General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Queens Park Surgery, Farrer Street, STOCKTON-ON-TEES, Cleveland, TS18 2AW

Pharmacy reference: 1119575

Type of pharmacy: Community

Date of inspection: 12/07/2024

Pharmacy context

The pharmacy is in the Queens Park Medical Centre in the market town of Stockton-on-Tees. It changed ownership earlier in 2024. It dispenses NHS prescriptions and sells some over-the-counter medicines. It has some of its prescriptions assembled by an offsite dispensing hub pharmacy to help with the workload. The pharmacy offers services including the NHS New Medicines Service (NMS) and the NHS Pharmacy First Service. And it offers seasonal flu vaccinations. The pharmacy team provides medicines in multi-compartment compliance packs to help some people take their medicines at the right time. And it delivers medicines to people's 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 suitably identifies and manages risks with its services. It has written procedures relevant to its services and team members follow these to help them provide services safely. Pharmacy team members learn and improve from mistakes. They keep people's confidential information secure. And they know how to identify situations where vulnerable people need help. They mostly keep the records required by law.

Inspector's evidence

The pharmacy had electronic standard operating procedures (SOPs). These included for dispensing, Responsible Pharmacist (RP) regulations and controlled drug (CD) management. Not all staff had completed reading and signing all of the new company's SOPs, but records showed that the team members were progressing with this. These electronic learning records allowed the pharmacy team leader, who managed the pharmacy, to see an individual's progress with reading the SOPs as well as other training so they could support team members with what to prioritise.

The pharmacy team recorded near miss errors electronically, and from the records seen, this was done regularly throughout the month. These errors were ones identified before people received their medicines. It was the RP's or team leader's responsibility to record these errors and the team member who made the error corrected it. This meant they had the opportunity to reflect on what had happened. The team leader completed a documented analysis of these errors monthly and shared the findings with the team in informal meetings. They had identified one source for errors was due to medicines being stored on the shelves in a disordered way. To improve this, each team member was allocated a particular area in the dispensary to keep tidy, clean, and complete date-checking activities. The stock on shelves appeared tidy and ordered during the inspection. The pharmacy recorded and reported dispensing errors online to the pharmacy's superintendent team. These were errors that were identified after the person had received their medicines. The team leader discussed a recent dispensing error during the inspection and the approach taken by the pharmacy to try to prevent the same or similar errors happening again. This involved separating some similar looking medicines out on the shelves, so that one was not confused for the other.

The pharmacy had a procedure for dealing with complaints. The team aimed to resolve any complaints or concerns locally. If they were unable to resolve the complaint, they escalated it to the area manager. The team leader shared a recent example of a complaint which was dealt with locally and how the pharmacy team had received refresher training on labelling certain medicines with shorter shelf lives. People could also submit complaints and concerns directly to the company's head office.

The pharmacy had current professional indemnity insurance. The Responsible Pharmacist clearly displayed their RP notice, so people knew details of the pharmacist on duty. Team members knew what activities could and could not take place in the absence of the RP. A sample of RP records checked during the inspection were found to meet requirements. The pharmacy kept its private prescription records electronically within the dispensing system. These did not always have the correct prescriber details recorded. The importance of maintaining accurate records was discussed during the inspection. A sample of the CD registers checked met legal requirements. The team completed weekly checks of the running balance in the register against the physical stock. A random balance check against the

quantity of stock during the inspection was correct. The pharmacy kept a register of CDs returned by people, and there were recent records of these returns being destroyed.

Pharmacy team members understood what to do to keep people's personal information safe and they separated confidential waste from general waste using designated confidential waste bags. These were stored sealed in a staff area at the back of the premises before being collected monthly by a third-party company to be destroyed. The company had a data protection policy, and it provided annual data protection training for team members. The RP had completed level 3 safeguarding training. Team members gave examples of signs that would raise concerns about the welfare of vulnerable people, and they knew what action to take if they did have such concerns. Key safeguarding contact information was displayed within the consultation room. There was a chaperone policy in place.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they support each other in their day-to-day work. Pharmacy team members know how to raise concerns, if needed. And they have opportunities to complete ongoing training so they can develop their knowledge.

Inspector's evidence

At the time of the inspection, the RP was a locum pharmacist. They were supported by a team that consisted of four qualified dispensers and one trainee dispenser. Other team members that were not present during the inspection were two qualified dispensers and two pharmacy students from local pharmacy schools. A regular locum pharmacist worked at the pharmacy two days per week. The team rota was arranged so that team members undergoing training worked with the regular pharmacist for extra support and supervision. During the inspection, there were some busy periods, and the team were observed to be calmly managing the workload throughout. The skill mix of the team appeared appropriate for the nature of the business and the services provided. A delivery driver worked part-time, five days a week at the pharmacy.

Team members had access to a variety of online training modules, some of which were mandatory, including the SOPs. They completed training during the working day when time allowed, with some parts of the week being more conducive to this than others. The RP had completed some self-directed training to allow them to deliver the NHS Pharmacy First service. Pharmacy team members asked appropriate questions when selling medicines over the counter. They gave examples of when they would involve other team members to help and were observed during the inspection referring appropriately to the RP.

Team members appeared to work well together. And they communicated effectively to plan and handover key tasks as the inspection was going on. They also made use of written handover communications. This helped ensure team members were kept informed of current priorities. This was important as some team members did not regularly work together due to the pharmacy’s extended opening hours. Team members felt supported discussing their mistakes openly and described a recent example, including how other members of the team responded positively to help prevent such mistakes happening again. The team had some performance related targets to achieve, and the team leader was comfortable discussing these targets with their manager if they were challenging. Team members knew how to raise concerns if necessary. The pharmacy had a whistleblowing policy and team members were aware of this.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and generally provide a suitable environment for the services provided. And the pharmacy has a consultation room to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy had a good-sized area with some seating for people to wait. There were entrances from the street and from the medical centre. The pharmacy counter provided a barrier to prevent unauthorised access to staff-only areas of the pharmacy. The dispensary was an adequate size for the workload being undertaken, with sufficient bench space for all team members to work and walkways kept as clear as possible to minimise trip hazards. The layout of the dispensary, with a central island where the RP stood, supported the supervision of medicines sales and queries. The lighting and temperature were suitable to work in and to provide healthcare services. The dispensary had a sink with access to hot and cold water for professional use and hand washing. There were staff and toilet facilities that were hygienic. There were some waste medicines in a designated waste bag kept in the staff toilet. This was removed and relocated during the inspection after a discussion with the pharmacy team leader.

The pharmacy had a private consultation room which could be accessed via a lockable door from the retail area and the dispensary. It was large enough for two seats, a desk, and a sink. But a significant amount of files and paperwork cluttered the room which detracted from the professional appearance. This was discussed during the inspection.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy sources its medicines from recognised suppliers. And it generally stores and manages them appropriately. Pharmacy team members complete regular checks to ensure medicines are suitable for supply. And they respond appropriately when they receive alerts about the safety of medicines. Team members appropriately manage the delivery of services safely and effectively.

Inspector's evidence

The pharmacy had ramped access from the street and level access from the medical centre to allow people with mobility issues to enter safely. And the retail area was free of any obstructions. The pharmacy team had the ability to provide people with large print medication labels, if they required it. The pharmacy provided a medicines delivery service during weekdays. People contacted the pharmacy to inform them a prescription was due and to request delivery. When these prescriptions were received and assembled, the team checked them off in their records. This allowed the pharmacy team to keep an audit trail of the prescriptions they were expecting. The assembled bags of medicines for delivery were stored separately, and the driver scanned barcodes on each bag to enter them on to an online delivery application. This then organised their route and provided an audit trail for the deliveries made. The driver returned any failed deliveries back to the pharmacy on the same day.

Some people had their medicines dispensed into multi-compartment compliance packs. Two team members mainly managed these, and a third was being trained for contingency. Team members ordered people's prescriptions seven days in advance of the pack being due, which allowed enough time to receive the prescriptions back, order any necessary stock and deal with any queries. The pharmacy used a record for each person that listed their current medication, dosage, and dose times. This was referred to throughout the dispensing and checking of the packs. From a sample of packs checked, the full dosage instructions, warnings, and medication descriptions were included. A team member explained patient information leaflets (PILs) were supplied for newly prescribed medicines. The importance of including a PIL with every supply of medicine was discussed during the inspection, and the team agreed to include these monthly.

The pharmacy sent a large proportion of its prescriptions to be assembled at an offsite hub pharmacy. The RP completed a clinical check of these prescriptions on the patient medication record (PMR) system. And there was an accuracy check of the data inputted before it was submitted to the hub pharmacy for assembly. The pharmacy annotated prescriptions that were assembled at the hub and filed them awaiting delivery from the hub. The annotations also made it clear which medicines on these prescriptions needed to be dispensed locally. There were safeguards in the system to ensure only non-urgent repeat prescriptions were sent to the hub pharmacy. And the team recalled prescriptions for dispensing locally, where there became an urgent need. Scanning of barcodes meant people didn't receive duplicate supplies when this happened.

The pharmacy team dispensed prescriptions using baskets, which kept prescriptions and their corresponding medicines separate from others. Pharmacy team members signed dispensing labels during dispensing and checking. This maintained an audit trail of team members involved in the process. The team used stickers to highlight if a prescription contained a fridge item, to ensure correct storage temperatures were maintained. The team was observed using other similar stickers when

dispensing for higher-risk medicines which highlighted to the RP to provide advice and counselling. The team regularly used other stickers for blood pressure checks and for repeat dispensing when the current issue of a prescription was the last of the batch. When the pharmacy could not entirely fulfil a prescription first time, team members created an electronic record of what was owed on the PMR system. And they gave people a note detailing what was owed. This meant the team had a record of what was outstanding to people and what stock was needed. The team checked outstanding owings as a regular task, and were managing these well, despite some long-term supply issues. A member of the pharmacy team described how they worked well with other local health providers, including the nearby GP Out of Hours service. This included proactively notifying prescribers at the service if the pharmacy had run out of commonly prescribed items, such as antibiotics. This was to improve the experience of people accessing the service and to avoid duplicating work for the prescriber and pharmacy team.

The pharmacy had a procedure for managing the checking of expiry dates of medicines. Team members highlighted short-dated medicines when they conducted date-checking tasks. They checked the sections of the dispensary they were responsible for and recorded when the expiry dates of medicines in a section had been checked. This ensured that the team had an audit trail of expiry dates checked. Medicines with a shortened expiry date on opening were marked with the date of opening, to ensure the team could check on suitability to supply. The pharmacy kept unwanted medicines returned by people in segregated containers, while awaiting collection for disposal.

The RP showed a good understanding of the requirements of dispensing valproate for people who may become pregnant and of the recent safety alert updates involving other medicines with similar risks. The team dispensed prescriptions in the manufacturer's original packs. And it had patient cards and stickers available to give to people if needed. The team leader acknowledged written interventions were not always recorded on each dispensing. But they understood the benefits of doing so for people's care.

The pharmacy obtained medicines from licensed wholesalers and specials manufacturers. It held medicines requiring cold storage in two medical fridges equipped with thermometers. Team members monitored and recorded the temperatures of the fridge daily. These records showed cold chain medicines were mostly stored at appropriate temperatures. There had been some recent temperatures recorded above the acceptable range and action had been taken with the pharmacy's head office. A check of the thermometer during the inspection showed temperatures within the permitted range. The pharmacy had a documented procedure for responding to drug safety alerts and manufacturer's recalls. It received these via email from the company's head office. A team member demonstrated recent examples of alerts that had been received and actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Team members use the equipment in a way that protects people’s private information.

Inspector's evidence

Pharmacy team members had a range of hard-copy and electronic reference materials available to them, via the internet. There was equipment available for the services provided which included otoscopes, a digital thermometer, and a blood pressure monitor. The pharmacy also had an ambulatory blood pressure monitor. Electrical equipment was visibly free from wear and tear and appeared in good working order. The pharmacy had a range of clean counting triangles and CE marked measuring cylinders for liquid medicines preparation. The team used separate equipment when counting and measuring higher-risk medicines.

The pharmacy's computers were password protected and access to people's records was restricted by the NHS smart card system. Computer screens were protected from unauthorised view and a cordless telephone was available for private conversations in a quieter area. The pharmacy stored completed prescriptions and assembled bags of medicines away from public reach in a restricted area.

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.