General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Burnopfield Pharmacy, Cedar Crescent, Burnopfield, NEWCASTLE UPON TYNE, Tyne and Wear, NE16 6HU

Pharmacy reference: 1090850

Type of pharmacy: Community

Date of inspection: 25/07/2019

Pharmacy context

This is a community pharmacy situated next to a surgery. It sells over-the-counter medicines and it dispenses NHS and private prescriptions. The pharmacy also offers advice about the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartmental compliance packs. These help people remember to take their medicines. And it delivers medicines to people's homes.

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 generally identifies and manages the risks associated with its services. Team members record and learn from any mistakes, which helps make the services safer for people to use. They are clear about their roles and responsibilities. The pharmacy keeps the records it needs to by law to make sure that it supplies medicines safely and legally. Team members know how to protect people's personal information. And how to protect vulnerable people

Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs) which the pharmacy team members have read. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as the dispensing prescriptions, hand-out, responsible pharmacist, sales of medicines and controlled drugs (CD) management. The superintendent (SI) reviewed these yearly. And last reviewed in October 2018. The SOPs had signature sheets and the team had read and signed the sections relevant to their role. The team could advise of their roles and what tasks they could do. And there was a notice which reminded the team of weekly and monthly tasks which they required to do.

The pharmacy workflow provided different sections for dispensing activities with dedicated benches for assembly and checking, with a separate area for compliance pack preparation. The team utilised the space well. The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used different colours of baskets with red for waiting, white for collections and blue for delivery to distinguish people's prescriptions by degree of urgency and this helped plan workload.

The pharmacy recorded near misses found and corrected during the dispensing process. The pharmacist recorded the near misses on a specific template and discussed these with the team at the time. Examples included wrong drug with Fucibet given but the required drug not recorded, a labelling error but no detail and a missing item but the item not specified. The pharmacist reviewed them at the end of the month and sent a copy of the review to the head office. Actions taken by the team had been separating thyroxine strengths as the boxes were very similar. They had a notice displayed with the Look Alike Sound Alike (LASA) drugs to help raise awareness of drugs with similar names and to help minimise errors with these. They also had a notice to remind them to take extra care with medicines for children and the elderly.

The pharmacy had a practice leaflet and a notice displayed in the pharmacy which explained the complaints process. The pharmacy gathered feedback through the annual patient satisfaction survey, with previous results being positive. Some people had made comments about the worn seating and the team had notified the head office. The General Pharmaceutical Council (GPhC) had received a recent concern. The pharmacy had dealt with the concern when they had become aware. And the team had investigated it. They had recorded the complaint at the time and learning shared with the team. They had followed the SOP. The team had highlighted and separated the medication involved in the recent concern. The pharmacy had current indemnity insurance through a recognised supplier with an expiry date of 31 October 2019.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records. A sample of the CD registers looked at were generally completed as required, with a few headings not filled in, running balances maintained and the register indicated monthly stock audits were undertaken. The team members checked the balance after each dispensing. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy kept a record of CDs which people had returned for disposal and it had a process in place to ensure the team destroyed these promptly. And did not allow a build-up in the CD cabinet.

The pharmacy kept records for private prescriptions electronically and recorded in a book. The pharmacy team advised that after checking with the SI they would probably only maintain the records electronically. The pharmacy kept special records for unlicensed products with the certificates of conformity completed.

The pharmacy displayed information on the confidential data kept and how it complied with legislation.

The pharmacy displayed a notice on how it looked after information. And had a privacy notice displayed at the counter. The team had covered General Data Protection Regulation (GDPR) information through their information governance and data protection policy. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. The team kept patient sensitive information securely. The pharmacy team shredded any confidential information as required.

The team had a SOP for the protection of vulnerable adults and children. They had the contact numbers for local safeguarding organisations in the SOP folder. The pharmacist had undertaken level two CPPE training. And the other team members had undertaken CPPE training to level one.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe and effective services. The pharmacy team members are competent and have the skills and qualifications they need for their role. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work.

Inspector's evidence

There was one pharmacist and three dispensers working in the pharmacy. One of the dispensers was registered as a technician and maintained her registration but was only employed as a dispenser. The team advised that the staffing was suitable but challenging when one of the team was on holiday. They sometimes received some help from another of the pharmacies. This was usually counter cover which provided some assistance and minimised some interruptions. But no additional dispensary help. The pharmacist advised she would discuss this further with the area manager.

Certificates and qualifications were available for the team. And kept in a file. The team members had training records. The head office sent out training to be undertaken such as Children's Oral Health and Risk Management. They used the resources from the Centre for Pharmacy Postgraduate Education (CPPE). Once the team members completed these they printed off the certificate. They sent a copy of the certificate to show completion to the head office. The team members also read magazines and leaflets from suppliers and other third parties to keep up to date. The pharmacist received performance reviews which gave her the chance to receive feedback and discuss development needs. The team had not had reviews although advised they had a form for reviews. The recalled it had been mentioned a year or so ago.

The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacist, area manager or the superintendent (SI). The team discussed issues as they arose during the day with suggestions of how to deal with issues. There was a whistleblowing policy and there was a notice with telephone numbers displayed in the rear dispensary, so the team members could easily access numbers if required.

The team carried out tasks and managed their workload in a competent manner discussing any issues which arose and dealing with any telephone queries. The pharmacy team did not have targets for services such as MURs. And they carried out these when they met the patient's needs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are of a suitable size for the services it provides. The pharmacy is clean and well maintained. And people can have private conversations with the team in a consultation room.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. And fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines waiting collection. The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The benches, shelves and flooring were all clean and the pharmacy maintained a cleaning rota which covered all areas of the pharmacy.

The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. The room temperature was acceptable, with fans in place, for the period of hot weather, which provided some relief. The pharmacy was well lit. Members of the public could not access the dispensary. The counter was clearly observed from the dispensary and the staff were aware of customers in the premises.

The pharmacy had a good sized, signposted, sound proofed consultation room which the team for used. There was a notice to highlight to people that they could use the room for private discussions. And a notice about the chaperone policy, asking patients if they would like a family member or chaperone present. The pharmacy team kept the consultation room locked when not in use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. The pharmacy manages its services adequately. It takes care when dispensing medicines in devices to help people take their medication. The pharmacy delivers medication to people's homes. But it doesn't get people to sign for the receipt of their medicines. So, it may be difficult to resolve any queries with deliveries. The pharmacy gets its medicines from reputable sources. And it generally stores and manages medicines and related items appropriately.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was some customer seating. The pharmacy displayed its services in the window and within the pharmacy. The hours of opening were on the door. There were some leaflets and information displayed for people. The pharmacy had leaflets promoting the way in which people were to reorder their medicines from September 2019. The pharmacy had a defined professional area. And items for sale were mostly healthcare related or general household items. Pharmacy only medicines could not be reached by customers.

The pharmacist undertook Medicine Use Reviews (MUR) but no New Medicines service (NMS) reviews. With MURs they referred people to the surgery if required. And on occasions suggested that people may require to receive a compliance pack to help them take their medicines. They occasionally checked people’s blood pressure during the MUR or if people requested a check. The pharmacy provided the Minor ailments service with paracetamol for children being popular. The team signposted people requiring the Emergency Hormonal Contraception (EHC) service to the surgery, unless they wanted to pay for this service. The pharmacist was waiting for the next training locally to complete the face to face part to be able to provide the service through the PGD. The training sessions had been cancelled, so the pharmacist could not complete this to provide the service.

The pharmacy supplied medicines to around 72 people in multi-compartmental compliance packs to help them take their medicines. The team made up the packs, four weeks at a time. One of the dispensers generally undertook this service, with others helping when required. She was going on leave. And had planned to ensure the packs were ready in her absence. So, the other team members would only have to deal with any packs requiring changes. The pharmacy kept completed packs in boxes for each individual patient. And colour coded for the weeks due. The team kept any additional information on the boxes and in the patient’s file, such as if the pharmacy needed to supply a controlled drug (CD) with the pack. The pharmacy supplied CDs, along with the pack, in separate containers. The dispenser noted any changes in the file and on the patient meditation record (PMR). The team replaced a patient file if there had been several changes, to keep the information clear. The pharmacy supplied Patient information leaflets (PILs) with the first tray of each cycle.

The pharmacy offered a substance misuse service. And had only one patient. They made up the fourteen days, ready. And supplied daily supervised.

There was a clear audit trail of the dispensing process. The team completed the ‘dispensed by’ and ‘checked by’ boxes which showed who had performed these roles. And a sample of completed

prescriptions looked, at found compliance with this process. There were some alerts stickers used to apply to prescriptions to raise awareness at the point of supply. These included warfarin, CD and 'speak to pharmacist' which ensured patients received additional counselling. And prevented supplies of CDs when the prescription was no longer valid.

When the pharmacy could not provide the product or quantity prescribed, full patients received an owing slip. And the pharmacy kept one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy went to the surgery and discussed with the doctors if items were unobtainable. This allowed the doctors to prescribe an alternative if necessary.

The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. And could explain the risks involved. The shelf section was clearly marked to indicate the risk, with a poster at the shelf. The pharmacy had undertaken an audit and had a couple of people in the at-risk group. They had received suitable counselling and the information.

The pharmacy provided a repeat prescription collection service. The ordering of prescriptions by people was being changed by the Clinical Commissioning Group in September. The pharmacy team were informing people of the change, supported by leaflets. They were ensuring any vulnerable patients would get their medicines and were working with the surgery to produce a list of people which the pharmacy could still order for. The pharmacy still ordered for the compliance pack patients.

The pharmacy had delivery sheets as a record of the delivery of medicines from the pharmacy to patients. The driver ticked when she had delivered any item. People did not sign to confirm receipt. The sheets were only kept for a week or so. The benefits of getting people to sign for medication at the delivery stage were discussed with the team. And keeping the records a little longer, in case there were any issues.

The pharmacy stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. The pharmacy stored some associated products, such as spoons, and skillets in boxes in the toilet area. The spoons were in a clear bag which the team members sealed after use. Discussion occurred that the team could move these items out of this area and stored these in a more suitable environment. The team advised of a suitable location. But the pharmacy may require some more shelving to accommodate these in an orderly fashion.

The pharmacy had a refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. In the hot weather the temperature had risen. They had called out an engineer who had attended. The temperature appeared to rise very quickly, if the door was open which was giving a high reading. But it returned down to an acceptable reading. And the team was still closely monitoring the readings.

The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. They marked short-dated items and took these off the shelf prior to the expiry date. They marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use. The pharmacy used recognised wholesalers such as AAH, Alliance and Phoenix.

In relation to the Falsified Medicines Directive (FMD) the pharmacy had registered with the supplier (accredited by SecurMed). They had a password but were waiting for the computer provider to

authorise this password. And, how to use the system. The company had not provided them with any further information.

The team used appropriate medicinal waste bins for patient returned medication. These were uplifted regularly. The pharmacy had appropriate denaturing kits for the destruction of CDs. Someone had recently attended to carry out witnessed destructions. The pharmacy had a process to receive drug safety alerts and recalls. The team actioned these and kept records of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people's private information.

Inspector's evidence

The pharmacy team members had access to a range of up to date reference sources, including the British National Formulary (BNF). They used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). The pharmacist kept a folder with spare PILs for antibiotics to ensure these were readily available to supply.

The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It had a separate range of measures for measuring methadone. It also had a range of equipment for counting loose tablets and capsules. There was a separate triangle for cytotoxics. The team had access to disposable wipes and alcohol hand washing gel. The blood pressure machine appeared in good working order and the team checked it as required. It had recently been replaced.

The pharmacy stored medication waiting collection on shelves where no confidential details could be observed by people. The team used the NHS smart card system to access to people's records. The team filed these in boxes in a retrieval system out of view, keeping details private.

The computer in the consultation room was screen locked when not in use. The computer screens were out of view of the public. The team used cordless phones for private conversations.

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.