General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Horsley Hill Pharmacy, 60 Horsley Hill Square, SOUTH SHIELDS, Tyne and Wear, NE34 6RF

Pharmacy reference: 1037648

Type of pharmacy: Community

Date of inspection: 17/08/2023

Pharmacy context

This pharmacy is in a suburb of South Shields. 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 Hypertension case finding service, the Community Pharmacist Consultation Service (CPCS) and provides antibiotics to treat urinary tract infections.

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 identifies and manages the risks associated with its services well. It has up-to-date written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it completes the records it needs to by law. Team members suitably protect people's confidential information, and they understand their roles in safeguarding the safety and wellbeing of children and vulnerable adults. They respond correctly when errors happen by identifying what caused the error and acting 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 had protected time at work to read new and updated SOPs. And they demonstrated a clear understanding of their roles and worked within the scope of their role. For example, the SOP covering the use of the barcode PMR system required the team to scan the barcode on one pack at a time to generate a label. And to label and dispense one pack before the next pack was selected and the barcode scanned. Which the team members were observed to be following.

The SOPs included details on how to record and learn from errors identified during the dispensing process, known as near misses. A sample of near miss records showed the details recorded by the team members enabled patterns to be identified. And demonstrated the team member involved had reflected on what had caused the error. For example, one entry captured the reason was an unusual strength had been prescribed, that the team member was not familiar with. 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. A monthly review of near miss errors and dispensing incidents took place with the outcome discussed with team members, along with the actions they could take to prevent similar errors. A recent review had highlighted that quantity errors were the most frequent. And team members were reminded to double check the quantity dispensed from partially used packs of medicines.

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 met legal requirements. The correct RP notice was displayed. The team completed regular balance checks of the CDs and the balance of a randomly selected CD register was checked and found to be correct. Appropriate records were kept of CDs returned by people for destruction. The team stored completed CD prescriptions in a labelled basket which was handed to the pharmacists to complete the register entry. This helped to ensure entries were not missed. A sample of records for the receipt and supply of unlicensed products found they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). Team members understood their roles in protecting people's private information and some had signed confidentiality agreements. Confidential waste was separated and shredded offsite.

Team members had safeguarding information and training appropriate to their role. And they had access to contact numbers for local safeguarding teams. 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 very well together, and they are good at supporting each other in their day-to-day work. Team members complete ongoing training to help them develop their knowledge and skills. They benefit from identifying areas of their own practice they wish to develop and are supported to acquire new skills.

Inspector's evidence

The superintendent pharmacist (SI) worked full-time with regular locum pharmacist support when required including occasions when two pharmacists were on duty together. The SI was supported by a large, experienced team including two full-time trainee pharmacists, a full-time accuracy checking technician (ACT) who managed the workflow, and two full-time pharmacy technicians. A full-time trainee accuracy checker dispenser, four full-time dispensers, two part-time dispensers and a delivery driver completed the team. At the time of the inspection most team members were on duty.

Team members worked very well together and supported each other. The pharmacy was busy, but the workload was well managed by the team members. 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. Several team members' training certificates were displayed in the retail area for people to see. The pharmacy owners had identified the skills of one experienced team member to help with the training on the new systems for teams at other pharmacies and to support the induction programme for new team members.

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 were also asked by the SI for ideas on what training modules they'd like to complete. And they were given training when new systems such as the PMR system using bar code technology were introduced. The team were given protected time at work to watch videos about the PMR system and to practice using the system before it went live. The facility to practice on the system remained in place so new team members could receive training. Team members received regular feedback on their performance which they used to discuss opportunities to develop their knowledge and skills.

The team held regular meetings for all team members including colleagues working in the downstairs dispensary, and they shared ideas. The pharmacy also used an online communication platform to ensure all team members were kept up to date with any changes or new processes.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and appropriate for the services provided. And the pharmacy has suitable facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy premises were 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. In response to the COVID-19 pandemic the pharmacy had installed a clear plastic screen on the pharmacy counter. Heating and lighting were kept to an acceptable level in the dispensary and retail areas. The main dispensary was small, but team members managed the space well and worked in a tidy and organised manner. A large dispensary downstairs that was used for the dispensing of multi-compartment compliance packs was well equipped. There was enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a defined professional area and items for sale in this area were healthcare related. A small, soundproof consultation room enabled the team to have private conversations with people and to provide services such as the NHS Hypertension case finding service. The pharmacy prevented unauthorised access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible for people. And it generally manages its services well to help people receive appropriate care. Team members use technology to support them to deliver the pharmacy services safely and effectively. They store medicines properly and they complete regular checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a small step, but there was a temporary ramp available for the team to help people when required. A large screen in the retail area provided people with a range of healthcare information. Team members provided people with information on how to access other healthcare services when required. They asked appropriate questions when selling over-the-counter (OTC) medicines and they monitored people's requests for OTC medicines to ensure the supplies were suitable for the person. The trainee pharmacists had several opportunities to provide people, who were informed they were trainees, with healthcare advice and guidance on their medicines. 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.

The pharmacy provided the antibiotic treatment for urinary tract infections against up-to-date patient group directions (PGDs). These gave the pharmacist the authority to supply the appropriate antibiotic after a positive result from a urine test. When the test was negative the pharmacist provided the person with appropriate advice and referred them to the GP when required. The NHS CPCS service was popular and several referrals came from the local GPs. The pharmacy supplied medicine to several 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 separated and stored securely. The prescriptions were stored in a dedicated folder and separated in sections labelled with the person's name.

The pharmacy provided multi-compartment compliance packs to help many people take their medicines. One team member managed this service but other team members were trained to provide support. A downstairs 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 chasing-up missing prescriptions and 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 descriptions of the products within the packs were not recorded and the manufacturer's packaging leaflets were not always supplied. So, people may not be able to identify the medicines in the packs and didn't have information about their medicines. The completed packs were stored separately in box files labelled with the person's name. The team had a good working relationship with the local GP teams. And had invited one GP team to attend the pharmacy to observe the dispensing and preparation of the packs. So, they were aware of the complexities of supplying medicines in packs.

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. One team member generated the label and attached it to the packaging. A different team member, usually the ACT, completed the process by bagging the completed prescription and attaching the bag label. This enabled the ACT to undertake accuracy checks of prescriptions that were not completed using the barcode technology. The bag label was embedded with a unique bar code which was scanned by the team when placing the medication in the collection area and the delivery section. A text message was sent 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 created a record detailing the date and time of supply for them to refer to when queries arose. People were asked to confirm their name and address, and on some occasions their date of birth, when the medication was handed. This helped to ensure it was supplied to the correct person. The team kept a separate record of the delivery of medicines to people. Fridge and CD 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 they marked medicines with a short expiry date to prompt them 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 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 generally 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. One fridge held medicine stock and it had a glass door that enabled the team to view stock without prolong opening of the door. The other fridge held completed prescriptions awaiting supply.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. 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 mostly held other confidential information in the dispensary which had restricted public access. However, some documents containing people's confidential information such as records of the supply of unlicensed medicines were kept on shelves in the consultation room where the public could 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.