General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Synergise Pharmacy, 56 Yarm Lane, STOCKTON-ON-TEES, Cleveland, TS18 1EP

Pharmacy reference: 1116088

Type of pharmacy: Community

Date of inspection: 07/02/2020

Pharmacy context

This pharmacy is on a main road on the edge of the town centre. It is open 100 hours a week. And it is open seven days a week. It dispenses NHS and private prescriptions and sells over-the-counter medicines. And offers advice to people on their medicines and healthcare. The pharmacy provides a substance misuse service to several people. It supplies a few people with medicines in multi-compartment compliance packs. This supports them to take their medicines. The pharmacy supplies medicines to several care homes in the area.

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 has procedures to identify and manage risks to its services. And pharmacy team members follow them to complete the required tasks safely and effectively. They know how to protect the safety of vulnerable people. The pharmacy provides people with the opportunity to feedback on its services. The pharmacy's team members record and learn from errors and mistakes during the dispensing procedure. But the reviews they undertake are often verbal and written reports lack information. So, they may be missing out on learning opportunities. The pharmacy generally looks after people's private information. And it mostly keeps all the records as required by law, in compliance with standards and procedures.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs). These provided the team with information to perform tasks supporting delivery of services. They covered areas such as the drug and alcohol service, care homes, dispensing of prescriptions and controlled drugs (CD) management. The pharmacist superintendent (SI) was in the process of reviewing these. He had completed some which had a review date of 27 January 2020. The team members were reading and signing these when read, as the SI completed them. The majority of the previous versions had been from November 2017.

The pharmacy had four computer terminals. It had one dedicated to the methadone Methameasure system, one for general dispensing and two for the preparation of the prescriptions for the care homes. It was in the process of obtaining another computer terminal for the homes process due to the pending increase in the level of business with homes. The pharmacy workflow provided different sections for dispensing activities with dedicated benches for assembly and checking. There was a dedicated area for preparing the homes. The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used different colours of baskets, with green for the homes, blue for the substance misuse prescriptions and red for collections. They placed any prescriptions for people waiting in the pharmacy at one side and the team members dispensed these straight away.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The pharmacist recorded these on a specific template. Examples included prednisolone 5mg with the wrong quantity, but the amount not specified. And lansoprazole orodispersible with the wrong form and amitriptyline 10mg instead of 5mg. The pharmacist was starting to get team members to record their own near miss errors. The team members advised they discussed near miss errors as they occurred and had held briefings. But had not had one since the end of last year. The pharmacy kept limited documentation following briefings. The team members had formed a Whats App group and shared some information such as near miss errors. But they normally used this for arranging staff working hours. The pharmacy had a practice leaflet and a notice displayed in the pharmacy which explained the complaints process. The pharmacy gathered feedback through the annual patient satisfaction survey. The results displayed had generally positive comments. There was information available to people about the complaints process. The pharmacy had a complaints reporting procedure which the team followed. The pharmacy had current indemnity insurance with an expiry date of 26 November 2020.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist generally

completed the responsible pharmacist records as required. On some occasions the pharmacist had forgotten to make an entry, but the next pharmacist had left a gap for the pharmacist to complete the entry when they were next working. The pharmacy maintained the CD registers electronically. The pharmacy usually checked CD stock against the balance in the register at the time of dispensing for solid medication. And undertook stock balance checks weekly, including for methadone. This helped to spot errors such as missed entries. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy maintained a book for CDs which people had returned for disposal. There had been some recent returns within the last week. The team member had put the date of return on the bag. But they had not recorded the details in the register. The pharmacy undertook few private prescriptions. It recorded these electronically. And these were in order. It kept special records for unlicensed products with the certificates of conformity completed as required.

The pharmacy displayed a privacy notice which explained how it kept confidential data and how it complied with legislation. The team had read General Data Protection Regulation (GDPR) information. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions safely. It generally kept information securely but had left a vaccination form on the table in the consultation room. No one had accessed the room. And it did not store any confidential information in the consultation room. The pharmacy team stored confidential waste in separate containers for offsite shredding. The pharmacy had a safeguarding SOP for the protection of vulnerable adults and children. The team had all read this and signed as read. The SOP did not have the contact details completed in the relevant spaces for local safeguarding teams. The pharmacist advised he had some details available but would add to the SOP for completeness. The pharmacist had undertaken level 2 Centre for Pharmacy Postgraduate Education (CPPE) training for safeguarding.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe and effective services. The pharmacy team members are suitably trained or working under supervision during training. They understand their roles and responsibilities in providing services. 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, three dispensers, an apprentice and a student who worked in the pharmacy. There were four regular pharmacists who covered the hours the pharmacy was open. The superintendent pharmacist generally worked four days a week, with some cover by other pharmacists in the evenings. And the other three pharmacists worked on Mondays , the weekend and some evenings. Two of the dispensers had completed training and one had started the course, online, at the end of October 2019. The SI advised he had taken an apprentice due some new care home business which he advised should commence in the next few months. He advised by July the pharmacy would be providing to an additional eight homes with 350 beds in total. The apprentice had only worked on month and the pharmacy had applied for the Buttercups training course for her to start. He felt that by July she would be able to undertake tasks as required. And this would help manage the anticipated workload.

One dispenser worked 22 hours weekly and the other two worked 39 hours weekly. The student worked 20 hours a week and the apprentice 32 hours. The team members worked additional hours to help out if required. The pharmacist advised that due to the extended hours there was sufficient staffing. And at quieter times there were few interruptions which meant the workload was suitably managed. The student had worked for nearly three months at the pharmacy and the SI advised he would enrol her on a suitable course to comply with GPhC requirements. One of the dispensers was undertaking the dispensing accuracy checking course with a view to check items for the homes. The pharmacist had completed training through the National Pharmaceutical Association (NPA) for the Meningococcal Meningitis ACWY vaccinations for people undertaking pilgrimages.

Team members described how they read through magazines and leaflets from suppliers and other third parties. They did not record any training from articles read. They did not receive structured training time. But when the pharmacy was quiet, they said they could take the training time, as and when they needed it. The pharmacy did not keep records of any ongoing training undertaken. One of the dispensers was taking over responsibility for performance reviews but the pharmacy had not yet established the process. The team members had informal discussions and two of the team were undertaking a needle exchange training course. Another member of the team was doing training for the Healthy Living Pharmacy. The team advised that they discussed issues and pharmacy matters when working in the pharmacy and the pharmacist kept them up-to-date. One of the other dispensers was taking responsibility for the rotas and other human resource tasks.

The team carried out tasks and managed their workload in a competent manner discussing any issues which arose and dealing with any telephone queries. They referred to the pharmacist when people

asked for advice on matters outside their role. The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacists or the superintendent (SI). There was a formal whistleblowing policy and telephone numbers were available so the team members could easily and confidentially raise any concerns outside the pharmacy if needed. The team advised there was an independent director they could contact if they had concerns.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are of a suitable size for the services it provides. The pharmacy is clean and suitably maintained. And it has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean and fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines and devices waiting for collection. The benches, shelves and flooring were all clean and the pharmacy followed a cleaning rota to ensure the team maintained this. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. The room temperature was comfortable, and the pharmacy was well lit. The sink in the dispensary for preparation of medicines was clean. And the pharmacy had separate hand washing facilities in place for the team. The room with the toilet had some damp patches but the owner was monitoring this and acted to suitably maintain the area and refreshed the paintwork as required.

The pharmacy had a separate room which people could access from the side of the building for the substance misuse service. The pharmacy team could see people entering the room and attend to them. In addition, the pharmacy had a separate good sized, signposted, sound proofed consultation room which the team used. There was a notice about the chaperone policy asking people if they would like a family member or chaperone present. The consultation room door had a lock, but the team members did not keep this locked.

The pharmacy had some low stands in front of the dispensary, at the side of the medicine counter to prevent people entering. The team could easily see people coming into the pharmacy. And attended to them as required.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. And it displays some information about health-related topics. It gets its medicines from reputable suppliers. If the pharmacy receives an alert that a medicine is no longer safe to use, the team takes the correct action to return it to the supplier. The pharmacy generally stores medicines well. The team members usually follow processes and mostly complete required audit trails to assist in safe delivery. The pharmacy team doesn't always supply patient information leaflets with packs. So, the most up-to-date and relevant information may not be available for people.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all. The side room used for the substance misuse service was accessible from the street to people using it. There was a bell on the main door and on the side room door which alerted the team to people entering. The team could also see people entering the side room on CCTV. There was some customer seating. The pharmacy displayed its services in the window and within the pharmacy. The hours of opening were on the window. The pharmacy had a practice leaflet with information relating to services and opening hours available for people to self-select. It displayed a range of healthcare information with some posters and leaflets available. It had a display table for people to select leaflets on topics such as minor aches and pains and coughs and colds. It had a section of pharmacy medicines which it kept behind the medicine counter. The team members assisted people if they wanted to purchase these items. The pharmacist spoke Urdu and conversed with people to provide advice.

The pharmacist offered the Meningococcal Meningitis ACWY vaccinations with certificates through Patient Group Directions (PGDs). He explained that this service had limited uptake, but he had provided it for the community. The team members signposted to other healthcare services such as Emergency Hormonal Contraception (EHC) if people wanted this service free of charge through the PGD. The pharmacist had not completed the training for this service.

The pharmacy provided a needle exchange service and supplied around 30 packs daily to people. It encouraged returns. The pharmacy provided the Community Pharmacist Consultation Service (CPCS). People accessed the CPCS service through NHS 111 referrals. The CPCS linked people to a community pharmacy as their first port of call. This could be for either the urgent provision of medicines or the treatment or advice for a minor illness. It had a few people who attended the pharmacy. Most had resulted in sales such as paracetamol for a child and ibuprofen to supplement the paracetamol.

The pharmacy supplied medicines to six people in multi-compartment compliance packs to help them take their medicines. The pharmacist advised he only undertook this service if the doctors requested it. The doctors carried out the assessments for people wanting to have their medication supplied in compliance packs. There was one pack completed for supply to the person. The team had not completed ‘dispensed by’ and ‘checked by’ boxes during the dispensing process. The pharmacist advised that they generally did but this was something he would improve. The team did not always supply people who received their medicines in compliance packs with patient information leaflets (PILs).

The pharmacy provided services to five care homes with 200 beds in total. The pharmacy used an electronic system. This produced electronic medicine administration records (MARs). The pharmacy

team worked about three weeks ahead for the preparation for the homes. The pharmacy supplied all medicines to the homes in original packs. If the pharmacy used a spilt pack it usually did not provide a PIL. But the pharmacist advised the homes had a file with PILs. And if it was a new item the pharmacy provided a PIL. He demonstrated that the system was fully auditable. The system linked to the homes, with electronic medicine administration charts and these showed when the homes had administered doses, providing a complete live up-to-date record. The audit system used was “base Camp” and the pharmacist demonstrated how it showed when the pharmacy required to do tasks. The pharmacy scanned items and labels using the system. Once the home had ordered prescriptions, the pharmacy checked to make sure they had all the prescriptions for the next supplies. The homes ordered all the prescriptions and they chased up any required prescriptions. The system was suitably managed and organised within the pharmacy. The pharmacy only delivered to the homes. And kept robust records of items sent through the systems facilities. It booked out all items electronically. And scanned item out to the driver using the bar codes. And through the system the pharmacy could see that the homes had scanned the items in when they received them.

The pharmacy provided a substance misuse service for methadone and buprenorphine to a large number of people. Around 95% of the people using the service received their supply supervised daily. A few people took a week’s supply away. The pharmacy used the Methameasure system for the methadone and followed a SOP for this process. People came into the room and waited for their supply. The buprenorphine was labelled using the system and supplies made up at the time they attended. The pharmacist tended to leave a box of each of the strengths buprenorphine on the bench by the Methameasure system ready for supplies and did not always return the original boxes in to the CD cabinet.

There was an audit trail of the dispensing process. The team mostly completed the ‘dispensed by’ and ‘checked by’ boxes which showed who had performed these roles. The pharmacist advised that the newer members sometimes forgot to initial the label, but he was reinforcing this. The team members used appropriate containers to supply medicines. And they used clear bags for dispensed CDs and fridge lines so they could check the contents 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. The pharmacist added these to remind the team that a pharmacist required to provide additional counselling with the medication. When the pharmacy could not provide the product or quantity prescribed in full, patients received an owing slip. And the pharmacy kept a copy with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers if items were unobtainable to ask for an alternative. The pharmacy team were aware of the valproate Pregnancy Prevention Programme. The pharmacy had undertaken an audit and had no people in the at-risk group receiving this medication. The pharmacy had the purple folder with the booklets and additional warning cards available to provide to people. It had highlighted the shelves with the stock to raised awareness to check.

The pharmacy used recognised wholesalers such as AAH, Alliance, Colorama and OTC. The pharmacy was aware of the requirements for the Falsified Medicines Directive (FMD). It had scanner in place and was accredited by SecurMed. But was not using it yet. 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 and they checked these to ensure the refrigerator remained within the required temperature range. The pharmacy team checked expiry dates on products and had a rota in place to ensure they checked all sections regularly. The team members marked short-dated items with a highlighter pen, and they took these off the shelf prior to the expiry date. The team members put labels on bottles of liquid

medication when they opened the bottle. And marked the date of opening. This allowed them to check to ensure the liquid was still suitable for use.

The team used appropriate medicinal waste bins for patient returned medication. The contents of the bins were securely disposed of via the waste management contractor. The pharmacy had appropriate denaturing kits for the destruction of CDs. The pharmacy received drug safety alerts and recalls directly from the Medicines and Healthcare products Regulatory Agency (MHRA). The team printed these off and signed them once they had actioned them.

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 used the Methameasure system and the methadone was kept in the unit with the door to this locked . The team cleaned and calibrated the Methameasure daily. It had measures marked for methadone use, water for antibiotics and one for morphine. It also had a range of equipment for counting loose tablets and capsules. The team members had access to disposable gloves and alcohol hand washing gel.

The pharmacy stored medication waiting collection in boxes in the dispensary. So, people could not see any confidential details. The team filed prescriptions in boxes in a retrieval system out of view, keeping details private. The computer screens were out of view of the public. The team used cordless phones for private conversations.

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.