General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Higherland Pharmacy, 3 Orme Road, NEWCASTLE, Staffordshire, ST5 2UE

**Pharmacy reference:** 1117887

**Type of pharmacy:** Community

**Date of inspection:** 17/01/2024

## Pharmacy context

This community pharmacy is located within a medical centre. Most people who use the pharmacy are from the local area and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it sells a small range of over-the-counter medicines. It supplies some medicines in multi-compartment compliance aid packs to help people take their medicines at the right time.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

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 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 generally manages risks to make sure its services are safe, and it keeps the records required by law. Members of the pharmacy team are clear about their roles and responsibilities, and they understand how they can help to protect the welfare of vulnerable people. The pharmacy has written procedures on keeping people's private information safe. But confidential information is not always stored appropriately which could risk breaching people's confidentiality.

### Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided, which some members of the pharmacy team had signed to show they had read and understood them. Two of the newer members of the pharmacy team had not indicated that they had read the SOPs, so there was a risk that they might not fully understand the pharmacy's procedures. They both agreed to read the SOPs as a priority. One of them explained that the RP had been through the pharmacy's procedures with him when he first started working there, and he asked if he wasn't sure. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their roles. Team members were not wearing uniforms or anything showing their role, so people might not be able to easily identify them or tell who was responsible for what. The name of the responsible pharmacist (RP) was displayed. An additional RP notice was also on display with a different pharmacist's details, which might cause confusion in the event of a problem or query. This was removed when pointed out.

The pharmacy team completed patient safety incident reports when dispensing errors occurred and learning was shared with the team. For example, following an incident when Edoxaban 60mg was dispensed instead of Etoricoxib 60mg, the RP encouraged team members to always take a mental break before carrying out the accuracy check, especially when the pharmacy was busy and team members were rushing. Near misses were discussed with the team member responsible and they were encouraged to reflect on the mistake. There was a near miss log, but this was not routinely completed and there were no documented reviews, so additional learning opportunities might be missed.

A dispenser described how he would deal with a customer complaint which was to attempt to resolve the situation himself, but he said he would escalate it to the pharmacist or pharmacy superintendent (SI) where necessary. There was an SOP for dealing with complaints, but there was nothing on display showing the complaint procedure or the details of who to complain to, so people visiting the pharmacy might not know how to raise a concern or leave feedback. Professional indemnity insurance arrangements were in place.

The RP had forgotten to sign in as RP, but he completed the entry when it was pointed out. Otherwise, the RP record appeared to be in order. Private prescriptions and emergency supplies were recorded electronically. Some entries of private prescriptions were incomplete as they did not include the prescriber's details. The RP agreed to remind the team to add the prescriber's details when dispensing private prescriptions. The controlled drug (CD) registers were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately.

The pharmacy had SOPs on information governance which included information about confidentiality and data protection. Assembled prescriptions and paperwork containing patient confidential information were not always stored appropriately to avoid people's details being seen by members of the public. Confidential waste was collected in a designated place and then sent to another pharmacy owned by the same company for disposal by a third-party company. A dispenser correctly described the difference between confidential and general waste.

The pharmacy had SOPs on safeguarding and there was a safeguarding folder which contained the contact details of who to report concerns to in the local area. A dispenser explained that he would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. The RP had completed level three training on safeguarding. He said he would keep a record of any concerns and contact the safeguarding lead for the area. The RP did not know if the pharmacy had a chaperone policy. He said that he would offer a chaperone if he felt it was necessary. But there was nothing on display indicating this, so people might not realise this was an option. The pharmacy team had been trained on domestic abuse and 'Safe Spaces,' and the RP confirmed that the consultation room was always available for anyone requiring a confidential conversation.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff to manage its workload and they complete the essential training they need to do their jobs. But ongoing training is not well organised and does not happen regularly, so the team's knowledge may not always be fully up to date. Team members are comfortable providing feedback to their manager and they receive informal feedback about their own performance.

### Inspector's evidence

The RP, two NVQ2 qualified dispensers, a trainee dispenser and a delivery driver were on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection and the team members were observed working collaboratively with each other and people who visited the pharmacy. Planned absences were organised so that no more than one person was away at a time. Absences were covered by re-arranging the staff hours or transferring staff from a neighbouring pharmacy. The RP was a locum pharmacist who had worked at the pharmacy for several years, and currently worked two days each week at the pharmacy. The other days were usually covered by locum pharmacists. The SI occasionally worked at the pharmacy. There was a trainee dispenser from a neighbouring pharmacy, who was helping our for a few months as the workload had increased. The trainee dispenser said he didn't dispense CDs or medicines requiring refrigeration and asked other team members if he wasn't sure about something.

Members of the pharmacy team carrying out the services had completed appropriate training and some certificates were on display. The pharmacy team could access training resources electronically and were given training time if they requested it when the pharmacy was quiet. But there wasn't a structured approach to training and development, and team members were not given formal appraisals. The pharmacy team discussed issues as they arose and received feedback informally from the RP and SI. A dispenser said he felt there was an open and honest culture in the pharmacy and said he would feel comfortable talking to the SI about any concerns he might have. He felt comfortable admitting errors and felt that learning from mistakes was the focus. There was a whistleblowing policy.

The RP said he felt empowered to exercise his professional judgement and could comply with his own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because he felt it was inappropriate. He said he was not under any pressure to achieve targets whilst working at the pharmacy.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy generally provides a suitable environment for people to receive healthcare services. It has a private consultation room so people can have conversations with team members in private. But the lack of space affects the working conditions and detracts from the professional image of the pharmacy.

### Inspector's evidence

The pharmacy premises were reasonably clean and in an adequate state of repair, but the pharmacy was very small, and the space was limited. The premises consisted of a waiting area with one chair, a small consultation room and a dispensary. There were notices on display informing people that only two people were allowed into the pharmacy at a time, due to the lack of space, and people sometimes had to queue at the door. Stacks of empty tote trays were in the waiting area ready to be collected by wholesalers, but this further reduced the area. The RP said there was a large waiting area in the medical centre which people could use. The temperature and lighting in the pharmacy were adequately controlled. Maintenance problems were reported to medical centre who owned the building. The entrance into the pharmacy was from the medical centre and people were served via a hatch into the car park when the medical centre was closed in the evenings. The RP confirmed that the consultation room was used when people needed a private area to talk. It was very cramped and it was being used for storage, which compromised the professional image. And there was nothing to highlight the availability of the consultation room, so people might not realise there was an option for a private conversation. There was a dispensary sink for medicines preparation with hot and cold running water. Hand sanitizer gel was available. The pharmacy team used the Staff facilities in the medical centre which included a kitchen area and WCs with wash hand basins.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy offers a small range of healthcare services which are easy for people to access. Services are generally well managed, so people receive appropriate care. The pharmacy sources, stores and supplies medicines safely. And it carries out some checks to ensure medicines are in good condition and suitable to supply.

### Inspector's evidence

The pharmacy was accessible to everyone, including people with mobility difficulties and wheelchair users. There was a ramp and an automatic door into the medical centre. Services provided by the pharmacy and its opening hours were not displayed, so people might be unclear about these. There was a couple of posters promoting healthy living. For example, weight loss and stop smoking. There was a home delivery service with an electronic audit trail. The delivery driver used an App to confirm deliveries. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was very limited in the dispensary, but the workflow was organised into separate areas with a designated checking area. The dispensary shelves were reasonably well organised, neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. The RP said he added a note to prescriptions if he needed to counsel people about them. He was aware of the requirements for a Pregnancy Prevention Programme to be in place and that people who were prescribed valproate should have annual reviews with a specialist. The RP said an audit had been carried out and he did not think the pharmacy currently had any patients in the at-risk group. Pharmacy team members were aware that original packs should always be supplied when dispensing valproate to ensure people receive the appropriate information and counselling.

Multi-compartment compliance aid packs were reasonably well managed. There was a partial audit trail for changes to medication in the packs, but it was not always clear who had confirmed these and the date the changes had been made, which could cause confusion in the event of a query. The dispenser assembling the packs didn’t always initial the packaging, so there was an incomplete dispensing audit trail, which could limit learning if something went wrong. A dispenser confirmed packaging leaflets were usually included so people were able to easily access additional information about their medicines. Disposable equipment was used. The RP said only people who had been referred by their GP would generally receive their medicines in packs. He assumed the GP carried out an assessment as to the suitability of a compliance aid pack before referring them. The RP said the pharmacy was at full capacity and could not take on any new compliance pack patients, due to shortage of space.

There was a small number of over the counter (OTC) medicines including pharmacy (P) medicines on shelves behind the counter behind. A dispenser explained what questions he asked when making a

medicine sale and he knew when to refer the person to a pharmacist. He was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if he suspected a customer might be misusing medicines such as a codeine containing product.

CDs were stored in a CD cabinet which was securely fixed to the wall. The keys were under the control of the responsible pharmacist during the day. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits, usually on the same day they were returned due to lack of space in the CD cabinet.

Recognised licensed wholesalers were used to obtain stock medicines and appropriate records were maintained for medicines ordered from 'Specials.' Medicines were stored in their original containers at an appropriate temperature. The dispensary was split into numbered sections to enable date checking to be carried out in an organised way, but the dispenser who usually did this was not present and other team members didn't know if she recorded it. Dates had been added to opened liquids with limited stability. Expired and unwanted medicines were segregated and placed in designated bins.

Alerts and recalls were received via email messages from the NHS area team, which all team members could access. But the dispenser who usually dealt with them was not present and it was not clear if she retained them or recorded her actions. The RP agreed to review this procedure, so the team were clear where to find the relevant information going forward. The team members knew that they could check some details on the Medicines & Healthcare products Regulatory Agency (MHRA) website.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

### Inspector's evidence

The RP could access the internet for the most up-to-date reference sources. For example, the electronic British National Formulary (BNF) and BNF for children. There was a large clean medical fridge for storing medicines. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. It also contained a memory card, so the previous temperatures were recorded electronically. All electrical equipment appeared to be in working order. There was a small selection of clean glass liquid measures with British standard and crown marks. One measure was marked and used for CDs and another for water. The pharmacy had a range of clean equipment for counting loose tablets and capsules. The trainee dispenser explained that cytotoxic drugs such as methotrexate were obtained in foil strips so there wasn't a need to handle them. But he said he would designate a separate counter, which he would wash and label, if he was required to count cytotoxics which were not in foil strips. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy. Most people using the pharmacy were patients from the medical centre. The pharmacy had two phone lines, one was a dedicated line between the medical centre and pharmacy to ensure communication was always possible.

## 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. |