General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: G W Herdman Chemists Ltd, Ryhope Customer Service Centre, Black Road, Ryhope, SUNDERLAND, Tyne and Wear, SR2 0RX

Pharmacy reference: 1092992

Type of pharmacy: Community

Date of inspection: 09/09/2019

Pharmacy context

The pharmacy is within a customer service centre. This has a library, surgery, physiotherapists and several nurse prescribers. The village has another pharmacy owned by the same company across the road from the centre. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy provides a prescription collection service. And it delivers medicines to people's homes which is a large part of the business.

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 written procedures that the team members generally follow. And they work in a safe way to provide services to people using the pharmacy. The pharmacy team members look after people's private information. And they know how to protect the safety of vulnerable people. The team members discuss mistakes they make during the dispensing process and make improvements when required. But they do not keep up-to-date records of these. So, they may be missing out on some learning opportunities to identify trends and prevent similar mistakes from occurring. The pharmacy provides people with the opportunity to feedback on its services. It maintains the records it must by law. But some records are not frequently or robustly checked. So, the pharmacy may not know if there are any errors or losses. And these will be harder to resolve.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting delivery of services. They covered areas such as the dispensing prescriptions and controlled drugs (CD) management. These were subject to a yearly review. These were last reviewed in April 2019. The SOPs had signature sheets and most of the team had read and signed the sections relevant to their role. The newer members advised of what tasks they could or could not do. And had a clear understating of their role.

The pharmacy workflow provided different sections for dispensing activities with dedicated benches for assembly and checking. There was a computer terminal at the front dispensing bench and one in a room off the back of the dispensary. The team pulled most of the electronic repeat prescriptions down from the NHS spine and printed these off in the room at the back of the dispensary. The team members sorted these into alphabetical order. And then started dispensing for the ones pulled down. They kept the next batch of ones pulled down separately to ensure they dispensed in order of when the pharmacy received the prescriptions. This was to ensure that most people's prescriptions would be ready when they expected them. The pharmacy team members used different sized baskets throughout the process to keep prescriptions and medicines together. They processed the prescriptions for people who were waiting, at the front dispensing bench. And they prepared the others on the island in the dispensary.

The pharmacy team had recorded near miss errors found and corrected during the dispensing process. But this had slipped during the last few months. The pharmacist locum discussed the near misses and told the team, but no detail was being recorded. The team gave examples of a near miss with pizotifen 0.5mg and 1.5 mg and metformin and melatonin. The stock on the shelves was well laid out and similar items were clearly segregated and stored in magazine racks to keep them clearly separated. The magazine racks indicated what items were in the box and the strengths. The staff advised they had done this for a long time and they added boxes for any new products when there were potential risks of a selection error, due to similar packaging or names. They discussed near miss errors as they occurred and took action.

The pharmacy had a notice displayed in the pharmacy which explained the complaints process. And it gathered feedback through the annual patient satisfaction survey. The recent survey was mostly positive. People had commented about the pharmacy not being open on Saturday. And they had explained that the building was not owned by them. And they could not get access on a Saturday. But

their other pharmacy in the village was open Saturday mornings. There was a procedure to record and report dispensing errors and the team provided the folder with incident reports. The team advised they always ensured the superintendent (SI) was aware of any complaints or incidents. The pharmacy had current indemnity insurance. The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records as required. 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 in a book, with few entries. The pharmacy kept special records for unlicensed products with the certificates of conformity completed.

The CD registers had most of the headings completed and it appeared that the pharmacy was undertaking some balance checks . There were a few crossing outs on entries, instead of the person resolving the issue making a clear correction with an annotation. The entries were ticked in places which the team had thought would be balance checks, but they were not clearly indicated as balance checks in the register. The team advised that this task had been undertaken by the dispensary manager who had left. The process had not followed the SOP which stated; weekly checks and the entry to state 'checked and verified by'. The inspector checked a quantity of stock against the register entry and they did not agree.

The team were most concerned how this could have happened. The process the pharmacy had for making sure they made entries in the register was robust. The team highlighted all CD prescriptions. And placed the prescriptions in a box until a team member entered them. The team member marked the top of the prescription as entered in the CD register. They highlighted this as a check. And then they filed it. The register showed any supplies that the team had given to the driver to deliver. The team looked through previous prescriptions and searched on the computer to see if they could find the missing amount. They were all very keen to resolve this. And worked together to undertake this. Just before the end of the inspection, there was a possible explanation. The following morning the SI confirmed by email, the outcome and resolution of the error. There had been a missing entry which the SI had now entered and noted as such in the register. The prescription on this occasion had not been marked and highlighted on the top following the procedure.

The pharmacy team were aware of the need for confidentially. And had a folder with information on confidentiality. There were training packs for General Data Protection Regulation (GDPR) information. But none of the team had completed these. There was a copy of a privacy notice in the folder, but this was not displayed in the pharmacy. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. The pharmacy team stored confidential waste in separate containers for offsite shredding. The pharmacy had safeguarding information including contact numbers for local safeguarding available for the team. The pharmacist had undertaken level 2 CPPE training. The team had a policy and procedure for the protection of vulnerable adults and children. And this explained what to do. The team members advised they would discuss any concerns they had with the pharmacist first.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are suitably trained or working under supervision during training. And they are in the process of registering for formal training, within required guidelines. Many of the team members are new but there are enough staff to manage the workload. And the team members understand their roles and responsibilities in providing services. The experienced members support the newer members. Pharmacy team members complete ongoing training on an ad-hoc basis. But the pharmacy doesn't provide structured ongoing training. So, team members may miss opportunities to complete learning relevant to their role. The pharmacy team members support each other in their day-to-day work. And they feel comfortable raising any concerns they have.

Inspector's evidence

There was one pharmacist, two dispensers and two medicines counter assistants (MCA), one apprentice and one trainee MCA working in the pharmacy. There had been several changes in the pharmacy staff earlier this year. So, several of the team members were new. In addition, the dispensary manager had recently left and another dispenser, both at the same time. The pharmacy did not currently have a regular pharmacist. But there had been regular cover, with the same pharmacist locum two to three days most weeks. And the superintendent pharmacist (SI) had worked a least one day each week. Three other regular pharmacist locums had covered other days. This maintained some consistency for the pharmacy. Recruitment for additional staff had been undertaken. And there had been interest, with two trained dispensers starting shortly.

The apprentice had started in March this year but there had been issues in her receiving her course. But these had been resolved and she was about a third of the way through the course. She undertook most of the training online. And was waiting for her assessor to come to the pharmacy to undertake her review. Another member of the team had started two months ago and was waiting to start the MCA course. The two MCAs had finished their course and one was waiting to start the dispensing course. And doing some supervised work in the dispensary. And the other was likely to start the dispensing course but was only working on the counter. The two experienced dispensers had agreed that they would share the supervising role to assist due to the dispensary manager leaving. They supported the newer members of the team, helped train them, and supervised and planned their work. The dispensers advised the staffing level was suitable and was working well.

The team members had records of their formal training and certificates. They did not have any records of ongoing training. They advised they had undertaken some training on topics such as Information Governance. And they read health-related magazines and leaflets on new products. They advised that the pharmacists and SI discussed any issues with them and kept them up to date with changes in legislation such as the rescheduling for gabapentin and pregabalin. The team did not have formal performance reviews but felt that they could discuss any issues with the SI. The MCAs followed the sales of medicines protocol when making over-the-counter (OTC) recommendations and referred to the pharmacist when necessary. And all the team members asked the dispensers or pharmacist if they had any queries.

There was a whistleblowing policy and telephone numbers were available, so the team members could easily and confidentially raise any concerns outside the pharmacy if needed. The newer starters advised

they would speak to the dispensers or SI if they had a concern. But they needed to read the policy and details. The pharmacy did not have any targets in place. And did not undertake services such as Medicine Use Reviews (MUR) and the New Medicines service (NMS).

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean, and suitable for the pharmacy services it provides. People can have private conversations with a pharmacist or team member in the 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 and devices 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 team members completed a cleaning rota to ensure they maintained this. They kept the floor spaces clear to reduce the risk of trip hazards. The room temperature was comfortable, and the pharmacy was well lit.

The pharmacy had a reasonable sized, signposted, sound proofed consultation room. The door had a key pad lock and the team generally kept the door closed but it was not kept locked. The team members took on board comments to ensure they locked the door due to items stored in the room. Members of the public could not access the dispensary due to the layout of the counter. There was a shutter which covered the entrance to the pharmacy from the concourse of the centre. The pharmacy pulled down the shutter when they closed. The counter was clearly observed from the dispensary and the staff were aware of customers in the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. And it displays information about health-related topics. The services are generally well managed. The pharmacy delivers medicines to people's homes. And it keeps a record of these deliveries. So, it can manage any queries effectively. The pharmacy gets it medicines from reputable suppliers and generally stores them properly. Although team members do not always accurately record the fridge temperature, so they cannot show that the pharmacy is always storing these medicines correctly.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was an automatic door into the centre and access to the pharmacy was directly from the concourse of the centre. There was some customer seating. There was a wide range of health-related leaflets and posters on display in the waiting area for people. The wall space had been well utilised and there were many posters on current and relevant topics which included a notice to encourage patients to return unwanted medication, information of several types of cancer and the recent 'love your heart' campaign. There was also a carousel unit with several leaflets for various conditions. The pharmacy had a defined professional area. And items for sale were mostly healthcare related. The pharmacy kept pharmacy only medicines behind the counter. And the team assisted people when purchasing these items. The team signposted people to their other pharmacy if they wanted their medicines in multi-compartmental compliance packs or if they wanted the smoking cessation service.

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. The team used appropriate containers to supply medicines. And used clear bags for dispensed CDs and fridge lines so the contents could be checked again, at the point of hand-out. There were some alerts stickers used to apply to prescriptions to raise awareness at the point of supply. These ensured patients received additional counselling. The team members used CD and fridge stickers on bags and prescriptions to alert the person handing the medication over that there was an item required to be added. And these also alerted the driver of the additional items needed prior to the delivery. 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 contacted prescribers if items were unobtainable at the current time for an alternative. The pharmacy kept a delivery sheet as an audit trail for the delivery of medicines from the pharmacy to patients. This included a signature of receipt of the delivery. The driver used a separate delivery sheet for controlled drugs. They passed information through the driver and asked people to contact the pharmacy if required. Or they telephoned people to pass on any information or advice regarding their medicines. The driver raised a concern that one of the people he delivered to appeared not to be at home which was unusual. He alerted the pharmacy team members present. And they were not aware that she had gone away. They checked with the surgery to see if they had any further information or if they could contact anyone to see if everything was fine.

The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. They

had the information pack which they had received and kept this accessible at the dispensing bench and checking area. The pharmacy had undertaken an audit and had kept a record of people who received valproate, using labels attached to the folder. This was in addition to the patient medication record. The team members recorded the dates when people had been counselled and been provided with the information and the risks. They advised there was an alert on the computer for valproate. And they checked their list and reinforced counselling as required.

The pharmacy generally stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. 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. But on occasions the record for the maximum temperature had been incorrectly recorded as the outside temperature reading. The records showed between 18 and 20 degrees Celsius. And no one had noticed that the readings had been outside the acceptable range. The dispenser advised she would ensure all the team knew that the acceptable range was between two and eight degrees Celsius. And that if it is otherwise, the team member should alert the pharmacist for any action. The maximum reading on the day of the inspection was six point nine degrees Celsius and another day had been five point five degrees Celsius.

The pharmacy obtained medicines from reputable sources. The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. The team members marked short-dated items and they took these off the shelf prior to the expiry date. The team members marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use. Some of the team members had an awareness of the Falsified Medicines Directive (FMD) but were not sure when the pharmacy would implement this. Some of the team members were aware of the standard operating procedures(SOPs) that the company had developed earlier in the year. But had not read any detail regarding this.

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. 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 and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people’s privacy.

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. The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It also had a range of equipment for counting loose tablets and capsules.

The pharmacy stored medication waiting collection on shelves where no confidential details could be observed by people. They clearly wrote the surname of the people in bold on the base of the bag which they could see on the shelves. This assisted in locating items. The computer screens were not visible to the public.

The team used the NHS smart card system to access to people's records. And had cordless phones which allowed them to have the conversation away for earshot of any people waiting in the pharmacy.

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.