General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Avenue Pharmacy (Sunderland) Ltd, 50 Roker Avenue, SUNDERLAND, Tyne and Wear, SR6 0HT

Pharmacy reference: 1037698

Type of pharmacy: Community

Date of inspection: 04/10/2022

Pharmacy context

This community pharmacy is in a residential area of Sunderland. Its main services include dispensing prescriptions and selling over-the-counter medicines. It supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines. And it delivers some medicines to people’s homes.

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 most of its services effectively. It keeps people's private information secure. And it uses the feedback that it receives to inform the accessibility of its services. The pharmacy generally keeps the records it must by law. Pharmacy team members understand how to recognise and respond to safeguarding concerns. And they engage in conversations to help reduce risk following mistakes made during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support the safe running of the pharmacy. These had last been reviewed in August 2020. Pharmacy team members were able to refer to a SOP matrix to support them in completing learning associated with the SOPs relevant to their job role. And the majority of team members had read and signed SOPs associated with their roles. One team member, who had not signed the SOPs, had transferred from another pharmacy within the company. They confirmed that they had read the same version of SOPs at their previous pharmacy. Team members were observed following SOPs when labelling and assembling medicines for acute prescriptions received throughout the inspection. A medicine counter assistant clearly explained what tasks could not be completed if the responsible pharmacist (RP) took absence from the pharmacy.

The pharmacy had some tools to support its team members in recording mistakes made during the dispensing process. But mistakes found and corrected during the dispensing process, known as near misses, was inconsistent at times. For example, the team had not formally recorded these types of mistakes since Spring 2022. Team members identified how they would be provided with feedback following a near miss and would seek to correct the near miss themselves. And there was some evidence of shared learning and risk reductions being taken to reduce risk. For example, clonazepam and clobazam had recently been separated on the dispensary shelves. A dispenser demonstrated how bright warning signs attached to the edges of shelves in the dispensary prompted extra checks when picking medicines. There was some evidence of historic learning from incidents called 'lessons of the week', displayed in the dispensary. The notices highlighted photographs of mistakes associated with medicines that looked alike and sounded similar. This had supported team members in sharing learning following mistakes, but due to the age of the notices they could be less effective at managing current risk. The pharmacy used the patient medication record (PMR) system to record details of dispensing incidents. And the RP explained that these were also reported directly to the superintendent pharmacist (SI). The SI and senior management team investigated incidents and took time to speak with people effected by a mistake about the actions taken to reduce the risk of similar mistakes occurring. Learning from an incident at another of the company's pharmacies had led to shared learning and each pharmacy creating a separate anticoagulant section in the dispensary. This supported team members in completing additional safety checks when dispensing these higher-risk medicines.

The pharmacy had a complaints procedure and it advertised how people could provide feedback about its services. The team had a good relationship with members of the public, and greeted most people visiting the pharmacy by name. A team member explained that feedback about the pharmacy was largely positive. Some minor concerns had been raised during the recent pandemic due to the pharmacy limiting the number of people in its public area. It had taken steps to review its infection

control protocols regularly throughout the pandemic, and had made alterations to access arrangements when it considered it safe to do so. The pharmacy had safeguarding procedures in place, and its team members understood the importance of acting on safeguarding concerns. The RP had completed level two safeguarding learning through the Centre for Pharmacy Postgraduate Education (CPPE). A member of the pharmacy team provided examples of how the team had supported people struggling with substance abuse. The team had provided a space for people to contact substance misuse services to seek the support they required. But they were not aware of how they should respond if somebody came into the pharmacy and asked for 'ANI', an initiative to help provide a safe space for people experiencing domestic abuse. The RP was aware of the 'Ask for ANI' safety initiative and a discussion took place to highlight the benefits of introducing some learning on the subject to support team members in responding to these types of requests for help.

The pharmacy had up-to-date indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. The controlled drug (CD) register was generally maintained in accordance with legal requirements. The pharmacy maintained running balances in the CD register but full physical balance audits against the register were infrequent. There was evidence of individual balance checks taking place when CDs were supplied. A random balance check conformed to the balance recorded in the register. The pharmacy did not always complete page headers in the register and it didn't always record details of the wholesaler when entering a CD. The pharmacy generally kept records associated with private prescriptions in accordance with legal requirements. But dates relating to prescribing and dispensing the prescription were occasionally omitted from records. And RPs did not always record the time they finished their shift in the RP record as required. The pharmacy held its records relating to the supply of unlicensed medicines in accordance with the requirement of the Medicines and Healthcare products Regulatory Agency. The pharmacy had procedures in place to support the safe handling of patient information. It held personal identifiable information on computers and within areas of the pharmacy only accessible to staff. Confidential waste was held securely and collected periodically by a secure shredding company.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a dedicated team of people who work together well. It supports its team members by providing regular feedback about their work and development. Pharmacy team members demonstrate enthusiasm for their roles. They engage in some conversations to help minimise risk. And they are confident in sharing their thoughts and they understand how to raise concerns at work.

Inspector's evidence

The RP was a regular locum pharmacist with good working knowledge of the pharmacy's processes. They were supported by two qualified dispensers and a medicine counter assistant during the inspection. Another qualified dispenser also worked at the pharmacy. And employed delivery drivers provided the pharmacy's medicine delivery service. The SI worked at the pharmacy regularly. And both the pharmacy's own team members and team members from the company's other three pharmacies worked flexibly to cover absences when required. The pharmacy displayed details of its team members qualifications. And it engaged its team members in annual appraisals to help support them in their learning and development. But they did not receive regular protected training time at work to complete ongoing learning associated with their roles.

The RP confirmed that the pharmacy did not set specific targets relating to services. Pharmacy team members were confident when explaining how they could provide feedback or share ideas at work. For example, a dispenser had shared an idea to improve workload management and record keeping associated with the multi-compartment compliance pack service. The pharmacy had implemented the idea and team members discussed how the new way of working supported them in answering any queries about the service. The pharmacy had a whistle blowing policy. And pharmacy team members knew how to raise and escalate a concern at work. Communication within the team was generally provided through informal discussions across the working day. But team members did not engage in regular, structured meetings to help share learning.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and suitable for the services provided. It has facilities to allow people to have a private conversation with a member of the pharmacy team.

Inspector's evidence

The pharmacy was secure and maintained to an appropriate standard. It was adequately clean and working areas were tidy. Lighting and ventilation was appropriate throughout the premises. Pharmacy team members had access to handwashing facilities including antibacterial hand wash and towels at sinks. Plastic screening fitted part-way across the medicine counter supported the pharmacy in managing some of the risks associated with providing face-to-face pharmacy services during a pandemic. The public area was open plan and stocked health related items and toiletries. A new private consultation room was in the final stages of completion. The room was situated to the side of the consultation area and it had been built with privacy and accessibility in mind. The room was accessible to people if needed, but it had yet to be decorated. The pharmacy’s previous consultation room was at the back of the premises, and had required people to walk round the outside of the building to access it.

The premises were spread over two floors with most tasks taking place on the ground-floor level. A barrier at the medicine counter deterred access through to the dispensary. Pharmacy team members used the space in the dispensary well with separate areas for labelling, assembling, and checking medicines. And there was protected space for completing higher-risk tasks such as assembling medicines in multi-compartment compliance packs. The team used rooms at the back of the pharmacy and on the first-floor level of the pharmacy as storage areas. But many of these areas were cluttered. A room used to hold overflow stock was kept in an orderly manner. The first-floor level of the premises also provided team members with kitchen and toilet facilities.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from reputable sources. And it generally stores its medicines safely and securely. But team members do not always follow the pharmacy's written procedures when providing medicines in multi-compartment compliance packs. So, they cannot be sure they always work in the safest and most effective way.

Inspector's evidence

The pharmacy was easily accessible from street level. It advertised details of its opening hours and services clearly for people to see. There was a range of health and social care information leaflets available for people to take. And team members engaged well with people visiting the pharmacy, taking time to talk to them about their health and wellbeing. They understood how to signpost a person to another pharmacy or healthcare professional when the pharmacy was unable to provide a service or supply a medicine. The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them behind the medicine counter.

The pharmacy team was aware of some aspects of the valproate Pregnancy Prevention Programme (PPP). It did not currently supply valproate to people in the at-risk group. The RP discussed how he would manage a prescription for valproate for a person within the at-risk group. And details of his approach was in accordance with the requirements of the PPP. The RP explained how they counselled people on the safe use and side effects of some higher-risk medicines. And people were encouraged to bring their monitoring records into the pharmacy. For example, INR monitoring records. But any checks associated with counselling for these higher risk medicines was verbal, and was not recorded on the patient medication record (PMR) to support continual care.

The pharmacy kept each person's prescription separate throughout the dispensing process by using baskets. And team members brought prescriptions belonging to people waiting in the public area, to the direct attention of the RP. The pharmacy retained prescriptions for owed medicines, and team members dispensed from the prescription when later supplying the owed medicine. It kept an audit trail of each person it delivered medicine to. This helped the team to manage any queries associated with the medicine delivery service. The RP provided further details of some 'home appointments' undertaken by the SI. This involved visiting people's homes to discuss their medicine regimens and to support them in taking their medicine safely. This type of visit would also be used to assess the suitability of supplying medicines in a multi-compartment compliance pack to people.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy used individual patient record sheets to support it in supplying medicines in multi-compartment compliance packs. And changes to medicine regimes and queries were recorded clearly with supportive information available. The pharmacy managed changes well by ensuring it received documented evidence of a change, such as a hospital discharge summary. Two team members generally shared workload associated with the service. The pharmacy generally provided patient information leaflets at the beginning of each four-week cycle of packs. It mostly assembled compliance packs ahead of it receiving the prescriptions. The process followed by team members considered the risks involved in this practice. Team members used up-to-date backing

sheets to pick the medicines. And this sheet was cross checked against the PMR. Accuracy checks took place against these records with all compliance packs assembled in this way identifiable and retained with full supportive information, including the original packs used to fill the compliance packs. There was a clear process for matching the compliance pack and backing sheet used to pick the medicines with the prescription. And the pharmacy did not release the packs for delivery or collection until sign-off by a pharmacist following the verification steps against the prescription. There was an audit trail in place to identify who had completed each task associated with the supply of medicines in this way. But no risk assessment of the process had been undertaken. And the practice was not in accordance with the pharmacy's SOPs.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It generally stored medicines in their original packaging in an orderly manner throughout the dispensary. But it stored some medicines in labelled amber bottles. The labels on the bottles did not always contain the full details of the medicine held inside them. The pharmacy stored medicines subject to safe custody arrangements appropriately in a secure cabinet. Medicines inside were held in an orderly manner. The pharmacy had a large medical fridge for storing medicines that required refrigeration. The fridge had a thermometer and alarm fitted that would sound if the temperature fell outside the accepted range of between two and eight degrees Celsius. But team members had not physically checked and recorded the fridge temperatures for a few months. There was no evidence that the fridge had been operating outside of the required range. A discussion highlighted the need to ensure a robust process for monitoring and recording this temperature daily was in place moving forward.

The pharmacy team reported completing date checking tasks periodically. And there was some evidence of stock rotation in the upstairs storeroom. But the team did not generally record these checks. A random check of dispensary stock revealed several out-of-date medicines. Pharmacy team members were observed checking expiry dates routinely when dispensing medicines which reduced the risk of an out-of-date medicine being supplied. And team members clearly highlighted the date of opening on bottles of liquid medicines to help ensure they remained fit to supply. The pharmacy had medicine waste bins and CD denaturing kits available. There was a lot of medicine waste waiting for secure disposal. This was appropriately stored separately from stock medicines. A team member demonstrated how the team received medicine alerts by email through the NHS Central Alerting System (CAS). And team members checked for new emails regularly to ensure they acted upon alerts in a timely manner.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to the equipment they require to provide the pharmacy's services safely. And they use this equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available including the British National Formulary (BNF). And the RP discussed using online resources to support them in providing pharmacy services. Pharmacy team members could access the internet to help resolve queries and to obtain up-to-date information. The pharmacy's computer was password protected. And information displayed on computer monitors was not visible from the public area. The pharmacy stored bags of assembled medicines away from the direct view of the public area to help protect people's privacy. The pharmacy had some clean equipment available for counting and measuring medicines. It highlighted equipment for measuring and counting higher risk medicines and stored this separately from other equipment. This helped to reduce any risk of cross contamination.

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.