General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medina Chemist Netherfield Ltd, 89 Victoria Road, Netherfield, NOTTINGHAM, Nottinghamshire, NG4 2NN

Pharmacy reference: 1106123

Type of pharmacy: Community

Date of inspection: 06/11/2019

Pharmacy context

This is a community pharmacy in the centre of a small town on the outskirts of Nottingham. The pharmacy is open extended hours over seven days a week. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. It also dispenses medicines to some local care homes. The pharmacy offers a delivery service to people's homes and to care homes seven days a week.

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 identifies and manages the risks associated with its services. It keeps people's private information secure and it advertises and responds to feedback about its services appropriately. The pharmacy keeps all records it must by law up to date. Pharmacy team members understand how to recognise, and report concerns to protect the wellbeing of vulnerable people. They act openly and honestly by sharing information when mistakes during the dispensing process happen. And they act to reduce risk following these types of concerns. But they do not record the outcomes of these discussions. This may mean there are some missed opportunities to share learning and measure the success of the actions taken to help reduce risk.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). These were personalised from templates provided by the 'Informacist' and 'Numark'. The range of SOPs available was expansive and covered some services which the pharmacy was not providing. The superintendent (SI) explained this had been discussed with him at a previous inspection. But he preferred to ensure all SOPs were available for information. The documented review date was February 2020. Roles and responsibilities of pharmacy team members were included. And a random sample of SOPs checked found pharmacy team members had signed those associated with their job roles. Pharmacy team members were observed working in accordance with dispensing SOPs during the inspection. And a trainee medicine counter assistant explained what tasks could and couldn't be completed if the RP took absence from the premises. The trainee was observed bringing requests for Pharmacy (P) medicines to the direct attention of the responsible pharmacist (RP) prior to completing a sale.

Workflow in the dispensary was managed well. People could present their prescriptions at two different counters which were continually monitored. There was separate space for labelling, assembling and accuracy checking medicines. A good amount of space at the back of the dispensary was available to complete tasks associated with the multi-compartment compliance pack service and care homes. This area provided a relatively distraction free environment for managing these higher-risk activities. The dispensary had allocated shelves for storing assembled medicines waiting to be checked. And pharmacy team members explained this area was used to hold managed workload associated with the prescription collection service.

The pharmacy had a near-miss error reporting procedure. Pharmacy team members explained they discussed their mistakes at the time they occurred. A notice in the dispensary reminded pharmacy team members of their responsibility in recording near misses. But they did not always record details of them. The last entry in the near-miss error record was in August 2019. Pharmacy team members were able to demonstrate how they acted upon their mistakes to help reduce risk. For example, amitriptyline and amlodipine tablets had been separated on the dispensary shelves due to the risk of picking error. And the pharmacy had adopted safe custody arrangements for tramadol modified release preparations as it had identified the risk of the wrong formulation being dispensed due to similar packaging. The pharmacy had an incident reporting procedure. The RP, who was the SI explained he had not had any reports of the pharmacy making a mistake which had resulted in a dispensing incident. He demonstrated records associated with concerns and complaints about medicines which were recorded

clearly on the Patient Medication Record (PMR) system. The system had a function to search for incidents which helped to ensure these records were available.

The pharmacy had a complaints procedure. This was clearly advertised in its practice leaflet which was available at the medicine counter. A pharmacy team member explained how she would manage a concern and refer details of the concern to the SI for further investigation and resolution. The pharmacy also advertised feedback through its annual 'Community Pharmacy Patient Questionnaire'. It published the results of this questionnaire for people using the pharmacy to see. And the RP explained how extra seating had been provided following feedback through the questionnaire.

The pharmacy had up-to-date indemnity insurance arrangements in place through Numark. The RP notice contained the correct details of the RP on duty. Entries in the RP record generally complied with requirements, there was one missed sign-out time in the sample of the record checked. The Prescription Only Medicine (POM) register generally complied with legal requirements. The most recent entry was missing the details of the prescriber and the patient's address. The SI acted immediately to complete the record. The pharmacy had a robust process for recording any emergency supplies of medicines it made. And it kept records for unlicensed medicines in accordance with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The pharmacy maintained running balances in its controlled drug (CD)register. And it completed full balance checks of all CDs weekly. The register was maintained in accordance with legal requirements. A physical balance check of MST Continus 5mg tablets found 56 tablets less than what the pharmacy had recorded in the register. The SI identified these were assembled in a multi-compartment compliance pack waiting to be checked. The dispenser who had assembled the pack explained it had been assembled the evening before and had been left out for checking. This meant the MST 5mg Continus tablets had not been stored in accordance with safe custody requirements. The SI immediately identified this as a risk and explained it would not normally be the case as packs containing CDs were normally checked immediately. He discussed limited space requirements within the CD cabinets and confirmed he would be sourcing and fitting new cabinets in response to this feedback. The SI forwarded evidence of the new cabinets which had been fitted a few days after the inspection. Several other balances of Zomorph and MST Continus preparations complied with running balances in the register. The pharmacy kept a patient returned CD register. And pharmacy team members entered returns in the register on the date of receipt.

The pharmacy stored people's personal information in staff only areas of the pharmacy. And pharmacy team members demonstrated how their working processes kept people's information safe and secure. All team members had completed some learning relating to confidentiality requirements. The pharmacy had updated its information governance procedures following the introduction of the General Data Protection Regulation (GDPR). But not all pharmacy team members had signed the procedures within the updated folder. The SI provided evidence that the pharmacy had submitted its annual NHS Data Security and Protection toolkit as required. Pharmacy team members disposed of confidential waste by using a cross shredder.

The pharmacy had procedures and information relating to safeguarding vulnerable people. Contact information for safeguarding teams was readily available for its team members to refer to. And the pharmacy advertised charities and local organisations designed to support vulnerable people. For example, a Childline support number. The RP had completed level two safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE). And he explained all pharmacists working at the pharmacy were required to complete this learning. Other members of the team had completed e-learning. Pharmacy team members were knowledgeable when explaining how they would recognise

and manage a concern relating to a vulnerable person. And examples of the pharmacy sharing concerns and working with surgery teams to help protect the safety and wellbeing of vulnerable people were provided. For example, the pharmacy had arranged to dispense some medicines to people weekly.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services effectively. The pharmacy promotes how its team members can provide feedback. And it acts on their feedback appropriately. It assists the learning needs of its team members through ongoing training. And pharmacy team members engage in conversations relating to managing their work load and patient safety.

Inspector's evidence

On duty during the inspection was the SI, two qualified dispensers, a trainee dispenser and a trainee medicine counter assistant. The pharmacy also employed another two qualified dispensers and two delivery drivers. The SI and two part-time pharmacists provided pharmacist cover. The pharmacy also employed regular locum pharmacists to cover leave when required. Pharmacy team members confirmed there was some flexibility to support cover for both annual leave and unplanned leave. And they explained pharmacists did not work without the support of a team member.

The pharmacy supported its team members in completing learning associated with their roles. For example, learning associated with national health campaigns such as children's oral health. The trainee medicine counter assistant had worked at the pharmacy for several months. She had recently been enrolled on a counter assistant course. A trainee dispenser explained she had completed the majority of training in her own time. But confirmed she received support with her learning and was confident in asking questions to support her learning when needed. She was reaching the end of her course. Pharmacy team members received an annual appraisal with the SI and some interim conversations took place when a need was identified.

The SI explained he was currently asking pharmacists to support the provision of the New Medicine Service (NMS) and Medicines Use Review (MUR) service. He confirmed there were no specific targets in place but felt these services could benefit people. Pharmacy team members supported pharmacists by identifying people who were eligible for services during the dispensing process.

The pharmacy team shared information relating to workload management and patient safety informally, through conversation rather than structured meetings. A discussion took place about how recording outcomes from these meetings could help to maximise shared learning opportunities. And assist pharmacy team members not on duty by ensuring they were up to date through reading through the learning outcomes.

The pharmacy had a whistleblowing policy in place. Pharmacy team members were confident at explaining how they would share concerns with the SI. But they were not all sure where to escalate concerns further if required, One member of the team explained how they could look on the internet. Pharmacy team members could provide examples of how the pharmacy had used their feedback to inform improvements to the dispensing workflow. For example, additional space for managing tasks associated with the care home service and multi-compartment compliance pack service had been introduced.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and maintained to the standards required. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was secure and clean. Floor spaces and work benches were free of clutter. Pharmacy team members reported maintenance concerns to the SI and local trades people were used to manage any concerns. The hand washing sink in the staff toilet was not equipped with antibacterial handwash at the beginning of the inspection. The team acted upon this and equipped the room appropriately during the inspection. Antibacterial handwash and paper towels were available at the dispensary sink.

The public area was accessible to people using wheelchairs and pushchairs. It stocked medicines and health related products. There was a clearly sign-posted consultation room. The room was a sufficient size. It was professional in appearance and offered a suitable space to hold private conversations with people. Off this room was a staff only area providing storage and toilet facilities to the team.

The dispensary had been extended considerably in recent years. Workload associated with the multi-compartment compliance pack service and care homes had helped to inform the need for this change. It was a good size and offered protected space for managing different workflows associated with the pharmacy's services. The medicine counter was located to the side of the dispensary. And this was close to the pharmacists checking station. And provided the pharmacist with a good level of supervision over activities taking place both at the counter and within the dispensary. A door led from the dispensary to a stairwell. This was kept locked between use. The first-floor level of the pharmacy consisted of store rooms which contained ex-retail stands, dispensary sundries and archived records.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy advertises its services and it makes them accessible to people. It has up-to-date procedures to support the pharmacy team in delivering its services. And its team members follow these procedures. The pharmacy obtains its medicines from reputable suppliers. And it has systems to ensure medicines are stored and managed safely and securely. Pharmacy team members take opportunities to speak to people about their health and wellbeing. And they provide people with relevant information about the medicines they are taking. But they do not routinely record the details of checks they make with prescribers and care home staff when supplying medicines. This may make it more difficult for the pharmacy to respond to a queries.

Inspector's evidence

The pharmacy was accessible from both the street and a carpark. The street level entrance provided access to the retail area and medicine counter. People entering the pharmacy from the carpark had access to a small waiting area. Designated seating was available for people waiting for prescriptions or pharmacy services. The pharmacy displayed details of its opening times and services prominently. It had a wealth of information relating to healthy living campaigns both in the public area and consultation room. For example, the NHS 'Help Us, Help You' campaign, information relating to managing blood pressure and 'tips for staying safe and steady'. The RP reflected on the outcomes of the services provided. For example, the pharmacy had engaged in a blood pressure service which focussed on identifying the risk factors of high blood pressure in the under 40's. Blood pressure results which were borderline or high were referred to their GP. The RP explained how this service had helped to detect hypercholesteremia. The pharmacy had the appropriate private Patient Group Directions (PGDs) and NHS PGDs accessible to support pharmacists delivering these services.

The pharmacy team members could explain the types of medicines which would require referral to the pharmacist. The SI explained he would provide verbal counselling about monitoring checks associated with medicines such as warfarin and methotrexate. But he did not record the details of these checks on people's medication records. The pharmacy had information and guidance to support it in managing the supply of valproate and isotretinoin to people in the high-risk group who required a pregnancy prevention plan. It had valproate warning cards available to issue to people, in accordance with the requirements of the valproate pregnancy prevention programme (PPP).

The pharmacy provided its multi-compartment compliance pack service to around 200 people at any given time. And it dispensed medicines to four care homes with a combined capacity of 120 residents. A pharmacy team member managed the supply of medicines in multi-compartment compliance packs. Other members of the team were also able to support this service. The pharmacy held records for the service on the PMR system. And the dispenser demonstrated how he checked details of the prescriptions received against this record. The dispenser explained changes to medication regimens were communicated to people verbally. But any checks made to confirm these changes were not documented. A sample of assembled packs included full dispensing audit trails. The pharmacy provided descriptions of the medicines inside to help people recognise them. And the batch number and expiry date of the medicine was also recorded. The pharmacy provided patient information leaflets at the beginning of each four-week cycle of packs. Regular medicines sent to people in the care homes were

provided in multi-compartmental compliance packs. The dispenser checked information on prescriptions against the Medication Administration record (MAR) to help identify any queries or missing items. Queries were communicated to the care homes by telephone. But the pharmacy did not keep records of these queries to support it in resolving them.

The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped to inform workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. Pharmacy team members ticked information on prescriptions and medicine packaging during their own checking processes. And they were observed checking expiry dates of medicines during the dispensing process. The pharmacy had electronic audit trails in place for its prescription collection service. This allowed it to ensure the required medicines were correctly prescribed. But it did not always chase queries about missing prescriptions or changes to medication with GP surgeries until speaking to a person about their medicine. The pharmacy kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when the medicine was later supplied. It maintained robust delivery audit trails for the prescription delivery service. People signed for their medication and carbon copy sheets were used to record this audit trail. People were provided with a copy of their delivery note.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. The SI demonstrated scanners which had been fitted to assist the pharmacy in complying with the requirements of the Falsified Medicines Directive (FMD). And he confirmed the pharmacy was registered with SecurMed. Some assembled bags of medicines on shelves in the dispensary contained barcodes. And the SI provided an oversight of the scanning tests the team had completed to date. The pharmacy was not routinely decommissioning medicines during the dispensing process as it was in the early stages of mapping its process. The SI confirmed the next review of SOPs would include FMD requirements. The pharmacy received drug alerts by email. Details of alerts were checked and acted upon in a timely manner. And the pharmacy maintained an audit trail of the alerts it had actioned.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. It also stored a range of medical devices such as nebulisers and blood pressure machines. These devices were from recognised manufacturers. The RP was observed providing counselling to people when they purchased medicines and when he handed out prescriptions. The pharmacy stored medicines in the dispensary in an organised manner and within their original packaging. The pharmacy team followed a date checking rota and a trainee dispenser was carrying out date checking tasks during the inspection. A random check of dispensary stock found short-dated medicines were highlighted. One out-of-date medicine was found during these checks, and this was brought to the direct attention of the RP. The team annotated details of opening dates on bottles of liquid medicines. The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste.

The pharmacy had secure cabinets for the storage of its CDs. Medicines inside the cabinets were stored in an orderly manner. Medicines to support the substance misuse service were stored with safety in mind. For example, different formulations of methadone oral solution were stored separately. And pre-assembled doses of methadone were stored in an organised manner. The pharmacy pre-assembled doses of methadone to help reduce the risk of workload pressure when a person attended for their medicine. The pharmacy highlighted CD prescriptions to prompt additional safety and security checks during the dispensing process. And this included highlighting the different formulations of methadone. The pharmacy's fridge was clean and stock inside was stored in an organised manner. The team checked the temperature of the fridge daily. Temperature records confirmed that it was operating

between two and eight degrees Celsius as required.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for providing its services. And pharmacy team members manage and use equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. Pharmacy team members also had access to the internet which provided them with further resources. The pharmacy protected its computers from unauthorised access by positioning them facing into the dispensary. And computers were password protected. The pharmacy held assembled bags of medicines within the dispensary. This protected people's private information on prescriptions and bag labels from unauthorised view. Pharmacy team members used NHS smart cards to access people's medication records. And they used cordless telephone handsets. The RP was observed moving to the back of the dispensary when speaking to a person over the telephone. This helped to protect the persons privacy.

The pharmacy stored some equipment for its services within the consultation room. For example, it had three blood pressure machines available. One machine had been allocated to the pharmacy as part of an NHS historic health check service. The RP confirmed blood pressure testing was for screening purposes only. And he referred people to their GP for further checks if there was any concern with the results. The pharmacy had some adrenaline autopens within the dispensary. And the RP explained how these would be made available when the flu vaccination service was provided. The pharmacy was having difficulty sourcing further stock of 500 microgram adrenaline autopens. The RP confirmed he had completed training associated with drawing up and administering adrenaline from ampoules in the event these were used. The pharmacy had clean, crown stamped measuring cylinders for measuring liquid medicines. And clean counting equipment for tablets and capsules.

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.