispensing. Team members signed the pre-printed dispensing labels as an audit trail for dispensing and checking. Because the pharmacy used labels generated by the third-party prescribing service system, it bypassed details of the prescription being entered onto the pharmacy's patient medication records (PMR). This meant they had no internal record of medication supplied. The risks associated with these practices had not been identified. The pharmacy did not know if treatment details were shared with the person's NHS GP or whether people's long-term conditions were monitored. The SI was unsure of how the quality of the service was monitored and the pharmacy hadn't undertaken any monitoring of the service itself. The pharmacy had not pro-actively contacted any patients to provide additional counselling or review their use of medication and check monitoring arrangements. The pharmacy had dispensed a number of prescriptions for cyclizine, which was indicated for the prevention of nausea and vomiting but also open to abuse because of its euphoric or hallucinatory effect. The pharmacy coudn't demonstrate any checks or interventions made as part of these supplies.

For NHS services the pharmacy had separate areas for labelling, dispensing, and checking of

prescriptions. Pharmacy team members referred to prescriptions when labelling and picking medicines. They initialled each dispensing label, to provide an audit of the process and to help with learning should there be any mistakes. Assembled prescriptions were not handed out until the responsible pharmacist had checked them. Team members used baskets during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. And they used stickers to show that a prescription had a fridge line or a CD that needed to be handed out at the same time as the other medicines. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew when to refer people to the RP for appropriate counselling. The pharmacy team had access to information to provide to people receiving valproate in the dispensary.

The pharmacy obtained its pharmaceutical stock from recognised wholesalers. It stored its medicines and medical devices in an organised manner and in the original manufacturer's packaging. Team members marked containers of liquid medicines with the date they were opened. They had a date checking procedure and random sampling in four different areas in the pharmacy found no out-of-date medicine. The pharmacy had medical waste containers and CD denaturing kits available to support the team in managing pharmaceutical waste. And the pharmacy had systems in place to ensure obsolete stock and medical waste was collected regularly by a third-party contractor for destruction.
The pharmacy had two fridges to store items at the recommended temperature, where necessary. The records demonstrated that team members monitored and documented the temperature daily. And the temperatures recorded were consistently within the required range. The team members received drug alerts electronically and kept an electronic audit trail of the actions taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services and team members use the equipment in a way that protects people's privacy.

Inspector's evidence

The pharmacy had a range of up-to-date reference sources, including the BNF and the children's BNF. Internet access was available. The pharmacy used two separate computer systems which weren't linked. One for dispensing NHS prescriptions and some private prescriptions. And a stand-alone system used solely for dispensing private prescriptions provided through the third party online prescribing service. Both systems were password protected. Computer screens were not visible to the public as they were excluded from the dispensary. A range of clean, crown stamped measures were available. And the pharmacy used a separate marked counter for counting cytotoxic medicines.

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.