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: 16/10/2023

Pharmacy context

This is a pharmacy in Jesmond in Newcastle. Its main activity is dispensing NHS prescriptions. It provides some people with their medication in multi-compartment compliance packs to help them take their medicines correctly. And it provides a range of NHS services including influenza vaccinations, and advice and treatment for urinary tract infections. It also provides a delivery service.

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 has up-to-date written procedures to help ensure it delivers its services safely and effectively. And it generally keeps the records required by law. Team members record and discuss their mistakes so they can learn from them. They know how to keep people's private information secure, and they have the skills to act to protect vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) that were relevant to its practice. These included SOPs for controlled drugs (CD), responsible pharmacist (RP), dispensing and date checking. The SOPs had been reviewed by the superintendent (SI) pharmacist in July 2022 and were re-read by team members in July 2023 following inspection. Team members had signed individual training logs to indicate they had read, understood, and would follow the SOPs. This included two locum pharmacists who worked within the pharmacy.

Team members electronically recorded errors identified during the dispensing process so they could learn from them. These were known as near miss errors and the team member who made the error was responsible for recording the details of the error when it was identified by the pharmacist. Errors recorded showed the details of the error, contributing factors and action taken. Team members had highlighted shelves in the dispensary where medicines that looked-alike or sounded-alike (LASA) were kept, such as gabapentin and pregabalin, and procyclidine and prochlorperazine. This was in response to errors made to help mitigate the risk of recurrence. The pharmacy also recorded errors that were not identified until after a person had received their medication. These were recorded electronically and on paper. The last electronic record was from a dispensing incident that occurred the previous November. Team members explained that the volume of near misses and incidents was low as each team member double checked their work before passing it to the pharmacist for a final check. The pharmacist explained that he had informal discussions with team members when an error was identified and completed a monthly patient safety review which was also discussed with the team.

Team members were experienced in their roles and were able to explain the tasks they were responsible for. They understood what could and could not take place in the absence of the RP. The RP notice was prominently displayed in the retail area of the pharmacy. The pharmacy had an information leaflet that explained how people could make a complaint if required. Team members explained that complaints were usually resolved at a local level by the pharmacist.

The pharmacy had current professional indemnity insurance. A sample of the records for controlled drugs appeared to meet legal requirements. And the record showed that regular running balances were completed. A check on two randomly selected CDs matched the recorded balance. Records of private prescriptions supplied were kept electronically, of the sample checked, they were in order, and corresponding prescriptions were kept. These were annotated to show that checks on the validity of the prescriber were undertaken when dispensing. Records for the provision of unlicensed medicines captured who the medicine was supplied to so any queries could be resolved. The electronic RP record did not record the time the RP ceased to be RP at the end of the working day, and only captured this information if another pharmacist assumed the duties of RP during the day.

Team members were aware of their responsibility to ensure that people's private information was kept secure. They had been given information when they commenced employment and information was available in the staff handbook. A privacy notice was prominently displayed in the retail area for people to read. Confidential information was kept separately in the pharmacy and shredded.

The pharmacy had a safeguarding and chaperone SOP for team members to refer to. Team members were aware of the steps they were required to take if they had concern for a vulnerable person. This included referring to the pharmacist who had access to a local safeguarding application. They were able to give details of a concern that had been referred to social services, although this had not been recorded. The pharmacist was Disclosure and Barring Service (DBS) checked.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has team members with an appropriate range of skills and experience to deliver the services safely and effectively. They support each other in their training and development. And they give suitable advice to help people with their healthcare needs.

Inspector's evidence

At the time of the inspection, there was the SI pharmacist, who was the RP, two trained dispensers, one trained medicines counter assistant (MCA) and one trainee MCA on duty. The SI covered most of the pharmacy's opening hours and two regular locums worked in the pharmacy, one on Thursdays and Fridays alongside the SI and the other on Saturdays. Additionally, there was a part-time MCA, a full-time dispenser, and a part-time delivery driver not present. Team members were seen to be working well together and managing the workload. They supported each other and the experienced MCA assisted with the trainee MCA's development alongside the pharmacist who acted as his tutor.

The pharmacist had completed additional training to deliver NHS services such as emergency hormonal contraception service and influenza vaccines. Team members explained they regularly asked the pharmacist questions to help with their own development. For example, one team member explained she frequently asked questions about medicines she hadn't dispensed before, such as what they were used for and whether they were appropriate to be taken with other medicines prescribed. Team members were observed asking appropriate questions and giving advice to people when selling medicines over the counter. They knew to be vigilant to repeated requests for medicines liable to misuse and knew how to respond to these requests by referring to the pharmacist. The trainee MCA explained how he referred queries to the experienced MCA or pharmacist. Team members felt comfortable to raise any concerns if required. They did not currently receive any performance reviews or appraisals.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and adequately sized for the services it provides. It has appropriate facilities for people requiring privacy when accessing pharmacy services.

Inspector's evidence

The pharmacy was clean, tidy, and free from clutter and trip hazards. And it portrayed a professional appearance. There was a large retail space which included medicines and healthcare items associated with the pharmacy. The premises was co-located with a post office. The dispensary had sufficient space for team members to move freely around and there were separate benches where different team members completed tasks safely and effectively.

The medicines were arranged tidily on the shelves in alphabetical order, and medicines requiring cold storage were kept neatly in the fridges. The dispensary was kept clean and team members had signed a cleaning rota to confirm cleaning had been completed. There was a soundproofed room where people could have private conversations with team members. The room had a desk, chairs, and a sink with hot and cold water. There was appropriate space in the room for services to be provided safely. The dispensary was elevated above the level of the medicines counter which provided privacy for dispensing activities to take place. The pharmacist’s checking bench was situated so that he could intervene in conversations at the medicines counter if necessary. Staff toilet facilities were clean and hygienic and sinks in the rest areas and dispensary were kept clean and provided hot and cold water for hand washing. The lighting was bright throughout, and the temperature was comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages the delivery of its services well. And it has suitable procedures to ensure people receive their medicines when they need them. Team members are generally aware of their responsibilities so people receive the information they need to help them take higher-risk medicines safely. Team members carry out checks to make sure medicines are in good condition and are suitable to supply.

Inspector's evidence

The pharmacy had level access from the street which helped people with limited mobility or with pushchairs. There was a range of healthcare information leaflets for people to read and to take away and there were posters in the window advertising the pharmacy's services. The delivery service was provided four days a week. The driver used delivery sheets which were annotated if a fridge or CD item was to be included. Fridge items were kept in a cool bag whilst out on delivery. People signed for their CD deliveries in a separate CD delivery book. Routine items were not signed for. If a delivery was unsuccessful, the driver ensured the medication was not left and rearranged delivery through the pharmacy on the same day or returned it to the pharmacy.

When dispensing, team members kept people's prescriptions and medicines together in baskets to help prevent errors. This had been introduced when the current owner took over and the dispensers felt the dispensing process was more organised and led to fewer errors being made. Stickers were used to highlight higher-risk medicines to ensure people received additional counselling. And stickers highlighted when a fridge item was required to be handed out. Team members manually annotated on the bags to highlight if there was more than one bag of medicine for a person, including if the item was kept in the fridge. Dispensing labels were initialled by the person dispensing and checking the prescription to provide an audit trail.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. The service was generally managed by one dispenser, but all team members were trained to deliver the service so there was contingency of cover for absences. The service was organised so that each person had a file which contained information about the medicines taken and the times they were taken. The file also included notes of any changes to people's medication, which were communicated to the pharmacy from the surgery, and recorded on a change sheet. This was signed by the pharmacist to confirm they were aware of the changes. People received details of their medication printed on sheets that were attached to the packs, but these did not include descriptions of the medicines. This means people may struggle to identify their medicines in the pack. The pharmacist explained that people were provided with patient information leaflets (PIL) at the start of each four-week cycle. The pharmacy kept records of when packs were supplied, including when the pharmacist used their professional judgement to supply more than one pack at a time. Packs that contained CDs or medicines that may lose stability when removed from their original pack were added to the packs on the day they were due to be supplied to minimise risk.

Team members had some awareness of the requirements of the valproate pregnancy prevention programme and a record was seen on a person's PMR record that they had been given advice. However the patient had not been given counselling on each dispensing and this was discussed during the

inspection. Patient group directions (PGDs) used to provide services such as emergency hormonal contraception and the influenza vaccination service were in date and signed by the pharmacists.

The expiry dates of the pharmacy's medicines were checked every three months and records showed that checks were last completed in July. Any medicines that were going out of date in six months were highlighted for use first. A sample of medicines checked were all in date. Some medicines were stored outside of the manufacturer’s original packs in amber bottles. These were mostly annotated with the batch number and expiry dates of the medicine, but two were found with either the batch number or expiry date missing. These were removed for destruction. Team members recorded fridge temperatures daily and knew the appropriate action to take if the temperatures deviated out with the required temperatures. They explained the fridge would beep to alert them to a temperature anomaly and the fridge would be reset. Pharmacy only medicines were stored behind the medicines counter to help ensure sales were supervised. Team members segregated medicines returned by people for destruction into dedicated bins. They received alerts and recalls for medicines and medical devices via email which were actioned and added to the patient safety review for discussion. Local alerts specific to the area such as urgent communications were printed off and signed by team members to confirm they had been read.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it uses its equipment appropriately to protect people's private information.

Inspector's evidence

The pharmacy had access to both paper and electronic copies of the British National Formulary (BNF) and British National Formulary for children (BNFc) so it could access up-to-date clinical information. It had equipment for the services it provided, including a blood pressure monitor for the hypertension case finding service and sharps bins for the influenza service. It had a range of crown marked measuring cylinders used to measure liquid medicines and these were highlighted to indicate which were for water and which were for liquid medicines. Triangles used to count medicines were cleaned before and after use, and a separate triangle was marked for counting cytotoxic medicines only. The pharmacy had two fridges for medicines that were required to be stored between specific temperatures to ensure stability of the medicine and these were in working order.

The pharmacy's computer systems were secured using the NHS smart card system and each team member used their own smart card and passwords. Team members used a cordless telephone so that conversations with people could be kept private. They stored completed prescriptions in a way that ensured people in the retail area could not see people's private information. Computer screens were positioned within the dispensary which had restricted access 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.