General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newburn Pharmacy, 1 Newburn Road, Newburn, NEWCASTLE UPON TYNE, Tyne and Wear, NE15 8LX

Pharmacy reference: 1037570

Type of pharmacy: Community

Date of inspection: 07/09/2023

Pharmacy context

This is a busy community pharmacy in Newcastle. Its main activity is dispensing NHS prescriptions. And it supplies some people with medicines in multi-compartment compliance packs to help them take their medicines at the right times. It also provides NHS services such as the hypertension case finding service and advice and treatment for urinary tract infections. And it provides a delivery service for people.

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 written procedures to help team members deliver its services safely and effectively. Team members record their mistakes and discuss them so they can learn from them. They generally keep the records that are required by law. And they know to keep people's private information secure and understand how to protect vulnerable people and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) that were relevant to its practice. These included controlled drug (CD) and responsible pharmacist (RP) SOPs. The SOPs helped inform team members how to complete tasks safely and effectively and were available in paper form for easy referencing. They had been written and reviewed by two pharmacists who worked within the pharmacy. The SOPs were annotated with the date of issue and the date of review, which was within the last year. Team members had signed to confirm their understanding and compliance with them.

Team members recorded errors they identified during the dispensing process so that they could learn from them. The person who made the error was responsible for recording the details. The errors were recorded on a paper near miss log, and there were several recent examples. A pharmacist collated the information from the near miss log into a monthly patient safety review and learning points were discussed with the team at the time of the near miss occurring and at the end of the month. Some changes had been made to help prevent similar errors being repeated. This included separating medicines that looked-alike and sounded-alike (LASA). However, learning points and action to be taken were not always recorded, so some learning opportunities could be overlooked. The pharmacy also recorded errors that were not identified until after a person had received their medicine. Following an error involving medicines being handed out to the wrong person, 'check name' stickers had been introduced and were attached to bags of medicines when there were people with similar names. The superintendent pharmacist (SI) explained that they were intending to introduce automated scanning technology which they believed would reduce the risk of errors.

The pharmacy had a roles and responsibilities SOP which detailed the tasks that team members were responsible for. The RP notice was displayed in the retail area and contained the details of the pharmacist on duty. Team members knew which tasks could and could not take place in the absence of the RP. The pharmacy had a machine within the retail area where people could give instant feedback on their experience. And there was an NHS complaints poster displayed which explained how to raise a concern. Team members explained that complaints were usually resolved at a local level but could be escalated to the SI where necessary. Current professional indemnity insurance was in place.

The pharmacy kept most records electronically, except for its record of CDs which were kept on paper. CD records included all required details. Running balances were recorded and checked at the time of dispensing. CD stock checks against the running balances were also completed monthly. Methadone was checked more frequently, with records showing that balance checks had been completed three times in August. A check on two randomly selected CDs matched the recorded balance. RP records were generally in order. But there were two days within the preceding few weeks when no records had been made to show who had been working as the RP. There were also further examples when the RP had not recorded the time their responsibility had ceased. This meant the pharmacy may not always be able to

show which pharmacist had been responsible at a specific point in time. Records of unlicensed medicines supplies were appropriately maintained. And the private prescription register and corresponding prescriptions were in order.

Team members were aware of their responsibilities to ensure that people's private information was kept secure. They were required to complete annual training regarding information governance (IG) and the General Data Protection Regulation (GDPR). Confidential waste was separated and shredded. The delivery driver used a sheet with people's names and addresses and knew this had to be kept secure when making the deliveries.

Team members were aware of their responsibilities for safeguarding vulnerable adults and children. They had all completed online training, and a safeguarding SOP was in place. They were able to give examples of action they had taken when they had concern for the wellbeing of a person, which included referring to the person's GP. The pharmacy technician confirmed that the delivery driver was also aware of his responsibilities and had reported back an incident whereby a person had fallen in their house, allowing the pharmacy to arrange help and get in contact with the person's relatives. There was a chaperone policy on display in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to manage the workload and deliver its services safely and effectively. There is an open and honest culture within the team, and they feel comfortable raising concerns if they need to.

Inspector's evidence

The pharmacy had three part time pharmacists who covered the opening hours. And they acted as the RP on the days they worked. Additionally, there was a pharmacy technician who was employed as an accuracy checker (ACT), four dispensers, one of whom was employed as an accuracy checker, a medicines counter assistant (MCA), a pharmacy student, and a delivery driver. There were some team members who were trainees, and they were all completing accredited training courses. The SI confirmed that the delivery driver had read the relevant SOPs and had been DBS checked. And subsequent to the inspection, he confirmed the driver had been enrolled on a training course. Team members were observed working well together to manage the workload. Part-time team members and staff from other branches could cover absences if necessary. The trainee medicines counter assistant explained that she was able to complete some of her training during quieter periods in the pharmacy, but otherwise completed the training at home. And she was supported in her training by the pharmacists, who she regularly discussed her learning with. Team members were encouraged to develop their learning and two of them had attended face to face training at the beginning of the year to be able to support people with smoking cessation. And there was a plan in place to upskill the team to be able to take people's blood pressure as part of the hypertension case finding service.

The medicines counter assistant described the questions she asked people before selling over-the-counter medicines to make sure they were suitable. And she described the steps she would take if she had any concerns regarding people frequently requesting medicines liable to misuse, which she would refer to the pharmacist. Team members felt able to discuss their mistakes openly and felt comfortable to raise concerns. They knew who to raise concerns with and were able to speak to the SI if needed. There was a whistleblowing policy in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and generally has suitable space for the services it delivers. It has an appropriately soundproofed room where people can access services and have private conversations with team members.

Inspector's evidence

The pharmacy was well laid out but some fixtures and fittings in both the retail area and the dispensary looked old and tired. The dispensary was small and there were totes of stock waiting to be put away which reduced the floor area and made moving around the dispensary more difficult. However, once the order had been put away there was enough floor space. Medicines were generally stored in long drawers within the dispensary, which when extended, also reduced the space. This made it more difficult for team members to move around the dispensary when the drawers were being used. There was a larger bench space where different team members were able to complete different tasks and which team members kept clean and tidy. The dispensary was screened from view of those in the retail area so that tasks could be completed without distraction.

There was an area adjacent to the dispensary where excess stock and medicines awaiting delivery were kept. And there was a separate stock room to the rear of the premises where retail stock and some medicines were kept. There were three or four small steps within this room which led to a storage area. A cabinet was situated the top of these stairs and there was a risk of stepping backwards while opening the cabinet door and falling down the steps. A team member explained that most people were aware of the steps and there was a warning sign on the cabinet alerting people to the steps behind them. She also confirmed they had considered moving the cabinet but there was nowhere else for it to be housed.

The pharmacy had a consultation room where people could access services or have private conversations with team members. There were sinks in the dispensary, staff room and toilet which provided hot and cold water for handwashing. 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. It stores its medicines appropriately and carries out checks to make sure they are kept in good condition and are suitable to supply. It has suitable procedures in place to prepare multi-compartment compliance packs. But sometimes this service can run behind, which may put the team under pressure when dispensing. The team identifies higher-risk medicines it supplies to people and gives advice to help make sure they are being used safely.

Inspector's evidence

The pharmacy entrance had level access which was suitable for people with limited mobility or pushchairs. The pharmacy delivered some people's medicines to their homes. People's names and addresses were put on a sheet which the driver used to manage the deliveries. And he signed the sheet to confirm he had made the delivery. Team members highlighted on the sheet the inclusion of a fridge line or CD. The driver prioritised the delivery of fridge lines to minimise the time they spent outside cold storage.

The pharmacy had patient group directions (PGDs) for some of the services it provided. These were not well organised and some of the PGDs were either out of date, or in date but not signed by pharmacists to confirm they had read and understood them. It was not clear if available copies of in-date PGDs were available, so there was a risk that some supplies made against them would not be properly authorised. Records were kept on an electronic platform, including for the provision of the urinary tract infection service. A sample seen of some records were sitting in a 'partially complete' record, which indicated that the consultation had not been fully completed. The pharmacist explained this was because follow up was due to complete the consultation.

When dispensing, team members kept people's prescription forms and medicines together in baskets to help prevent errors. And they used stickers on bags of dispensed medication to highlight if a fridge or CD line was to be included. If the prescription could not be fully dispensed, people were issued with an owing slip that detailed which items or quantities were still to be provided. The pharmacy team reviewed list of owings daily, and where necessary they attempted to arrange alternatives for medicines that were unavailable due to supply problems. Team members were aware of their additional responsibilities when dispensing certain higher-risk medicines. This included medicines such as methotrexate which was kept in a separate area of the dispensary, alongside counting triangles used solely for this medication. And they had information cards to give to people when they supplied methotrexate and steroids. They were aware of the pregnancy prevention programme for valproate and knew how to attach dispensing labels to not cover the perforated card supplied with original packs. A poster was displayed in the dispensary to remind the team to dispense valproate safely. The team was aware of the patients currently receiving valproate and confirmed none were in the at-risk category.

The pharmacy dispensed some medicines in multi-compartment compliance packs (MDS) to help people take them at the right times. There were three dispensers responsible for the service meaning that there was contingency for dispenser absence. The MDS packs were labelled with descriptions so that people could identify the individual medicines. But patient information leaflets were not generally

provided unless a new medicine was supplied, or people asked for them. Each MDS patient had an individual folder where all records pertaining to their packs were kept. At each four-weekly dispensing, a new record was printed off, and annotated with the date that the prescription was received and the date it was dispensed. Communications about any medication changes were kept within the folder. A dispenser explained that the packs were normally filled three or four days ahead. But because they were currently dealing with staff shortages due to holidays, they were only being filled a day or so ahead of them being supplied. She did not feel this put the team under pressure. Some compliance packs patients received medicines that may lose stability when removed from their original packs. These were not added to the pack until the day it was due to be supplied.

Team members completed three monthly expiry date checks of stock medicines. And they highlighted medicines that were going out of date within six months for use first. They had a date checking matrix which showed that some areas of the dispensary had been checked in July. And the MCA had a separate date checking matrix for retail stock which showed this had last been completed in August. Liquids with a shortened expiry date on opening were marked with the date of opening. Team members checked fridge temperatures daily and recorded them electronically.

Team members understood the process for managing drug alerts and medicines recalls. These were received by email and were printed off, actioned, signed, and kept in a folder for reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses the equipment and facilities in a way that protects people’s private information.

Inspector's evidence

The pharmacy generally made use of electronic copies of the British National Formulary (BNF) and British National Formulary for children (BNFc). It used stamped measuring cylinders that were marked for water and for liquid medicines to avoid cross contamination. A blood pressure machine was available and the date of first use was recorded in the hypertension case finding service SOP, so that the team would know when it needed to be calibrated or replaced.

Team members used a cordless telephone so that conversations could be kept private. Computers were protected against unauthorised access as they were password protected. Each team member had their own smartcards, but they admitted to using each other’s due to the sharing all computer terminals. Screens were positioned so that only team members could see them. Prescription forms and completed medicines were stored within the dispensary and on a bottom shelf at the medicines counter and so prevented people from seeing any private information.

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.