General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newline Pharmacy, Dereham Terrace, Choppington, Northumberland, NE62 5UR

Pharmacy reference: 9010517

Type of pharmacy: Community

Date of inspection: 12/04/2023

Pharmacy context

This is a busy pharmacy in the village of Stakeford in Northumberland. Its main activities are dispensing NHS prescriptions and providing some people with medicines in multi-compartment compliance packs to help them take their medicine correctly. It provides services such as the NHS urinary tract infection treatment service and a substance misuse service. It delivers medicines to people in their homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	4.3	Standard not met	The pharmacy does not manage and store all its medicines as it should. This includes storing its medicines outside of manufacturer's packs inadequately labelled. And the process the team follows for checking expiry dates is not robust.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy mostly identifies and manages the risks associated with its services. And it keeps the records it must by law. Team members discuss and record errors so they can learn from them and to reduce the risk of the same error happening again. They understand their responsibilities to keep people's personal information secure and they know how to help protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to help guide team members to work safely and effectively. These were kept on paper and were in the process of being transferred to an electronic format. The team members each had access to the new electronic SOPs. But the manager explained that while some team members had looked at the new SOPs briefly, they had not yet signed them to confirm their compliance and understanding of them. The SOP folder did not contain the responsible pharmacist (RP) and controlled drug (CD) SOPs. These were later found to be kept separately which may mean team members would struggle to know where to find a particular SOP if required. From the sample seen, the paper SOPs had been last reviewed in August 2021 by the superintendent (SI) pharmacist but there was no indication as to whether team members had reviewed their understanding of the SOPs at that time. However, the manager explained that a SOP was reviewed each week by the trainee medicines counter assistant (MCA) and any learnings from this shared with the team. For example, team members had recently reviewed the SOP for the sales of medicines protocol after a learning opportunity was identified by the manager when the trainee MCA was selling a product over the counter.

The pharmacy team members recorded errors made and identified in the dispensing process known as near misses. The RP recorded the near miss on paper. However, details of the action taken was sometimes not recorded which may mean that team members miss opportunities to learn from the error. Team members explained how they discussed the errors together as a team at the end of the week. And they made and implemented suggestions to try and prevent the same error occurring again. For example, they separated medicines known as look-alike and sound-alike (LASA) on the dispensary shelves and added warning stickers to the shelf to guide team members to pay closer attention to quantities. Team members also recorded errors identified after a person had received their medicine, known as dispensing incidents. Records showed that a recent dispensing incident had been investigated and reported to the patient's GP and to the SI who reviewed the incident.

Team members had clearly defined roles and responsibilities and they supported each other to complete tasks. The trainee MCA was seen asking other team members for help and advice where necessary. Team members understood what could and could not be carried out in the absence of the RP. The RP notice was prominently displayed in the retail area and reflected the correct details of the pharmacist on duty. The manager explained the MCA helped to ensure the correct notice was always displayed. The pharmacy had a documented complaints procedure which directed people to raise complaints or concerns with a team member. The pharmacy also had a form for people to feedback about their experiences in the pharmacy. The pharmacy had current professional indemnity insurance.

The pharmacy kept both paper and electronic records. RP records were kept on paper and from the sample seen were completed correctly. It kept paper records for CDs, and from the sample seen these

complied with regulations. Team members carried out weekly checks of the stock held against the running balance in the register. Random sampling of two medicines confirmed the quantity of stock held matched the quantity in the register. The pharmacy kept records of patient returned CDs with entries recorded as recently as March. The pharmacy kept records of supplies of unlicensed medicines known as “specials”, but some certificates were missing the details of the prescriber.

Pharmacy team members were aware of their responsibilities for keeping people’s private information secure. The pharmacy practice leaflet explained to people that the pharmacy complied with the Data Protection Act. Team members had also completed compulsory General Data Protection Regulation (GDPR) training. The manager explained confidential information was kept separately and shredded on site. They had undergone training regarding their responsibilities for safeguarding vulnerable adults and children. And they explained they would refer to the pharmacist in the first instance if they had any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained and qualified team members who work well together to manage the workload. And trainee team members receive suitable support and supervision. Team members regularly share learnings with one another. And they discuss their performance in formal meetings to help them improve their working practice.

Inspector's evidence

The pharmacy had a regular locum RP, a dispenser who was also the manager, a second dispenser and a trainee medicines counter assistant working at the time of the inspection. Team members further included an employed pharmacist, another dispenser, and a part-time delivery driver. There was a vacancy advertised for a dispenser. The pharmacy was busy and there were many prescriptions waiting to be checked, but team members were seen to be working effectively together to complete tasks and manage workload. And they were seen referring to the pharmacist for help and advice where necessary.

The trainee was working as an MCA and undertaking a level two pharmacy services assistant apprenticeship. The manager explained that he received coaching daily. The trainee MCA was seen referring to more experienced team members for help and advice when selling medication and when processing patient returned medicines. He was aware of his responsibilities to identify and refer repeated requests for medicines liable to abuse to the responsible pharmacist. But he explained it was something he had not yet encountered. Team members explained they received monthly company training and information on new products from pharmaceutical company representatives to improve their knowledge.

Pharmacy team members had received appraisals, with the most recent being completed in December 2022. They discussed their action plan of what they could do better going forward. The trainee MCA received regular in the moment appraisals of his performance. The team members regularly shared learnings with each other during their breaks such as increases in prescription charges and discussed knowing to signpost people to a palliatve care pharmacy. The pharmacy did not routinely set targets.

Principle 3 - Premises ✔ Standards met

Summary findings

Overall, the pharmacy is clean and hygienic. And it has appropriate spaces for people to have private conversations and to access services. The premises are of a suitable size but some areas are cluttered and slightly untidy. This may increase the risk of errors.

Inspector's evidence

The pharmacy premises were generally clean and free from trip hazards. Team members explained that the pharmacy was cleaned as and when required. The pharmacy was somewhat untidy and cluttered in some areas. The front retail area was spacious for people waiting to access services. The dispensary had separate benches for the completion of different tasks and despite there being large volumes of dispensed medicines in baskets on the benches, waiting to be checked, this was relatively organised. The pharmacist had a separate checking bench which was situated so that they could intervene in conversations at the medicines counter if necessary. Team members could make use of additional bench space on an island in the middle of the dispensary if necessary.

The pharmacy had three clinical consultation rooms. Of these three rooms, two were used for storage and one was used as a soundproofed space where people could have private conversations with team members and access services from the pharmacist. And all three rooms were secured when not in use. The pharmacy had a separate room where people could access services such as the supervision of medicines. This room was accessed via a separate external door and provided privacy for those accessing the service. The room was situated adjacent to the dispensary and there was a screen which provided security for team members and prevented unauthorised access to the dispensary.

The dispensary was situated to the rear of the premises which provided privacy for dispensing activities. The medicines counter provided a barrier preventing unauthorised access to the dispensary. There were screens on the medicines counter which provided additional security for team members. There was a sink in the dispensary which provided hot water for hand washing and cold water for professional use. And the sink area was clean and tidy. Further sinks with hot and cold water were available in the toilet and consultation room. There was central heating, and the temperature was ambient throughout.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not adequately store and manage all its medicines as it should. And there is a risk that people may receive medicines that are not suitable to use. The pharmacy provides a range of services to support people's healthcare needs. And overall it manages and delivers its services well.

Inspector's evidence

The pharmacy had a step free entrance from the street which allowed ease of access for people, including those with limited mobility and with pushchairs. The pharmacy provided a range of services, including NHS services. The RP explained people could seek advice and treatment for urinary tract infections (UTI), and receive seasonal influenza vaccinations. Pharmacy team members explained that patient group directions (PGDs) for NHS services such as the UTI service and seasonal flu vaccination service were accessed on an electronic system called PharmOutcomes and any records for this service were captured there. The pharmacy had a practice leaflet which provided information to people about the services provided. The pharmacy delivered medicines to people's homes. The driver asked people to sign to confirm the delivery of CDs. And any failed deliveries were returned to the pharmacy and a note left through the door.

The pharmacy's main activity was to dispense NHS prescriptions. And it dispensed some medicines into multi-compartment compliance packs to help people take their medicines safely. Each person had a separate storage location for their pack to help prevent them from becoming mixed with another person's pack. The pharmacy provided a service supervising the administration of medicines to people. The medicine was prepared the day prior to collection to help organise the workload. During dispensing, team members used baskets to keep individual people's prescriptions and medicines together so that they didn't become mixed up. And they initialled dispensing labels which provided an audit trail of who was involved in the dispensing process. Team members were aware of their additional responsibilites surrounding the dispensing of valproate to people in the at-risk group, explaining they always issued people with the pateint card at each dispensing.

The pharmacy did not keep all medicines in the original manufacturer's containers. Some medicines were kept loose in amber bottles. And many examples of these were seen on the shelves throughout the dispensary. These were labelled with the name of the medicine but there was no expiry date of the medicine or the batch number. This may mean that team members may not know if the medicine was out of date when dispensing, or if there was a recall, whether the medicine was part of an affected batch. Some medicines were identified on the shelves are being stored in measuring cups, without lids and with the end of the original box that identified what the medicine was sitting within the cup. This meant the medicines were not stored as per manufacturer's recommendations and there was a risk of loss of stability and contamination. The manager explained loose tablets found throughout the dispensary were generated as part of the multi-compartment compliance pack service when team members de-blistered more medicines that were required for the packs. But the pharmacy had not reviewed this practice or identified the risks. The locum pharmacist working provided reassurance that whilst they were working these medicines would not be used for dispensing. A storage room between the dispensary and the room where supervision of medicines took place contained excess stock and patient returned medicines. And some excess stock was stored in totes on the floor. The pharmacy had a fridge which was kept neat and tidy. And records of daily fridge temperatures were kept and from the

sample seen these indicated that the medicines were stored within the required two to eight degrees.

The pharmacy's date checking matrix was not available during the inspection for team members to use. A copy of one was supplied following the inspection. The pharmacy manager explained the medicines in the dispensary had last been checked in January. He explained the procedure was that the expiry dates of medicines were checked every three months and medicines identified as going out of date in the next six months were highlighted with stickers to alert team members during dispensing. But there were out-of-date medicines on the shelves and medicines with an expiry date in the next six months that had not been annotated with stickers identifying their short shelf life. The pharmacy also had an electronic SOP for date checking that guided team members to use different coloured stickers depending on the future expiry date. For example, the SOP indicated that different coloured stickers be used for medicines going out of date in a month and in three months. But team members were not fully following this procedure. The pharmacy received drug alerts and recalls via NHS mail and from one of their wholesale suppliers. The process was to print off drug alerts and recalls and action them.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the reference sources and equipment it needs to provide its services. It uses its equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to up-to-date references sources including both paper and electronic copies of the British National Formulary (BNF) and BNFc (for children). Team members explained they accessed the electronic version of the BNF on their mobiles which provided them quick access to relevant information if needed.

The pharmacy had equipment for measuring liquids, and these were marked to identify which were used to measure liquid medicines and which were for water. And they were British Standard marked. There was a cordless telephone so that the team could have conversations in a private area of the pharmacy. Confidential information was kept secure by use of password protected computers which were positioned so that only authorised people could view the screens. Patient identifiable information on medicines awaiting collection was kept secure by positioning these adjacent to the medicines counter in totes.

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.