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: 22/08/2022

Pharmacy context

The pharmacy is in the town of Netherfield, close to Nottingham. It is open extended hours, including late into the evening. And it offers a medicine delivery service seven days a week. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines to people in multi-compartment compliance packs. And it supplies medicines to people living in care homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.2	Standard not met	The pharmacy does not encourage its team members to report mistakes they make when dispensing medicines. And there is a lack of evidence to support learning from these types of events.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.1	Standard not met	Excessive clutter on the first-floor level of the pharmacy presents a significant hazard.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy does not have adequate systems in place to manage the volume of waste medicines it handles.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy doesn’t always manage identified risks to patient safety. It does not adequately record and review mistakes the team makes during the dispensing process. This severely limits ongoing learning and it increases the risk of a similar mistake occurring. The pharmacy advertises how people can provide feedback about its services. It keeps people’s private information secure, and it generally maintains all records required by law. Pharmacy team members have the necessary knowledge to recognise and respond to safeguarding concerns.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) in place. The range of SOPs available was expansive and covered some services which the pharmacy was not providing. The current version of SOPs had been reviewed a number of times, with its latest review date overdue. The pharmacy was awaiting delivery of a new set of SOP templates for local implementation from the pharmacy support service it subscribed too. Not all team members had signed the current version of SOPs to confirm that they had read and understood them. An experienced team member shared details of how verbal feedback would be provided following a team member making a near miss. And demonstrated some actions taken to reduce risk when dispensing. For example, by highlighting higher risk medicines to reduce the risk of a picking error occurring. But the pharmacy did not encourage its team members to engage in formal processes designed to support an open and continual culture of learning. For example, pharmacy team members did not record the mistakes they made during the dispensing process. And the pharmacy had not followed formal processes for reporting dispensing incidents for some time. This meant that its team members were not always working in accordance with SOPs designed to identify and manage risk.

The pharmacy had a complaints procedure. And pharmacy team members understood how to manage feedback and escalate a concern to either the RP or superintendent pharmacist (SI). The pharmacy protected people’s confidential information through the use of password protected computers. It stored paperwork containing personal identifiable information securely, within staff-only areas of the pharmacy. But it was holding a large amount of confidential waste due to its shredders breaking down. This was separated from general waste appropriately and it was held in a secure location. But the volume of confidential waste required attention. Pharmacy team members had an understanding of how to recognise a safeguarding concern, and safeguarding reporting procedures were available. The pharmacy had signed up to the ‘Safe Spaces’ initiative during the recent pandemic to offer support to people suffering from domestic violence. And its team members had completed learning associated with the ‘Ask for ANI’ safety initiative.

The pharmacy had up-to-date indemnity insurance arrangements in place. The responsible pharmacist (RP) notice displayed reflected the correct details of the RP on duty. The pharmacy had good monitoring systems associated with recording private prescriptions and medicines supplied in an emergency at the request of a prescriber or the patient. Other pharmacy records examined were generally made in accordance with legal and regulatory requirements with some minor omissions noted. For example, team members did not always record the full details of dispensing when supplying an unlicensed medicine. And the RP did not always sign-out of the RP record as required. The pharmacy maintained running balances within its controlled drug (CD) register. And it completed regular physical

balance checks of all CDs against the register. Random physical balance checks completed during the inspection complied with the running balances within the CD register.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload. It has appropriate arrangements to support its team members learning needs. Pharmacy team members work well together. And they understand how to provide feedback about the pharmacy and can raise a professional concern if needed. But they do not engage in structured safety reviews designed to identify risk and share learning.

Inspector's evidence

On duty with the SI was a second employed pharmacist, three qualified dispensers, a pharmacy student, a delivery driver, two trainee dispensers and an administrator. The pharmacy had recently employed a new trainee dispenser, and three other drivers worked at the pharmacy. Two regular locum pharmacists provided some late night and weekend cover each week. Workload at the pharmacy had increased during the pandemic and four team members had left the pharmacy within a short space of time. In response to this the pharmacy had reviewed its staffing levels and skill mix. As a result of this review it had increased the number of hours of pharmacist support each week and it had employed new team members. Trainee dispensers were either enrolled or due to be enrolled on GPhC accredited training courses following completion of a successful induction period. But two delivery drivers had joined the team after October 2020 when the GPhC's training requirements for all support staff with a role in the supply of medicines had changed. And the pharmacy had not enrolled these team members on accredited training to support them in their role. The SI took immediate steps to speak to the team members affected and to enrol them on an appropriate training course.

Team members completed some ongoing learning associated with their roles and responsibilities. For example, reading pharmacy media publications, and keeping themselves informed of changes to pharmacy services. A qualified dispenser reflected on the learning time and support they had received whilst completing an apprenticeship qualification at the pharmacy. Pharmacy team members reported having regular conversations about their learning and performance at work. These took place as one-to-one sessions with the SI, either in person or by telephone. The pharmacy did not set specific targets related to its services. Team members reported a focus on providing services efficiently and on providing a positive experience to people using the pharmacy. The pharmacy had a whistleblowing policy and team members spoken to were aware of how to provide feedback and raise a concern about the pharmacy if needed. Several team members provided examples of how they were given the opportunity to put into practice their ideas. For example, by making improvements to stock layout in the dispensary, and by implementing new processes to monitor some aspects of record keeping. Feedback within the team was generally provided through informal discussions across the working day. Team members did not engage in structured patient safety reviews. This meant there were some missed opportunities to share learning.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy does not ensure its team members work from premises that are free from health and safety hazards. This is due to clutter in areas of the pharmacy presenting a significant hazard. The pharmacy premises are secure and the team maintains its working areas appropriately, including ensuring its private consultation space is available for people to use.

Inspector's evidence

The pharmacy's website provided helpful information about the pharmacy, including the name and address of another two pharmacies within the ownership group. But it did not contain the details of the owner or SI. And there was no information available to support people in checking the registration status of either the pharmacy or the SI. The website was not used to promote online services as the pharmacy provided all services with the exception of the medicine delivery service from the physical pharmacy premises. The premises were suitably secure against unauthorised access. The open plan public area of the pharmacy stocked health related items and toiletries. Robust plastic screening and gates clearly separated the medicine counter and dispensary from the public area of the pharmacy. A small, private consultation room was available to the side of the public area. The room was accessible to people using the pharmacy. Lighting throughout the premises was bright. And heating and ventilation arrangements were adequate. Hot and cold water was available alongside antibacterial hand wash and towels at sinks.

The pharmacy had benefitted from a refit during the pandemic. This had significantly increased the size of the dispensary and had supported the need for team members to socially distance whilst working. But some minor maintenance work was still required in some areas of the dispensary to help prevent trips and falls at work. For example, a step in the dispensary was not highlighted in any way and space to hold assembled medicines awaiting supply to care homes was not optimal. This was because team members had to carefully navigate around bags held at floor level in a corner area of the dispensary. A door off the dispensary provided access to the first-floor and second-floor level of the pharmacy. Both rooms on the first-floor were heavily cluttered with medicine waste and equipment related to the care home services. It was not possible to walk in to either room due to this clutter being several foot high. This posed a significant health and safety risk. The risk of a fire at the premises was also increased due to this clutter and the bags of confidential waste held in the second-floor office. The second floor provided office space for the pharmacy's administrator. Access to the stairwell leading to this office required navigating around items held on the first-floor landing. This could potentially prevent timely escape from the premises in the event of a fire or other adverse event.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy does not have adequate, safe provisions to support it in managing its returned and out-of-date medicines. It obtains its medicines from reputable sources. And it stores its stock medicines and assembled medicines safely and securely. The pharmacy team engage people in conversations about their health and their medicines. But it does not always supply information leaflets when dispensing medicines. This may limit the information people have available to support them in taking their medicines safely.

Inspector's evidence

The pharmacy was accessible from both the shopping 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. The pharmacy's website provided information about a range of private pharmacy services. And the website made it clear to people that these were only accessible by attending the pharmacy in person. The private services were not currently being provided as pharmacists were refreshing their learning ahead of signing a new suite of patient group directions (PGDs) to support delivery of these services.

The pharmacy stored Pharmacy (P) medicines within the dispensary and close to the medicine counter. Its team members understood how to manage requests for over-the-counter medicines subject to abuse and misuse, and when to refer a request directly to a pharmacist. Pharmacists provided verbal counselling in person or over the telephone to help people use their medicines safely. The pharmacy had information and guidance to support it in managing the supply of 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). A discussion about the specific requirements of the valproate PPP took place, and the SI was signposted to further resources to support the pharmacy team in ensuring it fully met these requirements.

Pharmacy team members used baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped to inform workload priority. Team members completed full dispensing audit trails to identify who had assembled and who had checked a medicine. The pharmacy retained prescriptions for owed medicines, and dispensed from the prescription when later supplying the owed medicine. The pharmacy held records associated with the medicines it delivered to people. This supported the team in answering any queries relating to the service.

The pharmacy made supplies of medicines to the care homes in a number of ways dependent upon the home's needs. Some care homes received medicines in original boxes, some received medicines in weekly multi-compartment compliance packs and others received the medicines via a monthly rack multi-compartment compliance system. The pharmacy supplied medication administration records (MARs) routinely when supplying medicines to people residing in care homes. This included supplying MARs electronically to one home. The pharmacy provided patient information leaflets to the care

homes when supplying medicines in original packs and upon requests from the care homes. It had some processes in place for managing queries with the care homes. For example, a team member would telephone a home to report a missing item on a prescription. But they did not generally keep a record of these queries to support them in resolving them. The pharmacy had recently assessed the workload pressures associated with providing care home services to a high number of care homes. And in response to this review it had reduced the number of care homes it supplied medicines to. A dispenser demonstrated a work schedule to help manage supply of medicines to the care homes. And they discussed how the recent review had supported the team in managing workload more effectively.

The pharmacy managed the supply of medicines in multi-compartment compliance packs through its patient medication record (PMR) system. This included checking details on prescription forms against individual medication records to identify any changes. The team generally managed changes through verbal communication with surgery teams. It did not routinely document any associated checks made when a change was identified. This meant it was more difficult for the team to show how it had managed a change should a query arise. A sample of assembled packs included full dispensing audit trails. And the pharmacy provided descriptions of the medicines inside to help people recognise them. Team members also recorded the batch number and expiry date of each medicine inside the pack on the dispensing label. The pharmacy provided patient information leaflets with some compliance packs, but these were not always provided at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It held these medicines in their original packaging within the dispensary. But storage in some areas of the dispensary was not managed well. For example, some boxes of medicines on the shelves were mixed in with boxes of different medicines due to it being some time since the dispensary was organised. And a number of medicines were scattered on the floor below dispensary shelves despite some shelves being empty. A member of the team was in the process of organising stock and it was evident this was having a positive impact on the safety of stock management. A photograph provided by the SI following the inspection showed further progress with this stock management review. The pharmacy had secure cabinets for the storage of medicines subject to safe custody. Stock medicines inside the cabinets were stored in a safe and an orderly manner. There was a small build-up of out-of-date higher risk medicines which highlighted the need for the pharmacy to organise for an authorised witness visit to allow it to safely denature these medicines. The pharmacy had two medical fridges. These were clean and stock inside was stored in an organised manner. The team checked the temperature of the fridges daily to ensure they were operating within the required temperature range of two to eight degrees Celsius. But the team only recorded the temperature of one fridge on its PMR system. Guidance was provided to support the team in creating a second temperature record on the PMR system. And the SI took the opportunity to label each fridge to ensure the records could be completed accurately moving forward. The pharmacy team completed date checking tasks periodically. But the pharmacy did not keep a record of these checks to help inform the frequency of them. A random check of dispensary stock confirmed team members highlighted short-dated medicines. And no out-of-date medicine were found during these checks. The team annotated details of opening dates on bottles of liquid medicines.

The pharmacy received details of medicine alerts electronically and the SI demonstrated how team members checked and responded to these alerts. The pharmacy had some provisions for the management of patient returned and out-of-date medicines. But the current provisions did not meet the pharmacy’s requirements. This meant there was a vast build-up of medicine waste stored in a bathroom on the first-floor level of the premises. Some of the waste was stored in carrier bags, bin bags and wholesaler totes. And it was not possible to identify what was inside each bag. The SI reported that the licensed medicine waste carrier attending the pharmacy to collect the waste would contact the team ahead of collection. Team members would then transfer medicine waste containers and bags to

the dispensary for collection. This process could not be completed without risk due to the amount of waste and restricted access into the room where it was stored.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the required equipment for providing its services. It maintains its equipment to ensure it remains fit for purpose and safe to use. And its team members use the equipment in a way which protects people's privacy.

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 could access the internet to help resolve queries and to obtain up-to-date information. The pharmacy stored bags of assembled medicines in the dispensary. This meant details on bag labels were not seen from the public area of the pharmacy. And information displayed on the pharmacy's computer monitors was not visible from the public area.

The pharmacy had a range of clean equipment available to support the delivery of its services. It identified equipment for measuring and counting higher risk medicines separately from other equipment. This helped to reduce any risk of cross contamination. Electrical equipment was subject to regular portable appliance testing checks. And a blood pressure machine in the consultation room, used for screening purposes only, was from a reputable manufacturer of medical devices.

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.