General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Knights Ellbeck Harbour Pharmacy, Seaham

Primary Care Centre, St. Johns Square, SEAHAM, County Durham, SR7 7JE

Pharmacy reference: 1112185

Type of pharmacy: Community

Date of inspection: 21/07/2023

Pharmacy context

The pharmacy is in a busy medical centre in Seaham. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. Pharmacy team members provide other healthcare services to people, including the seasonal flu vaccinations and treatment for minor urinary tract infections. And they provide medicines to some people in multi-compartment compliance packs.

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 adequately identifies and manages risks associated with its services. And it has documented procedures to help it provide services effectively. Pharmacy team members understand their role in helping to protect vulnerable people. And they suitably protect people's private information. They record and discuss the mistakes they make so that they can learn from them. But they don't always document why mistakes happen and so they may miss opportunities to make improvements to the pharmacy's services.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to help pharmacy team members manage risks. The superintendent pharmacist (SI) had reviewed the SOPs in 2021. The SOPs were available to pharmacy team members electronically, but team members explained they usually referred to printed copies kept in the pharmacy. The printed copies available had last been reviewed in 2015, so they were not the most up-to-date procedures. This was discussed with the pharmacy manager, who removed the old set of procedures during the inspection and replaced them with printed copies of the most up-to-date SOPs. The manager also gave their assurance that they would remind team members about how to access the SOPs electronically. All pharmacy team members had read the current SOPs, including a new pharmacy team member, who confirmed they had read the procedures shortly after starting to work at the pharmacy. Team members explained they had signed to confirm their understanding, but these records had been sent to head office for storage. This meant there were no records available in the pharmacy confirming which team members had read and understood the SOPs.

The pharmacy's service which provided treatments for minor urinary tract infections to people was busy. Most people were referred to the pharmacy for testing and treatment by local GPs. Pharmacy team members explained how they had considered some of the risks of delivering the service to people, such as the suitability of the pharmacy's consultation room to deliver the service from, ensuring that team members had completed the necessary training, the availability of the necessary equipment, and having the correct SOPs in place. Team members did not know if these assessments had been written down to help them manage emerging risks on an ongoing basis. The pharmacy had a patient group directive (PGD) which provided the legal framework for the service. But the copy of the PGD available in the pharmacy had expired in March 2023. The pharmacist explained they were confident that a new PGD was in place, and that this was usually dealt with by the pharmacy's head office. They gave their assurance that they would obtain a copy of the most up-to-date document immediately.

Pharmacy team members highlighted and recorded near miss and dispensing errors they made when dispensing. There were documented procedures to help them do this effectively. They discussed their errors and why they might have happened. And they used this information to make some changes to help prevent the same or similar mistakes from happening again. For example, separating and highlighting gabapentin and pregabalin on the shelves, to help prevent the wrong medicines being selected. Pharmacy team members did not always capture enough information about why mistakes had happened or the changes made to prevent a recurrence to help aid future analysis and learning. But they gave their assurance that these details were always discussed. The pharmacy's assistant manager analysed the data collected every month to look for patterns. They recorded their analysis. And

pharmacy team members discussed the patterns found at a monthly patient safety briefing.

The pharmacy had a documented procedure in place for handling complaints or feedback from people. Pharmacy team members explained that people usually provided verbal feedback. Any complaints were immediately referred to the pharmacist to handle. The pharmacy displayed a poster, which included information about how people could provide the pharmacy with feedback.

The pharmacy had up-to-date professional indemnity insurance in place. It kept accurate controlled drug (CD) registers, with running balances in most registers. Pharmacy team members audited these registers against the physical stock quantity every week. But the pharmacy did not maintain a running balance in its methadone register, so any stock irregularities may be overlooked. The pharmacy kept and maintained an accurate register of CDs returned by people for destruction. It maintained a responsible pharmacist (RP) record. But the record had frequent gaps in the sign-out time of the RP, which compromised the accuracy of the record. The pharmacist displayed their RP notice. Pharmacy team members monitored and recorded fridge temperatures daily. They kept accurate private prescription and emergency supply records.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags, which were collected regularly and taken for secure destruction. The pharmacy had a documented procedure in place to help pharmacy team members manage sensitive information. Pharmacy team members explained how important it was to protect people's privacy and how they would protect confidentiality. A pharmacy team member gave some examples of signs that would raise their concerns about vulnerable children and adults. And how they would refer their concerns to the pharmacist. The pharmacy had procedures for dealing with concerns about children and vulnerable adults. Pharmacy team members completed mandatory safeguarding training every year.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the right qualifications and skills for their roles and the services they provide, or they are completing appropriate training. They complete ongoing learning to keep their knowledge up to date. Pharmacy team members feel comfortable discussing ideas and issues. And they use feedback to make effective changes to improve their environment and the way they work.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the regular responsible pharmacist (RP), a locum pharmacist, a pharmacy technician, three qualified dispensers, four trainee dispensers, one of which was the pharmacy manager, a foundation trainee pharmacist, a trainee medicines counter assistant, and a pharmacy student on a summer work placement. The pharmacy manager explained there had been a significant turnover of staff recently. The pharmacy had struggled to recruit qualified team members to replace the team members who had left. So, it had recruited unqualified team members and was in the process of training them. The manager was confident that the pharmacy was able to provide its services well, at the same time as training the new team members.

Pharmacy team members undertook ongoing training regularly by completing training modules sent by head office. Or they completed modules available on the NHS Electronic Learning for Health platform. Training on sepsis had recently been completed. Team members explained how they also read various reading materials received in the pharmacy and discussed topics together. The pharmacy did not have an appraisal or performance review process for team members. Team members explained they would raise any learning need informally with the pharmacist or experienced colleagues, who would teach them or signpost them to appropriate resources.

Pharmacy team members felt comfortable sharing ideas to improve the pharmacy's services. One recent example had been a change to help improve the way the pharmacy processed and prepared multi-compartment compliance packs for people, to help them more easily track the progress of packs at each stage of the dispensing process. Pharmacy team members explained they would raise professional concerns with the pharmacist, manager or area manager. They felt comfortable raising concerns and confident that concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy, and team members were clear about how to raise concerns anonymously.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services it provides. And it has a consultation room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. And the benches where medicines were prepared were generally tidy and well organised. The pharmacy's floors and passageways were free from clutter and obstruction. The pharmacy kept equipment and stock on shelves throughout the premises. It had a private consultation room, which was clearly signposted, and pharmacy team members used the room to have private conversations with people. There was a clean, well-maintained sink in the dispensary used for medicines preparation. There was a staff toilet, with a sink which provided hot and cold running water and other facilities for hand washing. The pharmacy kept its heating and lighting to acceptable levels. Its overall appearance was professional and suitable for the services it provided.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy team members manage and provide the pharmacy's services safely. The pharmacy suitably sources its medicines. And it stores and manages its medicines appropriately. The pharmacy's services are accessible to people, including people using wheelchairs. It has processes in place to help people understand and manage the risks associated with some higher risk medicines. But team members do not always supply people receiving their medicines in compliance packs with information leaflets to help them take their medicines in the safest way.

Inspector's evidence

The pharmacy had level access from the street through automatic doors. Pharmacy team members explained how they would communicate in writing with people with a hearing impairment. And they could provide large-print labels and instruction sheets to help people with a visual impairment.

The pharmacy sent most prescriptions to the company's off-site dispensing hub for people who required their medicines in multi-compartment compliance packs, where medicines were picked and assembled by a dispensing robot. Dispensers generated labels to be printed and attached to packs at the hub. The prescriptions and labels were clinically and accuracy checked by the pharmacist against the pharmacy's master records, then submitted to the hub to be prepared and dispensed. When the pharmacy received the completed packs back from the hub, pharmacy team members married up the packs with the relevant prescriptions and any medicines that had been prepared in the pharmacy, such as items that could not be placed in the packs such as creams and insulin. Then they added the bags to the prescription retrieval shelves ready for collection or delivery. The hub attached backing sheets to the packs, so people had written instructions of how to take their medicines, which included descriptions of what the medicines looked like, so they could be identified in the pack. But the pharmacy did not routinely provide people with patient information leaflets about their medicines each month. They only provided leaflets to people when their medicines were newly prescribed.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on dispensing labels during dispensing. This was to maintain an audit trail of the people involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if they were at risk. They checked if the person was aware of the risks if they became pregnant while taking the medicine. And whether they were on a pregnancy prevention programme and using effective contraception. The pharmacy had stock of some information materials to give to people to help them manage the risks of taking valproate. The pharmacist explained how the pharmacy had completed an audit of people who received valproate from the pharmacy approximately two years ago, but it had not completed a more recent audit.

Pharmacy team members attached labels to bags of dispensed medicines that contained a unique barcode. When they were ready to store a completed prescription bag on the retrieval shelves, they scanned the barcode using a hand-held device. The information on the device was linked to the electronic patient medication records system. Pharmacy team members chose a location to store the bag. And they scanned the barcode attached to the location and placed the bag on the shelf. When people came to collect their medicines, pharmacy team members entered their details into the hand-

held device. The device then told them where the bags were stored. Pharmacy team members marked the bag as collected and a record was made of the time and date of collection. They explained that the system helped to prevent bags kept in different locations being missed and people leaving without all their prescription medicines. For example, if part of their prescription was being stored in the fridge or the controlled drugs cabinet as well as on a shelf. Pharmacy team members also explained that the system helped them to identify if a patient had forgotten to collect a prescription previously. The pharmacy delivered medicines to people, and it recorded the deliveries it made. The delivery driver left a card through the letterbox if someone was not at home. The card asked people to contact the pharmacy.

The pharmacy obtained medicines from licensed wholesalers. It had disposal facilities available for unwanted medicines, including CDs. Team members monitored temperatures in two pharmacy fridges each day and recorded their findings. The temperature records seen were within acceptable limits. But some team members did not know how to reset the thermometers to make sure they recorded the minimum and maximum fridge temperatures over 24 hours. This was discussed with the pharmacy manager, who agreed to provide further training for team members to ensure temperatures were recorded accurately. Team members recorded checks of medicine expiry dates every three months. Pharmacy team members highlighted and recorded any short-dated items up to three months before their expiry with a sticker on the pack. They relied on people noticing highlighted packs while dispensing to remove them before they expired. No out-of-date medicines were found on the shelves when these were randomly checked, and several packs were highlighted with stickers. The team discussed implementing a monthly stock expiry record to help prevent medicines expiring before they were noticed and removed. Pharmacy team members responded to any alerts or recalls they received about medicines from manufacturers and other agencies. Team members removed any affected medicines from the shelves, and they recorded the actions they had taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And the team manages and uses the equipment in ways that protects the security of people's private information.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources it had available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had a set of clean, well-maintained measures available for medicines preparation. It had secure facilities to collect confidential waste. And it kept its password-protected computer terminals in the secure areas of the pharmacy, away from public view.

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.