General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newmarket Pharmacy, 155 Newmarket, LOUTH, Lincolnshire, LN11 9EH

Pharmacy reference: 1123906

Type of pharmacy: Community

Date of inspection: 25/07/2019

Pharmacy context

The pharmacy is next to a GP surgery on the edge of a town centre. It sells over-the-counter medicines and dispenses NHS and private prescriptions. It offers advice on the management of minor illnesses and long-term conditions. It supplies medicines in multi-compartmental compliance packs, designed to help people remember to take their medicines. 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 has systems in place to help identify and manage the risks associated with its services. It responds appropriately to the feedback it receives. And it keeps people's private information secure. Pharmacy team members have the skills required to respond to safeguarding concerns. They act openly and honestly by sharing information when mistakes happen. The pharmacy generally keeps all records it must by law. But some gaps in these records occasionally result in incomplete audit trails. This could make it difficult for the pharmacy to show exactly what has happened should a problem arise.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). These included responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The latest version had been reviewed in January 2019 and contained details of a two-year review date. The SOPs set out the roles and responsibilities of staff. Pharmacy team members confirmed reading and signing SOPs. But training records were not available at the time of inspection. The pharmacy manager, who was new in post, provided copies of training records for all staff shortly after the inspection after liaising with a company director. The team were observed completing tasks in accordance with dispensing SOPs throughout the inspection. A member of the team explained what tasks could and couldn't be completed if the RP took absence from the premises. And the pharmacy manager, who was an accuracy checking technician (ACT), explained the circumstances she undertook an accuracy check of a medicine.

The dispensary was a sufficient size. Separate areas on work benches were used for labelling, assembly and final accuracy checking. And high-risk dispensing activities, such as assembling multi-compartmental compliance packs were completed in an area of the dispensary out of view of the public area. This limited the risk of distraction during the dispensing process.

Pharmacy team members discussed their own near-miss errors with the pharmacist. Although near-misses were recorded, the records did not contain details of contributory factors or actions taken to prevent similar mistakes occurring. Pharmacy team members explained how they shared details of re-occurring near-misses and acted to reduce risk following these discussions. For example, the pharmacy team had separated medicines in similar packaging on the dispensary shelves to reduce the risk of picking error during the dispensing process. The pharmacy used an electronic programme to record details of dispensing incidents to the superintendent pharmacist's team. Records provided clear details of the incident which occurred. But, the pharmacy did not record learning points and actions routinely. Pharmacy team members could demonstrate the actions they had put in place following discussing these types of mistakes. For example, the team had moved pregabalin and gabapentin to two separate areas of the dispensary following an incident.

The pharmacy had a complaints procedure in place. But at the time of inspection it was not advertising how people could provide feedback. It did display results from its latest 'community pharmacy patient questionnaire'. And a member of the team explained how she would manage and escalate a concern if required. The pharmacy had shared learning following a trend in feedback relating to NHS prescription fines. Pharmacy team members now acted to check each exemption status and ensure the clinical

system held the correct exemption details before submitting claims for prescriptions dispensed through the Electronic Prescription Service (EPS).

The pharmacy had up to date indemnity insurance arrangements in place. The RP notice contained the correct details of the RP on duty. A sample of the responsible pharmacist record found four missed entries. But it was found that some entries were made on an electronic record rather than directly into the pharmacy's manual record. A discussion took place about the need to ensure all locum pharmacists were aware of the company's processes for maintaining the responsible pharmacist record. The pharmacy also maintained both a manual and electronic private prescription record. Entries examined generally met legal requirements. But the date of prescribing was inaccurate within a couple of entries. The pharmacy also recorded emergency supplies of medicines electronically. But did not always record the nature of the emergency when making an emergency supply at the request of a patient. The pharmacy kept certificates of conformity relating to unlicensed medicines. But a few records required completing with details of who the unlicensed medicine had been supplied to.

The sample of the controlled drug (CD) register examined was generally compliant with legal requirements. But the pharmacy did not always enter the address of the wholesaler when entering receipt of a CD. The register was maintained with running balances and the pharmacy checked these against physical stock several times a month. The RP was investigating three balance discrepancies at the time of inspection following a routine stock check. These were found. And the RP notified the inspector of improvement actions involving checking balances after assembling multi-compartmental compliance packs containing CDs following her investigation. Physical balance checks of several morphine preparations were carried out and complied with the balance in the register. The pharmacy maintained a CD destruction register for patient returned medicines. And the team entered returns in the register on the date of receipt.

The pharmacy displayed a privacy notice. It had some information governance procedures and pharmacy team members understood the requirements of the General Data Protection Regulation (GDPR). The pharmacy stored person identifiable information in staff only areas of the premises. It held some information in its consultation room. But this was not on open display and the pharmacy did have measures in place to prevent unauthorised access into the room. The pharmacy had submitted its annual NHS information governance toolkit. The pharmacy team disposed of confidential waste in designated bags. These were collected by a company director for centralised secure disposal periodically.

The pharmacy had procedures and information relating to safeguarding vulnerable people in place. Pharmacy team members had read procedures and explained they covered safeguarding during their training. They explained clearly how they would manage a safeguarding concern. And the pharmacy had access to contact details of local safeguarding teams. The RP had completed level two safeguarding training. She provided an example of how the pharmacy worked to safeguard the welfare of a person requiring support with their medicines.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and knowledgeable people working to provide its services and to manage its workload effectively. It has some systems in place for supporting the learning needs of its team members. The pharmacy encourages feedback from its team members and supports them in applying their professional judgement. Pharmacy team members engage in regular conversations relating to safety and service delivery. But they do not always record the key outcomes of these discussions. This means members of the team not on duty at the time may miss out on some opportunities to share learning.

Inspector's evidence

On duty at the time of the inspection was the RP (a regular locum pharmacist), the pharmacy manager (ACT), a qualified dispenser, a trainee dispenser and a delivery driver. The pharmacy also employed another trainee dispenser. The pharmacy had recently reviewed its staffing levels and skill mix. The pharmacy's previous manager provided some housekeeping support to the pharmacy.

Pharmacy team members did not receive protected learning time. But the trainee dispenser confirmed she felt supported in her role. There was some encouragement towards completing continual training. For example, some members of the pharmacy team were completing healthy living training. The pharmacy team received regular updates about pharmacy services and changes through one of the directors. Trainee dispensers had received a six-month performance and development review. But other pharmacy team members had not received a formal appraisal within the last few years.

The pharmacy team was friendly and engaged people in conversation about their health and wellbeing. The RP explained how she contributed to targets relating to services such as Medicine Use Reviews (MURs) and New medicines Service (NMS). She stated she was happy to undertake services and was observed to be well supported by the team.

The pharmacy team shared information through daily informal discussions about workload, reading emails and engaging in conversations about patient safety. The team held staff meetings to discuss changes or new processes. But the pharmacy did not record details of these discussions to encourage reflection and review of the actions discussed. The pharmacy had a whistleblowing policy in place. Pharmacy team members explained they would feedback to the manager or a director in the first instance. And felt able to contact the superintendent pharmacist directly too. They explained they were encouraged to implement their ideas and were confident in doing so. For example, the RP and trainee dispenser had met with a local practice manager to discuss the timely receipt of prescriptions relating to the multi-compartmental compliance pack service. This had been prompted by a concern from the team after it had deviated from SOPs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and maintained to the standards required. The pharmacy has a consultation room designed to maintain the privacy of people accessing the pharmacy's services.

Inspector's evidence

The premises were clean, secure and well maintained. The pharmacy team members reported maintenance concerns to one of the directors. And the pharmacy used local tradespeople to fix any issues. The pharmacy had air conditioning and lighting throughout the premises was bright. It had designated hand washing sinks equipped with antibacterial soap and towels.

The public area had wide spaced aisles. It was modern and welcoming. A signposted consultation room was accessible to one side of the area. The room was beyond a tape barrier from the public area which restricted unauthorised access. During the inspection, the pharmacist used the room after a person requested a private conversation. The room provided a suitable space for holding private conversations with people. But at the time of inspection it held some old computer equipment, this did distract from the professional environment of the room.

The dispensary was an adequate size for the level of activity taking place and work benches were clear between use. Pharmacy team members dispensed acute and managed workload in the front section of the dispensary. They used the back section for work associated with the delivery service and multi-compartmental compliance pack service. The team were storing a few baskets on the floor in the back of the dispensary at the beginning of the inspection. The team moved these to a work bench following a discussion about the potential risks of storing medicines in baskets at floor level. To the side of the dispensary was a door which led to staff toilet facilities and a small store room. The pharmacy used the storeroom to hold medicine waste and dispensary sundries.

Principle 4 - Services ✔ Standards met

Summary findings

Pharmacy services are accessible and effectively managed. The pharmacy obtains its medicines from reputable sources. And it has systems in place to help ensure these medicines remain fit for purpose. But the pharmacy does not always supply information leaflets when dispensing medicines. This means people may not have all the information required to help them take their medicine safely. And the pharmacy does not always store medicines within their original packaging. This means it may be difficult to trace these medicines if a query arises.

Inspector's evidence

The pharmacy was accessed from street level through a push/pull door. Pharmacy team members explained how they would go to the door to assist people who may struggle to push the door open. Parking was available at the front of the pharmacy. The pharmacy advertised details of its opening times and services. Pharmacy team members understood how to signpost people to other pharmacies or healthcare providers in the event they could not provide a service. The pharmacy provided seating for people waiting for prescriptions or services. It advertised healthy living guidance. But pharmacy team members explained they did not get much engagement with these campaigns.

The pharmacy team were aware of the risks associated with the supply of high-risk medicines. And a dispenser discussed the requirements of the valproate pregnancy prevention programme (PPP). The pharmacy had high-risk warning cards ready to issue to people in the high-risk group. And it highlighted valproate preparations on the dispensary shelves to prompt additional checks during the dispensing process. The pharmacy highlighted prescriptions for CDs and its team members could explain the validity period of a CD prescription and discussed checks made at the point of handout to a person. Pharmacists managed counselling of other high-risk medicines. But they did not record details of any monitoring checks made or advice provided on people's medication records. This meant it could be difficult for the pharmacy to demonstrate how it was supporting people on these medicines.

The pharmacy had a robust system for ordering and monitoring the receipt of prescriptions for the multi-compartmental compliance pack service. One pharmacy team member led the service with others trained to support the service. For example, to help cover leave. Individual profile sheets were in place for each person on the service. And changes to people's medication regimens were dated on these sheets. But records did not always clearly document the verbal checks made with surgery teams to confirm these changes. A sample of assembled packs contained full dispensing audit trails. And the pharmacy provided descriptions of the medicines inside the packs to help people identify their medicines. But the pharmacy did not routinely supply patient information leaflets (PILs) with packs. A discussion took place about the legal requirement to supply a PIL each time the pharmacy dispensed a medicine.

The pharmacy used baskets throughout the dispensing process. This kept medicines with the correct prescription form. Acute prescriptions were brought to the direct attention of the pharmacist. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team kept original prescriptions for medicines owing to people. The team used the prescription throughout the dispensing process when later supplying the medicine.

It maintained delivery audit trails for the prescription delivery service and people signed to confirm they had received their medicine. The pharmacy used separate delivery records to record deliveries of CDs. And it used cool bags to store cold chain medicines sent out for delivery.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. Pharmacy team members demonstrated some awareness of the aims of the Falsified Medicines Directive (FMD). The pharmacy had received scanners and were aware that processes to comply with FMD were in development. But the team did not know when these would be implemented. The pharmacy received drug alerts through email and acted on these. The pharmacy team printed the alerts. And these were kept for reference purposes.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. This meant the RP had supervision of sales taking place and was able to intervene if necessary. The pharmacy did not always store medicines in the dispensary in an organised manner. For example, some medicines had fallen into others and required organising. There were also several boxes of medicines which contained more than tablets than the original pack size indicated. A closer inspection of these packets found multiple brands of the medicine stored inside. This risked these medicines being missed during routine date checks and when the pharmacy carried out checks after receiving a drug alert. And it may increase the risk of dispensing errors. The pharmacy team followed a date checking rota to help manage stock. Short dated medicines were identified. The team annotated details of opening dates on bottles of liquid medicines. No out-of-date medicines were found during random checks of dispensary stock. The pharmacy had medical waste bins and CD denaturing kits available to support the team in managing pharmaceutical waste.

The pharmacy held CDs in secure cabinets. It stored out-of-date CDs in a separate cabinet to stock. There was a substantial number of out-of-date CDs and patient returned CDs. The pharmacy had transferred patient returned CDs to a denaturing kit to save space in the cabinet and reduce the risk of these medicines being mixed up with out-of-date medicines. But the contents of the kit had not been mixed with water to render the CDs irretrievable. The RP acted immediately to do this following a discussion about the risks of storing returns in this way. The out-of-date CDs did not impact on the storage room for other CDs but did impact on the time taken to do balance checks of the register. A discussion took place about the need to apply to the NHS CD accountable officer for an authorised witness to attend the pharmacy to witness the denaturing of these out-of-date medicines. The pharmacy held stock CDs and assembled CDs in an orderly manner within cabinets. Pharmacy team members could explain the validity requirements of a CD prescription and demonstrated how CD prescriptions were highlighted to prompt additional checks during the dispensing process.

The pharmacy's fridges were clean and stock inside was stored in an organised manner. But the pharmacy did store food and milk in one of the fridges. It managed this risk by storing the food and drink in a drawer, away from medicine at the bottom of the fridge. Temperature records confirmed that the fridges were operating between two and eight degrees Celsius as required.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the equipment it needs for providing its services safely. And it checks equipment to ensure it remains in working order. Its team members use equipment with care to ensure people's private information is kept secure.

Inspector's evidence

The pharmacy had up-to-date written reference resources available. These included the British National Formulary (BNF) and BNF for Children. The internet provided the team with further information. Computers were password protected and computer monitors faced into the dispensary. Pharmacy team members used NHS smart cards to access people's medication records. The pharmacy stored assembled bags of medicines to the side of the dispensary. This protected people's private information against unauthorised view. The pharmacy team members used cordless telephone handsets when speaking to people over the telephone. This meant they could move out of ear-shot of the public area when having confidential conversations with people over the telephone.

Clean, crown stamped measuring cylinders were in place for measuring liquid medicines. The pharmacy had clean counting equipment for tablets and capsules, and this included a separate triangle for use with cytotoxic medicines. Pharmacy team members assembled medicines into single-use multi-compartmental compliance packs and gloves were accessible to staff assembling these packs. The pharmacy's electrical equipment was subject to portable appliance testing. Stickers on equipment showed these checks had last been carried out in June 2018.

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.