General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newington Pharmacy, 525 Anlaby Road, HULL, North Humberside, HU3 6EN

Pharmacy reference: 1091624

Type of pharmacy: Community

Date of inspection: 09/01/2020

Pharmacy context

This community pharmacy is on a busy road close to Hull city centre. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies medicines in multi-compartment compliance packs to help some people take their medicines. And it delivers medication to people's homes. The pharmacy provides the seasonal flu vaccination service and a travel vaccination service. And a supervised methadone consumption service.

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	2.5	Good practice	The team members support each other in their day-to-day work. They are encouraged to share their experience and ideas on how to improve the efficient delivery of services. The team members identify improvements to the delivery of pharmacy services. And they introduce processes to improve their efficiency and safety in the way they work.
3. Premises	Standards met	3.2	Good practice	The pharmacy has good arrangements for people to have private conversations and consultations with the team. The pharmacy has a dedicated screened area available so people can take their medicines on the premises but away from other people using the pharmacy.
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 team identifies and manages the risks associated with its services. The team members have training and guidance to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. They take the action needed to help prevent similar mistakes happening again. But they don't fully record all their errors. So, the team may miss opportunities to help identify patterns and reduce mistakes. People using the pharmacy can raise concerns and provide feedback. The pharmacy has written procedures that the team follows. But the team members do not sign to say they have read the procedures. So, the pharmacy cannot evidence that the team members understand the correct procedures.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team members had read the SOPs, but they had not signed the SOPs signature sheets to show they understood and would follow them. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error, their learning from it and actions they had taken to prevent the error happening again. The pharmacy recorded dispensing incidents and shared the error with all the team to learn from. These were errors identified after the person had received their medicines. A sample of dispensing incident reports looked at found the learning points and actions taken to prevent a similar error were not recorded. After a recent delivery error, the team identified that generating two bags labels with the person's address on had contributed to the error. So, the team members now produced one bag label and made sure they placed it on the correct section of the bag. The pharmacy undertook monthly and annual patient safety reviews using the error reports. To spot patterns and make changes to processes. One of the pharmacy technicians led on this. The latest annual review highlighted that the team had reduced near misses by team members checking their own work before passing it to the pharmacist or accuracy checking technician for the final check. The team members were also encouraged to ask each other to double check the medicines dispensed. The pharmacy technician listed the medicines often involved with errors. The list included clobetasol cream dispensed against prescriptions for clobetasone cream.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it had a leaflet providing people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. And in the form of a chart displayed in the retail area.

The pharmacy had electronic controlled drug (CD) registers, a sample looked at found that they met legal requirements. The system captured the current stock balance for each register and prompted the team when a stock check was due. This helped to spot errors such as missed entries. The pharmacy

recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training on the General Data Protection Regulations (GDPR). The pharmacy did not display a privacy notice or other information source to advise people of the confidential data kept at the pharmacy. And how the pharmacy protected this information. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacists and pharmacy technicians had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The delivery drivers reported to the pharmacy team any concerns they had about people they delivered medicines to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large team with the qualifications and skills to support the pharmacy's services. The team members support each other in their day-to-day work. The pharmacy encourages the team members to share their experience and ideas on how to improve the efficient delivery of services. The team members identify improvements to the delivery of pharmacy services. And they introduce processes to improve their efficiency and safety in the way they work. The pharmacy provides the team members with opportunities to develop their knowledge and skills. And it gives team members regular feedback on their performance.

Inspector's evidence

The Superintendent Pharmacist, the pharmacist manager and regular locum pharmacists covered the opening hours. The pharmacy team consisted of 28 team members including four pharmacy technicians and a recently qualified technician waiting to register. Three of the pharmacy technicians were accuracy checking technicians (ACTs). And two of the ACTs had managerial responsibilities. The rest of the team consisted of full-time and part-time qualified dispensers, medicines counter assistants (MCAs), a trainee MCA, a pharmacy apprentice and delivery drivers.

One of the ACTs checked the compliance packs sent to the care homes. Another ACT checked the packs sent to people living at home and prescriptions dispensed in the main dispensary. The third ACT was involved with the dispensing of the compliance packs so maintained their checking skills by checking prescriptions dispensed in the main dispensary. Team members were allocated specific roles during the day such as repeat prescription ordering or preparing the deliveries. The pharmacy provided extra training through e-learning modules from the Virtual Outcomes organisation. The team members had protected time to complete the training. The pharmacy regularly held team meetings. And it used a social media platform to inform team members of new training modules and meeting requests. The pharmacy provided performance reviews to the team. So, they had a chance to receive feedback and discuss development needs.

Team members could suggest changes to processes or new ideas of working. The team read updates from the computer software provider to identify any changes that would benefit the team. Two members of the team managing the compliance packs identified that getting stock from the robot in the downstairs dispensary for each prescription was not an efficient way of working. So, from information provided after a computer update the team members found they could print a list of all medicines from recently labelled prescriptions. One team member took the list to the computer linked to the robot to retrieve all the stock for the labelled prescriptions. And marked the list to show the stock had been picked. The ACT who checked the compliance packs for homes had experience of providing this service from working at another pharmacy. And had introduced new systems to support the delivery of this service. The ACT introduced a system of marking each medicine on the prescription once it was checked and bagged, to show this had happened. And sending a copy of the prescription to the care home. So, the care home team could refer to this when checking the supply from the pharmacy. The pharmacy had targets for its services and the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And it has good arrangements for people to receive their medicines in private and have confidential conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. And alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people and providing services such as the travel vaccinations. The team also used a smaller room off the retail area for confidential conversations. The pharmacy had a separate entrance and room for people to use when collecting their methadone doses. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. And it had a separate entrance for people to use early in the morning and late at night. This provided the team with some level of security during these opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides services that support people's health needs. The team members manage the pharmacy services well. They identify issues that affect the safe delivery of services. And they act to address them. The team members use technology to help make services more efficient. And they assemble compliance packs in a controlled environment to avoid distraction. The pharmacy team members keep records of prescription requests and deliveries made to people. So, they can deal with any queries effectively. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via three entrances, one through an automatic door. And all entrances were step free. The pharmacy team used a section of the retail area to promote healthy living advice. An eye-catching display focused on the dry January campaign. And provided information such as the benefits of giving up alcohol and the statistics linked with drinking alcohol. The display included helpful tips for reducing alcohol intake and a calendar for people to record their alcohol intake. These calendars were available for people to take away. The team had access to the internet to direct people to other healthcare services.

The pharmacy kept a small range of other healthcare information leaflets for people to read or take away. The pharmacy had a range of up-to-date patient group directions (PGDs). These provided the pharmacists with the legal authority to provide services such as administering the flu vaccination and the travel vaccines. But only one of the pharmacists trained to provide the service had signed the PGDs. The pharmacist who had signed the PGDs was the only one providing the service. The pharmacy received prescriptions from specialist clinics for injections that were administered to a person on certain days. The team dispensed each injection in to a box labelled with the date of administration. And stored the boxes for each person in separate containers labelled with the person’s name and address. So, the injection was available at the time the person needed to receive it.

The pharmacy provided multi-compartment compliance packs to help around 200 people living at home take their medicines. And to people living in care homes. People living at home received monthly or weekly supplies depending on their needs. The service was supported by a dedicated team consisting of two ACTs and qualified dispensers. A pharmacy technician managed the team providing this service. The pharmacy provided separate rooms for the preparation of the packs. One room had computer terminals and a telephone line. So, team members did not have to go downstairs to the main dispensary to access the computer and to make a telephone call. The team members identified they had reached a maximum number of people to provide this service to. So, to take on more people could risk the safe delivery of the service. The team explained this to people asking about the service. And signposted the person to another pharmacy or asked the person if they wanted their name added to a waiting list.

To manage the workload the team divided the preparation of the packs supplied to people living at home across the month. And it kept a list of people due their packs each week. The team usually ordered prescriptions one week before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. The team checked received prescriptions

against the person's list of medicines on the electronic patient record (PMR) and the backing sheet supplied with the packs. And queried any changes with the GP team. The team received some prescriptions once a week which meant the packs had to be prepared weekly rather than four weeks together. The team picked the stock for a month's supply for these weekly trays and kept the stock in baskets labelled with the person's name and address. So, each time the prescription arrived the team knew the medicines were available to dispense. The team picked all the stock with reference to the prescription before dispensing the medicines in to the packs. The team did not record the descriptions of the products within the packs. And only sent the manufacturer's patient information leaflets every two months. The team printed off a weekly list to record the packs made up for supply and the packs that needed preparing. The team stored the completed weekly packs on dedicated shelves labelled with the person's name and address. The team rarely received information from the hospital about people who had been admitted or discharged.

The pharmacy provided the compliance packs service to people living in 30 care homes and eight residential settings. The team started the process for supplying the care home packs around two and a half weeks before the next supply was due. The pharmacy usually sent the packs and other medicines to the care home five days before the next cycle started. This gave the care home team time to check the supply and chase up missing medicines. The team provided the care home team with medicine administration charts to record when the person had received the medicines. The charts included a section for the care home team to record where on the person's body to apply medicines such as a cream or patch. The care home team used the charts to request the medicines for the next supply. And sent the charts to the pharmacy to order the prescriptions. The care home team used the chart to inform the pharmacy team of medicines that had been stopped. And medicines that the person still had but did not need to be ordered. The pharmacy team marked the chart with the date of the next supply and when the prescription request was made. The pharmacy team emailed the prescription request to the GP surgery. The team printed off the email request and marked it with the date the supply was due to the care home. The team stored the requests in baskets labelled with each care home awaiting the prescriptions. The team kept the medicine request after supplying the medicines in case queries arose. Such as when a GP team suggested the care home team was over ordering medicines. But the care home team stated it was the pharmacy team ordering the medicines. The pharmacy team was able to show the GP team the order sheets from the care home and what the care home team had requested. The pharmacy team checked the received prescriptions against the medicine request list from the care home to identify missing items. And contacted the GP team to query missing items or changes. The pharmacy could access the person's repeat list of medicines and could see when the medicine was last issued to check if it was due.

The team kept the received prescriptions in the baskets labelled with each care home until the team was ready to label the prescription and the administration charts generated. The team used tote boxes to hold the stock picked for the care home packs and stored the boxes in a separate room for a team member to dispense in to the packs. The ACT when checking the packs for the care homes marked each item on the prescription after completing the accuracy check and bagging the medicines. The number of ticks indicated the number of packs sent and the number of containers of medicines not included in the packs such as inhalers. The team sent a copy of the prescription with the supply of packs to the care home. So, the team at the care home could see what was prescribed and checked by the ACT when checking the supply from the pharmacy. The pharmacy attached a copy of the prescription to each person's electronic record (PMR). The pharmacy team referred to this prescription when dealing with queries from the care home team about missing medicine. The pharmacy team met with the care home teams to discuss any issues and to provide training to the care home teams. The pharmacy team had advised the care home teams to move paracetamol prescribed as a when required dose from the packs to supplies in original packs. So, the person was not a risk of getting a dose of paracetamol when they did not need it. The team used a labelled basket holding prescriptions for medicines such as antibiotics

supplied outside of the monthly cycle. The delivery drivers worked until 6pm so the team usually focused on these prescriptions around 4pm after completing other tasks. So, the care home received the medicines on the same day.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses using a MethaMeasure pump linked to a dedicated laptop. The person presenting for their methadone dose placed their finger on to a scanner linked to the laptop. This brought up the person's photograph and dose. The pharmacist updated the MethaMeasure programme with methadone doses on receipt of a new prescription. The pharmacy kept the prescriptions in dedicated files in alphabetical order. So, the team could easily locate the prescription when the person presented at the pharmacy. The pharmacist undertook a clinical check of the prescription. The pharmacists had trained senior members of the dispensing team to hand out the methadone doses when the person presented for their dose. The training involved the pharmacist observing the team member dispensing the methadone doses before signing the team member off as being able to check the correct dose was selected and to hand over the dose. The pharmacists and ACTs did not check the dose measured out. And a risk assessment had not been completed to ensure this process was safe. The pharmacy trained these team members to support the service by ensuring people presenting for their doses were not kept waiting for a long time especially when the pharmacy was busy.

The team members provided a repeat prescription ordering service. And they kept a record of the request. So, they could chase up missing prescriptions, order stock and dispense the prescription. The team used the electronic medication record (PMR) to record information such as when a person needed a medication review. So, all the team were aware of this when the person queried where their prescription was. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had completed audits of the supply of valproate to check if anyone met the criteria. The pharmacists ensured that any person who met the criteria was on a PPP and was given appropriate advice. The pharmacy had the PPP cards to provide people with information when required. The team used the PMR to record details of conversations with people such as asking people prescribed diabetic medicines if they had an eye check or foot check in the last 12 months. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit.

The pharmacy had a robot installed. The team used the robot for most prescriptions that were not part of the multi-compartment compliance packs. Each computer terminal in the main dispensary was linked to the robot. A shoot delivered the medicine picked by the robot to each terminal for the dispenser to check the item picked and attach the dispensing label before the pharmacist did a final check. The team placed split packs of medicines in a tote for scanning back in to the robot. The team did this task when other key tasks were completed. The team providing the multi-compartment compliance pack had access to a separate computer linked to the robot to select medicines for the packs.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves and when checking the items picked by the robot. The team members used this as a prompt to check what had been picked. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. The pharmacists did not record when they had clinically checked the prescription to enable the ACTs to do their check. So, there was no evidence to show the prescription had been checked by the pharmacist to ensure it was clinically appropriate. The pharmacy had a stamp to capture these

checks, but team members had not used it.
When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy used a section to the rear of the main dispensary for deliveries. Tote boxes labelled with a Hull postcode held the deliveries for that area. A set of shelves held deliveries returned by the driver when the person was not at home. The pharmacy used an electronic system to record the deliveries due each day and allocate them to a driver via a smart phone App. So, the driver could see their deliveries due each day. The team added information such as prescriptions that included a fridge item or a controlled drug. So, the driver knew to ask a team member for these medicines. The driver used the App to get a signature from the person receiving the medication. The team members had access to this so they could check the receipt of the medicine when queries arose.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 02 January 2020. The team checked the expiry date on stock sent from the wholesaler before putting it in to the robot. The team divided stock in to those with a date of less than six months and medicines with longer than six months. The team scanned the two groups of medicines in to different sections of the robot. The robot kept a record of the expiry date and highlighted medicines with a short expiry date or an out-of-date medicine when the team selected the product. The team used a sticker to highlight medicines stored outside the robot that had a short expiry date. No out-of-date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of cetirizine oral solution with six months use once opened had a date of opening of 09 December 2019 recorded. The team recorded fridge temperatures using a digital reader that gave a detailed breakdown of the fridge temperatures across the day. The fridges had a built-in alarm that sounded when the temperatures went outside the range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (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 had equipment and software to meet the requirements of the Falsified Medicines Directive (FMD). The team was not fully compliant as the pharmacy had attempted to update the robot to meet FMD. But the solutions suggested by the company who provided the robot had not worked. The pharmacy obtained medication from several reputable sources. And 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 the team mostly uses the pharmacy's facilities and equipment in a way to protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. The pharmacy had three fridges to store medicines kept at these temperatures. One fridge had a glass door that enabled the team to view stock without prolong opening of the door. The team used baskets to separate the stock in the fridge. The pharmacy completed safety checks on the electrical equipment. And the team regularly checked the Methameasure methadone pump each day for accuracy.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The team used cordless telephones to make sure telephone conversations were held in private. The pharmacy stored completed prescriptions away from public view. And it held most private information in the dispensary and rear areas, which had restricted access. But some completed flu vaccination forms containing people's private information were found in a file on a shelf in the consultation room.

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.