General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Northstead Pharmacy, 1 Northleas Shops, Northstead, SCARBOROUGH, North Yorkshire, YO12 6JG

Pharmacy reference: 1038981

Type of pharmacy: Community

Date of inspection: 22/06/2023

Pharmacy context

This community pharmacy is amongst a small parade of shops in a suburb of Scarborough. Its main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some people with their medicines in multi-compartment compliance packs to help them take their medicines properly. And it delivers medicines to people's homes. The pharmacy offers other NHS services including the NHS Community Pharmacist Consultation Service (CPCS).

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 mostly identifies and manages the risks associated with its services. It has written procedures that the pharmacy team largely follows. And it mostly completes the records it needs to by law. Team members protect people's private information correctly and they understand their roles in safeguarding the safety and wellbeing of children and vulnerable adults. They respond suitably to errors by discussing what happened and taking action to prevent future mistakes. But they do not fully record the details of errors and so they may miss opportunities to learn and improve the safety of services.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. There was no index with the SOPs to help team members locate a specific SOP when required. Team members had read the SOPs, but they had not signed the SOPs signature sheets to show they understood and would follow them. They demonstrated a clear understanding of their roles and worked within the scope of their role.

The SOPs included details on how to record and learn from errors identified during the dispensing process, known as near misses. A sample of records of errors made showed limited details on what had been prescribed and dispensed and the team's learning from the error. In the section of the record capturing the actions taken to prevent the error from happening again many of the entries were limited to the word 'corrected.' 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, making all team members aware of the incident and the actions taken to prevent a similar error. For example, following a selection error, the team were alerted to the similarities between the two medicines. It was discussed that the two products were not separated on the shelves, which had contributed to the error. The accuracy checking technician reviewed the error records each month and shared key findings at the team meetings. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. Complaints and feedback were shared with the pharmacist owners to respond to. Team members encouraged people to provide feedback on the pharmacy's services. Several people had commented how helpful the walk-in CPCS service was which had helped them to receive appropriate medical treatment.

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 mostly met legal requirements. There were a few minor omissions in the RP record, when the RP had failed to sign out. Appropriate records were kept of CDs returned by people for destruction. Team members had completed training about the General Data Protection Regulations (GDPR) and a privacy notice was displayed in the retail area. The team separated confidential waste for shredding offsite.

The pharmacy did not have a safeguarding procedure for the team to follow. But team members had completed up-to-date safeguarding training appropriate to their role. This included training about the safe space initiative which helps people experiencing domestic abuse. The delivery drivers 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 well together, and they discuss ideas to enhance the safe delivery of the pharmacy's services. Team members have opportunities to undertake some training so they can suitably develop their skills and knowledge. And they feel comfortable raising concerns and making suggestions.

Inspector's evidence

One of the pharmacist owners worked full time at the pharmacy with the remaining hours covered by locum pharmacists. The pharmacists were supported by a full-time accuracy checking technician (ACT) who had previously worked in a hospital pharmacy. The remaining team members were two full-time dispensers, one who had recently moved from the other pharmacy in Scarborough owned by the company. And two part-time qualified dispensers who worked in the role of medicines counter assistants (MCAs). Four part-time delivery drivers worked across both pharmacies owned by the company. The pharmacy was recruiting for a qualified dispenser. At the time of the inspection the pharmacist owner, the ACT, two dispensers and a dispenser working in the role of MCA were on duty. Team members had specific roles but supported each other such as when several people presented at the pharmacy counter.

The ACT generally had opportunities to complete accuracy checks of prescriptions to maintain their skills. But this had reduced slightly as they undertook more dispensing activity to support the team's workload. The pharmacist owners had approached the ACT to use their experience in a pharmacy manager role, which they had agreed to do. Training was planned to support the ACT in this role.

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. The pharmacy had recently procured access to a pharmacy training platform and each team member had been allocated a log-in number. But none of the team had started to use it. Team members had performance standards set and they received informal feedback on their performance. But they didn't have the opportunity to formally reflect on their performance and identify opportunities to progress and develop their skills for example in one-to-one sessions. One of the dispensers who worked in the role of MCA had asked the new owners for time in the dispensary to ensure they maintained their knowledge and skills. This was agreed and a rota was being developed to ensure team members shared the responsibility of working in different sections of the pharmacy.

The team held regular meetings and notes were kept of the matters discussed for team members who could not attend to refer to. And for all team members to refer to at a later date if required. Team members shared ideas and examples of their own learning and good practice in a 'what good looks like' session. Recent meetings had been used to discuss patterns with near miss errors and weekend cover. Team members were also encouraged to raise concerns in these meetings and individually with the pharmacist owners.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and adequately sized for the services it provides. It has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy 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. Heating and lighting were kept to an acceptable level in the dispensary and retail areas. The dispensary was small, but team members managed the space well and worked in a tidy and organised manner. Dispensing benches were mostly free from clutter, but some baskets used in the dispensing process were piled on top of each other, creating an increased risk of errors.

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. The pharmacy prevented unauthorised access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible and help people to meet their healthcare needs. Team members manage the pharmacy services safely and effectively to help make sure people receive medicines when they need them. They store medicines properly and they mostly complete regular checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

Access to the pharmacy was via a small step with handrails located either side of the door. There were healthcare information leaflets for people to read and to take away. And 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 request for OTC medicines to ensure the supplies were suitable for the person. This sometimes involved a referral to the pharmacist who intervened in the sale to ensure the appropriate medicine was supplied. The computer on the pharmacy counter had access to the electronic patient medication records (PMR). So, when a person presented the team member could check what stage the dispensing of their prescription was at.

The pharmacy provided the NHS Community Pharmacist Consultation Service (CPCS) which enabled people to receive medication to treat minor illnesses rather than making a GP appointment. And to receive urgent supplies of their medication. People were referred to the service via NHS 111, their GP and could access it directly via a walk-in service, which was very popular. The pharmacist described several examples of people promptly receiving medication for a minor ailment or being referred directly back to the GP when the medical condition required this.

The pharmacy provided multi-compartment compliance packs to help several people take their medicines. One team member managed this service with support from other team members when required. A room to the rear of the dispensary away from any distractions was used for dispensing and checking the packs. Prescriptions were requested in sufficient time to allow queries such as missing items to be managed. And a record was kept when each stage of preparing the packs was completed. So, team members could provide information to people asking when their medication was due. A check of the medicine picked from the shelves was completed before the medication was dispensed to help reduce errors. The descriptions of the medicines within the packs were recorded and team members supplied people with the manufacturer's patient information leaflets. This meant people could identify the medicines in the packs and had information about their medicines.

The pharmacy supplied medicine to some 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 bagged separately with the prescription attached and stored securely.

The team provided people with clear advice on how to use their medicines. Team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided. However, they hadn't undertaken an audit to identify anyone prescribed valproate who met criteria. So, they could confirm whether anyone prescribed valproate was at risk and provide them with the appropriate information. The team reported no-one prescribed valproate met the criteria.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Pharmacy team members initialled dispensed by and checked by boxes on dispensing labels, to record their actions in the dispensing process. The pharmacy used CD and fridge stickers 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. People received a text message from the pharmacy advising when their prescription was ready. Team members regularly checked the section holding completed prescriptions and contacted the person if the prescription hadn't been collected for five weeks. The pharmacy delivered medication to many people in the Scarborough area and a record was kept of the deliveries for the team to refer to when queries arose.

The pharmacy obtained medication from several reputable sources and the team members mostly followed the pharmacy's procedures to ensure medicines were safe to supply. They regularly checked the expiry dates on medicines, but they didn't mark 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 for the fridge storing stock were within the correct range. But the fridge storing completed prescriptions was out of range and showed readings of either 8 or 10 degrees over a six-day period. Notes had been added to the record stating it had been warm in the dispensary. But there was no evidence that a second reading had been taken to see if the temperature had returned to normal. A reading was taken during the inspection and found to be within range. The pharmacist owner was not aware of this matter until it was highlighted during the inspection. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. And it stored out-of-date and returned CDs separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (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 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. The largest of the fridges held medicine stock and it had a glass door that enabled the team to view stock without prolong opening of the door. The smaller 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. The team positioned the computer on the pharmacy counter in a way to prevent disclosure of confidential information. Additional computers had been installed to support the team's workload for example the generating of dispensing labels and ordering of medicinal stock. Team members stored completed prescriptions away from public view and they held other private information in the dispensary and rear areas, which had restricted public 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.