General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Burradon Pharmacy, 33/34 Front Street, Camperdown, NEWCASTLE UPON TYNE, Tyne and Wear, NE12 5UT

Pharmacy reference: 1092304

Type of pharmacy: Community

Date of inspection: 07/03/2024

Pharmacy context

This is a pharmacy in the village of Camperdown in Newcastle. Its main activity is dispensing NHS prescriptions, and it provides some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. It provides a range of NHS services including the hypertension case finding service and Pharmacy First service. And it provides a delivery service, taking medicines to people in their 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's written procedures help manage risk and guide team members to work safely and effectively. Team members record errors made during the dispensing process and they make changes to help prevent a recurrence of a similar error. They mostly keep the records required by law and they keep people's private information secure. They know how to respond to concerns for the welfare of vulnerable people accessing the pharmacy's services.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which assessed the risks of its services and helped guide team members to work safely and effectively. These included SOPs for controlled drug (CD) management, dispensing and responsible pharmacist (RP). Team members had signed to confirm they understood and would comply with them. The pharmacy had been issued with updated SOPs in the weeks before the inspection which were to be implemented by the team in due course. These were due to be reviewed in two years by the superintendent (SI) pharmacist team.

The pharmacy recorded errors identified during the dispensing process known as near misses. The details of the error were recorded by the person who made the error. The entries did not always capture the full details of the errors. Team members transferred the errors from paper to an online electronic platform which shared the details with the company's head office. The pharmacist completed a monthly analysis of the information produced from the near misses to produce a "patient safety report" and discussed this with team members. It detailed action taken to help prevent a recurrence of the same or similar errors such as highlighting look-alike and sound-alike (LASA) medicines on shelves in the dispensary. The pharmacy completed electronic incident reports for errors that were identified after a person had received their medicines. And they completed reports for incidents involving CDs and reported these to the controlled drug accountable officer (CDAO). The pharmacy had a complaints procedure which was displayed in the retail area. Team members aimed to resolve any complaints or concerns informally. If they were unable to, the pharmacist would contact the regional manager for assistance. There was a machine at the medicines counter for people to give instant feedback on the service they had received.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their role. And there was a roles and responsibility SOP for reference. Team members were able to refer to a SOP for the activities that could and could not take place in the absence of the RP. The RP notice was displayed in the retail area and reflected the correct details of the pharmacist on duty. The RP record was compliant, with a few minor omissions of the time the RP ceased duty. The pharmacy had electronic registers for recording the receipt and supply of its CDs. And to record CD medicines returned by people who no longer needed them. The entries checked were mostly in order with a error identified in one register that was subsequently resolved. Team members checked the physical stock levels of medicines matched the balance in the CD register on a weekly basis. The pharmacy kept certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. It kept complete electronic records for its supplies of private prescriptions and kept associated paper prescriptions.

The pharmacy had a privacy notice displayed in the retail area informing people of how their data was used. Team members received annual training for information governance (IG) and general data

protection regulations (GDPR) and were notified when this was due for renewal. The pharmacy separated confidential waste for shredding by a third-party company. Team members knew of their responsibilities to safeguard vulnerable adults and children and would refer any concerns to the pharmacist. The pharmacy displayed a flow chart for team members to refer to if needed. The pharmacist had links to a local internet site where they could report any concerns. And they had completed their Centre for Pharmacy Postgraduate Education (CPPE) level three safeguarding training in the last two years. There was a chaperone policy displayed on the consultation room door.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and qualified team members to help manage the workload. Team members complete ongoing training to help develop their skills and knowledge. And they ask appropriate questions when helping people with their healthcare needs.

Inspector's evidence

An employed pharmacist was working as the RP and there was one other team member, a trained dispenser, working at the time of the inspection. They were observed supporting each other to manage the workload. The pharmacy also employed a trainee pharmacist, another trained dispenser, an accuracy checking pharmacy technician (ACPT) and a delivery driver. The ACPT was primarily used as a dispenser when on duty. The pharmacist, trainee pharmacist and one dispenser worked full time, and other team members worked part time. The pharmacist explained staffing levels were assessed when any unexpected absences arose. And short term absences were usually managed by part-time team members supporting where necessary. For any long-term absences, support could be arranged via management from other nearby branches in the company. Annual leave was planned in advance so that contingency could be arranged.

Team members had completed accredited training for their roles. The trainee pharmacist's training was overseen by the pharmacist who was their tutor and they received protected learning time to support their training. Team members received regular monthly training modules on an electronic company platform, and they explained the most recent training was about athletes foot. The pharmacist had completed training to deliver the NHS Pharmacy First service. Team members received newsletters from the company's head office which highlighted important reminders and updates. For example, the most recent newsletter informed team members of the recent classification change of codeine linctus. Team members received performance reviews and the pharmacist had begun the process of completing the reviews. Team members felt comfortable to raise concerns and knew how to raise concerns if needed. The pharmacy had a whistleblowing policy if needed.

Team members asked appropriate questions when selling medicines over the counter. They knew to be vigilant to repeated requests for medicines liable to misuse. They referred any such requests to the pharmacist who would have supportive conversations with people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. It has appropriate facilities for people requiring privacy when accessing the pharmacy's services.

Inspector's evidence

The pharmacy had two main areas, a front large retail space and a spacious dispensary. The rear of the pharmacy had storage facilities and an area for team members to have their breaks. The pharmacy portrayed a professional appearance. There was a medicines counter with a barrier which restricted unauthorised access to the dispensary. The dispensary was organised and clean and had different bench spaces for the completion of different tasks. A central island provided space for both the preparation of medicines by a dispenser and the final check by a pharmacist. The central position of the pharmacist's checking bench allowed for effective supervision of the dispensary and medicines counter. The dispensary had a sink which provided hot and cold water and was used for the preparation of medicines. The toilet and staff area were clean and had separate facilities for hand washing.

The pharmacy had a soundproofed and spacious consultation room where people could have private conversations with team members and access services. The room had a sink with hot and cold water. The room was accessed from the retail area for people and from the dispensary for team members. It was equipped with a desk, two chairs and a computer. The temperature was comfortable throughout the dispensary and the lighting was bright.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services safely and effectively. Team members complete checks on medicines to ensure they remain fit for supply. And they provide people with the necessary information to help them take their medicines safely. Team members respond appropriately when they receive alerts about the safety of medicines.

Inspector's evidence

The pharmacy displayed the services it offered in the front window of the premises. It had a small step from the pavement, which allowed access to those using prams. The pharmacy provided large print labels for those with visual difficulties. It had health leaflets displayed in the consultation room for people to read or take away. The pharmacy provided the newly launched NHS Pharmacy First service which was underpinned by patient group directions (PGDs) and these were available in paper form for easy referencing and were signed by the pharmacist.

Team members used baskets to keep people's prescriptions and medicines together and to prevent them becoming mixed-up. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Stickers were used to highlight the inclusion of a fridge line, CD or if the pharmacist wanted to speak to a person when the medicine was being handed out. Team members were aware of the pregnancy prevention programme (PPP) for people taking valproate. There was a valproate poster displayed on the wall for team members to refer to. And the pharmacy had additional patient cards to supply. The pharmacist confirmed they currently did not have any people taking valproate in the at-risk category. Valproate was issued in a multi-compartment compliance pack to a person and they were supplied with a warning card.

Team members were observed completing checks when handing out medicines to people to ensure they had been supplied to the correct person. The pharmacy had a delivery service taking medicines to people in their homes. The pharmacist confirmed that a small number of people had given written consent for their multi-compartment compliance packs to be delivered through their letterbox. The pharmacy's SOP did not reflect this process; however, the company had given permission and had a consent form highlighting the risks to people. It asked people to confirm there were no pets or children present and it had considered other risks, for example, the pharmacist did not allow any CDs to be delivered in this way. Examples of the consent forms were seen. The pharmacist explained they did not review the process to ensure that a person's circumstances remained the same and the consent form asked people to inform them of any changes to their circumstances. For other deliveries where consent was not documented, people were left with a "failed delivery" card and the medicine was returned to the pharmacy.

The pharmacy supervised the administration of medicine for some people and doses were prepared on the day they were due. The pharmacist dispensed and then left a break before checking them but didn't involve a dispenser in the process. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. Team members ordered the prescriptions in advance to allow time to resolve any queries. Each person had a medication record which detailed the medicine they took and their dosage times. And any changes were communicated from the GP surgery or via the discharge medicines service. The pharmacist had

created a flow chart for team members to follow when people had a change to their medication. Team members provided descriptions of tablets on the packs so they could be easily identified and provided patient information leaflets.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only medicines (P) were stored behind the medicines counter so sales of these medicines were supervised by the pharmacist. Team members had a process for checking the expiry date of medicines. The dispensary was split into different sections and date checking was completed every three months, with the most recent having been completed in January. Items that were going out of date in three and six months were highlighted with different colours to alert team members to use these first. And they had completed an additional date check of excess medicines due to a dispensing incident. The pharmacist checked expiry dates as part of their final accuracy check. A random selection of fifteen items found one out of date medicine which was removed. The pharmacy had two fridges to store medicines that required cold storage. Team members recorded the temperatures daily with records showing that the fridge was operating between the required two and eight degrees Celsius. Team members received notifications about drug safety alerts and medicine recalls via email and these were printed off and actioned. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to reference sources including the British National Formulary (BNF) and the British National Formulary for children (BNFc). It had access to equipment for services, including two blood pressure monitors and an ambulatory blood pressure monitor used in the NHS hypertension case finding service. The ambulatory blood pressure monitor had been calibrated one month previously and the blood pressure monitors were less than two years old. The pharmacy had otoscopes and tongue depressors used in the NHS Pharmacy First Service. And it had crown stamped measuring cylinders which were marked to identify which were for water and which were for liquid medicines. It had triangles used to count tablets and a separate triangle used for cytotoxic medicines such as methotrexate. There were two medical grade fridges in use, and both had glass fronts which allowed the medicines to be seen without opening the doors.

The pharmacy had a cordless telephone so that conversations could be kept private. It stored medicines awaiting collection in staff only areas so that people's private information was secured. Confidential information was secured on computers using passwords and NHS smartcards were in use. And screens were positioned in the dispensary and consultation room in a way that prevented unauthorised people from seeing confidential 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.