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: 07/03/2023

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 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 mostly identifies and manages the risks associated with its services appropriately. It advertises how people can provide feedback about its services. And it keeps the records required by law. Pharmacy team members know how to recognise and act on safeguarding concerns. And they engage in some learning following the mistakes they make during the dispensing process to help reduce the risk of similar mistakes occurring.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) which the superintendent pharmacist (SI) had recently reviewed. And pharmacy team members had completed learning associated with the SOPs. The pharmacy had changed access arrangements to its SOPs since the date of the last GPhC inspection in August 2022. Team members had immediate access to most core SOPs, including those related to dispensing services and controlled drug (CD) management. They could access other SOPs which were not generally required on a day-to-day basis by attending the administration office on the second floor of the building. Most of these SOPs related to services the pharmacy was not providing. But the pharmacy had filed responsible pharmacist (RP) SOPs within this secondary folder rather than its core folder. This could increase the pressure on individual RPs and team members as the SOPs were not immediately available to refer to.

Pharmacy team members engaged in learning following mistakes made and found during the dispensing process, known as near misses. Near miss records indicated consistent reporting from August 2022 until December 2022. But formal reporting had declined in recent months. Team members explained how they shared information following near misses to help reduce the risk of a similar mistake occurring. For example, a team member had recently shared learning following medicines being put back into the wrong stock box when splitting packets for dispensing. This had resulted in team members being reminded of the importance of paying particular care and attention when splitting boxes of medicines for dispensing. The pharmacy recorded mistakes found following the supply of a medicine to a person, known as dispensing incidents. It did this both locally and through a national shared learning portal. Records of these types of mistakes included investigating the root cause of the mistake and recording the actions taken to reduce the risk of a similar mistake occurring. There was evidence of periodic safety reviews to support continual learning. For example, a pharmacist had identified patterns in near misses between August and December 2022 to help support the team in implementing actions designed to reduce risk.

The pharmacy had a complaints procedure, and this was clearly advertised within its practice leaflet which it made available to people within its public area. Pharmacy team members understood how to manage feedback and escalate a concern to either the RP or SI. The pharmacy had procedures to support its team members in recognising and reporting safeguarding concerns. Learning on the subject involved reading and discussing these procedures. Pharmacists had completed some further safeguarding learning. Team members understood how to recognise a safeguarding concern. A team member confidently explained how they would respond to a situation where a person attended the pharmacy seeking support through either the ‘Safe Spaces’ or ‘Ask for ANI’ safety initiatives, designed to protect those experiencing domestic violence.

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. The team was storing some multi-compartment compliance packs awaiting accuracy checks on a worktop directly next to the public area of the pharmacy. A transparent plastic screen protected direct access to the contents, but the arrangement left information on prescription forms at risk of being seen by unauthorised personnel. A discussion about this risk led the team to act immediately to relocate the compliance packs to a more suitable location within the dispensary. Confidential waste was separated from general waste and was shredded. The pharmacy had up-to-date indemnity insurance arrangements. The RP notice displayed reflected the correct details of the RP on duty. A sample of pharmacy records including the CD register, RP register, and Prescription Only Medicine (POM) register were in good order. But the pharmacy did not always record the prescribers' details when completing certificates of conformity for the unlicensed medicines it supplied to people. The pharmacy maintained running balances within its CD register and these were generally checked against physical stock levels weekly. 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. And it has processes which appropriately support their learning needs. Pharmacy team members work well together and are supportive of each other. They understand how to provide feedback about the pharmacy and can raise a professional concern if needed.

Inspector's evidence

The RP was an employed pharmacist and was working alongside the SI and a regular locum pharmacist. Another regular locum pharmacist also worked at the pharmacy. The pharmacy support team consisted of three qualified dispensers, four trainee dispensers, an administrator, five delivery drivers and a new team member who had commenced their role as a trainee dispenser within the last week. Team members worked across the pharmacy's extended opening hours and supported in covering each other's leave arrangements.

The new team member had commenced induction learning; other trainees were enrolled on a GPhC accredited course relevant to their role. One of the qualified dispensers was undertaking some pre-learning prior to acceptance on a pharmacy technician training programme. Trainee team members were confident in seeking support from the pharmacists in relation to their learning and development. But they did not receive protected learning time during working hours. 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. Pharmacy team members reported having regular conversations about their learning and performance at work. But the pharmacy did not adopt a formal appraisal process to record these types of discussions.

Team members reported a focus on providing services efficiently and on providing a positive experience to people using the pharmacy. A pharmacist discussed some targets relating to providing the NHS New Medicine Service (NMS) and described how the team managed the service to ensure people received additional support when taking a new medicine. The pharmacy had a whistleblowing policy and team members spoken to knew how to provide feedback and raise a concern about the pharmacy if needed. Team members provided examples of how they contributed to workload management through informal daily discussions. Structured patient safety reviews took place periodically with notes from the review available for team members to refer to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and working areas are maintained appropriately. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room. The pharmacy's website does not give people all the relevant details about the pharmacy. So, this could make it harder for them to know who the superintendent pharmacist is, or to check registration details.

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 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. 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 dispensary was a substantial size. But workbench space for holding assembled medicines for people residing in care homes was limited. This meant some medicines were held in containers at floor level which was not ideal. Care had been taken to store these containers away from walkways to avoid the risk of trip or fall. A door off the dispensary provided access to the first floor and second floor of the premises. The pharmacy used two rooms on the first floor to store medical waste and equipment associated with its care home services. A third room was set up with a computer and workbenches, a team member used this room to label prescriptions associated with the care home services. The room was not currently used for any other dispensing tasks. The second floor provided office space for the pharmacy's administrator. The pharmacy stored some unused equipment and stationary awaiting disposal near a window in this second-floor room and this required attention to ensure it did not build-up and become unmanageable. A discussion with the SI highlighted the need to ensure the plans for the registered pharmacy held by the GPhC included the first-floor level of the pharmacy where labelling tasks took place.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services well are accessible to people. It obtains its medicines from reputable sources. And it generally stores its stock medicines safely and securely. Pharmacy team members complete a range of audit trails to support them in answering queries related to the pharmacy's dispensing services safely. But they are not always providing information leaflets when supplying medicines. This may on occasion limit the information people and their carers have available to support them in taking their medicines safely.

Inspector's evidence

The pharmacy had two entrances at street level, one from the town's main shopping street and one from a carpark at the back of the premises. 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. Its website had a list of services which could be accessed in the pharmacy, but the list was not accurate. This meant information on the website could potentially be misleading to people. Pharmacy team members described how they could signpost people to other healthcare providers if a person attended for a service or medicine the pharmacy was unable to provide.

The pharmacy stored Pharmacy (P) medicines within the dispensary and behind 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. The pharmacy displayed a prominent sign informing people of a pharmacists right to refuse a request for a medicine subject to abuse and misuse potential. The sign informed people that they could expect to be signposted to another healthcare provider in the event a request for a medicine was refused. 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 and valproate to people in the at-risk group in line with Pregnancy Prevention Programmes (PPPs). And its team members understood the requirements to refer prescriptions for a person within the at-risk group to a pharmacist when dispensing these medicines. There was some reliance on team members needing to check prescription forms attached to bags of assembled medicines to help them identify the need to refer to a pharmacist. The pharmacy had not engaged in audits relating to the supply of higher-risk medicines to ensure this current process was effective. The SI demonstrated pharmacist stickers available to support team members in referring to a pharmacist. But accepted team members did not routinely use these. 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. The team kept an up-to-date schedule to support it in managing the service. And team members with a role in providing the service communicated key messages about workload through a secure messaging application. The pharmacy supplied medicines to people residing in care homes in a number of ways, dependent upon the requirements of the individual care home. This included dispensing original packs and supplying medicines in multi-compartment compliance packs. The pharmacy supplied medication administration records (MARs) routinely when supplying medicines to people residing in care homes. It communicated with care home staff via NHS secure email, this supported it in keeping an audit trail of the queries made by both a care home and the pharmacy. The pharmacy supplied patient information leaflets (PILs) when supplying medicines in original packaging and for new medicines routinely. But it didn't always supply PILs to the care homes when supplying medicines in the compliance packs each cycle. One of the locum pharmacists led the care home service. This included supporting team members onsite with managing the dispensing service and liaising directly with care home staff to support them. The pharmacist provided examples of how the pharmacy's extended opening hours supported care home teams in accessing pharmacist support. For example, the pharmacist was able to provide clear information to a care home manager following a recent query relating to a missed dose of medicine.

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 managed changes through communication with surgery teams and recording the change on the PMR. 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 it didn't routinely supply these at the beginning of each four-week cycle.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It held most medicines in their original packaging within the dispensary. Medicines held outside of their original packaging were stored in amber bottles with the batch number and expiry date of the medicine recorded on the label of the bottle. But team members did not always record the date of assembly on these bottles to help inform checks that the medicine inside remained safe and fit to supply. 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. The pharmacy had two medical fridges. These were clean and stock inside was stored in an organised manner. Team members completed an electronic record to confirm each fridge was operating between two and eight degrees Celsius as required. There were some minor gaps in this record, fridge temperatures either side of the gaps had remained within the required temperature range.

Pharmacy team members recorded date checking tasks on a record within the dispensary. Pharmacists were observed checking expiry dates during their final accuracy check of a medicine and short-dated medicines were highlighted through the use of stickers. A random check of dispensary stock found one out-of-date medicine. The team highlighted some but not all liquid medicines with their date of opening. The SI acknowledged the need to remind all team members of the importance of doing this to help inform the safe supply of a medicine. The pharmacy received details of medicine alerts electronically and retained details of checked alerts. The pharmacy received weekly medicine waste collection from a licensed medicine waste carrier to support it in managing the volume of medical waste it received from care homes and members of the public. The pharmacy held the medicine waste in yellow waste bags in a room designated for this purpose.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had up-to-date reference resources available via the internet. These included the British National Formulary (BNF) and BNF for children. It stored bags of assembled medicines in the dispensary. This meant personal details on bag labels and prescription forms were not seen from the public area of the pharmacy. Information displayed on the pharmacy's computer monitors was not visible from the public area.

The pharmacy had a range of 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 as part of the NHS Hypertension Case-Findings Service, was on the list of monitors validated for use by the British and Irish Hypertension Society.

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.