General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 38 Astley Road, Seaton Delaval, WHITLEY BAY, Tyne and Wear, NE25 0DG

Pharmacy reference: 1037729

Type of pharmacy: Community

Date of inspection: 28/06/2023

Pharmacy context

This is a pharmacy in a row of shops in the village of Seaton Delaval, Whitley Bay. Its main activities are dispensing NHS prescriptions and providing multi-compartment compliance packs to people to help them take their medicines safely and effectively. It sells medicines over the counter and provides services including vaccinations. It delivers 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 has suitable written procedures to help ensure it delivers it services safely. And it keeps the records it must by law. Team members discuss mistakes, and they make records to help their learning. They keep people's private information secure, and they know how to protect vulnerable people.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) relating to the services provided, which helped guide team members to work safely and effectively. They were available in an electronic format and authorised by the superintendent pharmacist (SI). And all team members confirmed on the electronic platform they had read and understood them. Compliance was monitored by the company's head office. A sample seen of the responsible pharmacist (RP) SOPs showed they had been updated in June 2022.

The pharmacy recorded errors made during the dispensing process known as near misses. These were recorded on an electronic platform and the records seen showed errors were recorded each month. The pharmacist, on a monthly basis, used the information from near miss records to identify trends. Near misses were discussed at the time with the team member who had made the error, and suggestions from team members were made to prevent a recurrence of the error in the future. For example, due to repeated near misses involving the incorrect form of an inhaler, a sticker had been put on the shelf highlighting the differences between two forms. Medicines that looked-alike and sounded-alike (LASA) were highlighted on labels produced by the pharmacy's patient medication record (PMR) system to be used as part of the dispensing process. LASA medicines were separated on the shelves to help reduce selection errors. The pharmacist completed a monthly safety review which detailed what improvements team members could make to their working practice. The most recent review highlighted the need for team members to be vigilant in checking expiry dates when dispensing a yearly supply of contraceptive medicine to make sure the medicine was in date for the duration of treatment. Another learning point was to make sure team members translated Latin abbreviations into English on the dispensing labels. Team members electronically recorded errors highlighted after a person had received their medication, known as dispensing incidents. They had not had any dispensing incidents occur recently, but they confirmed the process was to complete an investigation and root cause analysis and the details of the report were shared with the SI.

Team members roles and responsibilities were reflected in a SOP. They knew what could and could not take place in the absence of the RP. The RP notice was displayed prominently in the retail area and reflected the details of the pharmacist on duty. The pharmacy had a complaints policy displayed in the retail area and detailed in the pharmacy's leaflet so people knew how they could provide feedback. The pharmacist explained how they would attempt to resolve any complaints and, if unresolved, the complaint could be escalated to the SI. This was not a process that often had to be engaged as they felt they had good relationships with people who accessed their services. And feedback was positive. At the time of the inspection, a person had left the team members flowers as a thank you for assisting them.

The pharmacy had current professional indemnity insurance. It kept mainly electronic records, except for the record of its supply of private prescriptions, which were kept on paper. A sample seen of the

controlled drugs (CD) register showed that all required details were captured. And that team members checked CD stock against the register running balance weekly. A check on a randomly selected CD confirmed that the stock matched the balance. Records of patient returned CDs were made at the time they were returned, and the medicines were detroyed in a timely manner. Records of the RP on duty were in order. The pharmacy dispensed unlicensed medicines known as "specials" and the associated certificates of conformity detailed who prescribed the medicine and who received it. This meant there was an audit trail in the event of queries. The record of private prescriptions supplied to people captured the required details and the prescriptions were stored in an organised way for easy referencing.

Team members were aware of their responsibilities to ensure that people's private information was kept secure. This included refresher training for information governance (IG) and general data protection regulations (GDPR) annually. And any non-compliance with training was highlighted by the company's head office. Team members were up to date with training, having completed GDPR training in May 2023. There was a data processing notice displayed in the retail area of the pharmacy. And confidential waste was separted for destruction by a third-party company.

Team members were aware of their responsibilities for safeguarding vulnerable adults and children. The pharmacist, pharmacy technician and trainee pharmacist had all completed training. The pharmacist confirmed they had no instances that required engaging the processes in the pharmacy. But team members knew who to contact and local safeguarding team contact numbers were accessible in the pharmacy. The pharmacy displayed a chaperone policy in a prominent position at the medicines counter.

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. Team members receive training and development relevant to their roles. There is an open and honest culture within the team. Team members discuss their mistakes together to learn from them. And they feel comfortable raising concerns if they need to.

Inspector's evidence

During the inspection the pharmacist manager was the RP and was supported by a pharmacy technician and trainee pharmacist. Two dispensers and two delivery drivers also worked in the pharmacy. Team members were observed working well together to manage the workload. Part-time team members and team members from other branches covered absences and holidays.

The pharmacy encouraged team members to complete ongoing training on the company's learning hub and provided them with opportunities to develop their competencies. The pharmacist explained some of the training could be completed more quickly than others. And for the training that required a longer time input, team members received protected learning time, or they would be supported to complete the training out with business hours. A dispenser had commenced training to become an accuracy checking dispensing assistant (ACDA). The RP was the tutor for both the trainee ACDA and the trainee pharmacist. And they received protected learning time each week. The pharmacist was trained to complete adminstration of vaccinations and completed ongoing training to retain their skills. This included annual refresher training and a face-to-face training event every three years.

Team members were vigilant to repeated requests for medicines liable to misuse both for purchases over the counter and on prescription. They knew when to refer to the pharmacist. The pharmacist detailed an intervention whereby she had identified frequent prescriptions being approved by the GP for a medicine liable to misuse. She discussed her concerns with the GP and support was given to the person. Team members read communications from the company's head office of shared learnings from incidents that had occured within other pharmacies in the company. And they read about emerging drug issues that had occured, such as misuse of medicines in other pharmacy settings. Team members felt able to discuss their mistakes openly and felt comfortable to raise concerns, although they had never needed to. They received annual reviews to discuss their objectives and development needs which included a check in after six months. The pharmacist explained that targets that were set were achievable and did not compromise patient safety in any way.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy, and it provides sufficient space for the services it delivers. It has a suitably soundproofed room where people can access services and have private conversations with team members.

Inspector's evidence

The pharmacy was clean, tidy, free from clutter and portrayed a professional appearance. The retail area was spacious and there was a small dispensary to the rear. Team members organised the space in the dispensary well and medicines were stored neatly on shelves. There was a good workflow with different bench spaces for team members to complete different tasks. The medicines counter acted as a barrier and allowed access to the dispensary for authorised people only. The dispensary was protected from view of people in the retail area, so dispensing tasks could take place without distraction. The pharmacist's checking area was situated so that they were able to intervene in conversations at the medicines counter if required. There was a small room situated adjacent to the dispensary which was used primarly for storage.

The pharmacy had a soundproofed consultation room where people could have private conversations with team members and access services from the pharmacist. The room had a desk and appropriate space to allow services to be carried out safely. The pharmacy had a cleaning rota which detailed which cleaning tasks were to be completed and when. And it was up to date and signed by team members to confirm that the various tasks had been completed. There was a sink in the dispensary for professional use and for handwashing. And the toilet facilites were clean, hygienic and provided hot and cold water and soap for handwashing. The lighting was bright throughout the dispensary and the temperature was comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services well. It has appropriate procedures to help make sure people receive their medicines when they need them. And team members provide advice and support for people taking higher-risk medicines to help make sure they can take them safely. Team members store and manage medicines as they should. And they carry out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy had a small step from the street. It had an automatic door to help access. Team members described how they helped people who had difficulty accessing the premises. The pharmacy could provide people with large print labels if they had visual impairment, and it had a hearing loop for those with hearing difficulties. The pharmacy delivered some people's medicines to their homes and people signed an electronic record to confirm receipt of delivery. The pharmacy had visibility on the electronic device of the deliveries being made, which helped resolve queries. Deliveries containing fridge lines were delivered within a few hours.

The pharmacy provided NHS services such as the hypertension case finding service and a minor ailments service, including treatment for urinary tract infections. A small number of the NHS services were underpinned by patient group directions (PGDs) and the pharmacist was using the most current versions. And interventions were recorded electronically for reference. The pharmacist described how the hypertension case finding service had led to successful interventions for people who had been referred to the prescriber for treatment.

When dispensing, team members kept people's prescriptions and medicines in baskets to help prevent errors. And they used stickers to highlight actions needed, such as an intervention by the pharmacist or the presence of a fridge line or controlled drug on the prescription. They highlighted prescriptions for higher-risk medicines, including using stickers for warfarin and valproate to highlight that additional counselling was required when handing out the medication to a person. The pharmacy had leaflets and record books for higher-risk medicines to help people to take their medicines safely. Team members were aware of the patient safety cards to be given to people in the at-risk category taking valproate. And they displayed a poster about valproate to help them remember the requirements for dispensing and counselling people. Approximately half of the prescriptions received by the pharmacy were assembled off-site, using automation, at the pharmacy's hub pharmacy. The pharmacist explained how this helped with their workload. Team members were aware of what could and could not be dispensed in this way.

The pharmacy dispensed medicines into multi-compartment compliance packs to help people take their medicines effectively. And team members followed written procedures to help make sure people received their medicines when they needed them. Each person had a record of their medicines to be supplied in the packs and the times of day each medicine should be taken. When people's medication changed, the pharmacy kept a record of the communication. Prescriptions were ordered ahead of time so any queries could be resolved with the GP. Team members provided patient information leaflets with the packs, so people had the necessary information to take their medicines. They did not always add the descriptions of medicines on the packs which may help people to identify their medicines.

Team members were prompted by the company's online platform to complete checks on the expiry date of medicines. They highlighted medicines with a short expiry date and recorded these short-dated and expired medicines on the online platform. Of a sample checked during the inspection, the medicines were in date. Medicines in the fridge were kept neatly and organised. Team members recorded the temperatures of the fridge daily and records were in order. They understood the process for managing drug alerts and medicines recalls. These were received via NHS email or directly from the company's head office. They printed, signed and dated the alerts to confirm the action was taken. Medicines that were returned by people were kept seperately and collected for disposal by a third-party company.

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 to protect people's private information.

Inspector's evidence

The pharmacy had a range of equipment for its services, including a monitor to measure people's blood pressure. It was due to be calibrated in December 2023. It had an ambulatory blood presure machine which the pharmacist confirmed was used for the NHS hypertension case finding service and was shared amongst several branches within the company. It was not known when this was due for calibration, but the pharmacist confirmed that it had only been in used since the service was introduced the previous year. The pharmacy used crown-marked measuring cylinders that were marked for measuring water and medicines. There were kits used for the destruction of controlled drugs.

Team members used a cordless telephone so that conversations could be kept private. Computers were protected against unauthorised access as the team used NHS smartcards and passwords. Screens were positioned so that only team members could see them. They stored people's prescriptions and medicines waiting collection in a way that prevented people in the retail area from seeing people's 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.