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: 21/11/2023

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 not all met	3.1	Standard not met	Some of the staff only areas of the pharmacy are excessively cluttered. This creates a risk of team members making mistakes and presents trip hazards.
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 written procedures that help guide team members to work safely and effectively. And it mostly keeps the records it must by law. Team members discuss and record errors so they can learn from them to help reduce the risk of a recurrence. They understand their responsibilities to keep people's personal information secure and they know how to safeguard vulnerable adults and children.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which were designed to help guide team members to work safely and effectively. They included controlled drug (CD) management, responsible pharmacist (RP) and dispensing SOPs. They were implemented after the previous inspection in April 2023 and they were mostly signed by team members to say they understood them and would follow them.

The pharmacist recorded details of errors identified during the dispensing process known as near misses. Records showed that some errors had been recorded over the previous two months, but none were recorded in the current month. Some records showed that potential contributing causes had been identified, such as similar packaging. But for others, only details such as what the error was had been captured. This may mean that opportunities to learn from the error may be missed. Team members did not review the data produced to identify any trends in errors made. However, they had implemented a new system where one team member selected medicines required for prescriptions and another dispensed them. As a result of this two-person check, they reported the number of near misses had reduced. The pharmacist discussed errors of a more serious nature with team members at the time the error was made. The pharmacy completed incident reports for errors that were not identified until after a person had received their medication. And these were shared with the superintendent (SI) pharmacist for review. Team members were unable to produce any incident reports during the inspection.

Team members described their roles and what they were responsible for. And there was a responsibility matrix to support this, although it had not been completed. The RP notice was displayed in the retail area and team members were aware of what activities could and could not be completed in the absence of the RP. The pharmacy had a complaints policy which directed people to raise concerns with a team member. It sought feedback from people about their pharmacy experience via feedback questionnaires, but these were awaiting review. The pharmacy had current professional indemnity insurance.

The pharmacy had paper-based CD records and the entries checked were in order. Team members checked the physical stock level of CDs against the balance recorded in the CD register. And records of patient-returned CDs were maintained. The pharmacy kept records of CD stock transferred for use within another pharmacy in the company, but some of the associated requistion forms could not be located. Its RP record was mostly in order, with one minor omission seen from the sample checked. And it held certificates of conformity for unlicensed medicines, but audit trails were not maintained as team members did not always complete the details of who received the medicine.

Team members were aware of their responsibilities for keeping people's private information secure. There were new information governance policies provided by a third-party company, but these had not been read by team members. Confidential waste was kept separately for shredding. Team members

were aware of their responsibilities for safeguarding vulnerable adults and children. And the pharmacist had recently updated their safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE).

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled team members to provide its services. And overall, they manage to complete the workload. Team members complete some ongoing training and receive opportunities to develop their learning. They ask suitable questions to help people with their healthcare needs and feel comfortable raising concerns.

Inspector's evidence

The pharmacy team at the time of the inspection included a locum pharmacist, who was the RP, and three dispensers. One of the dispensers was also the pharmacy manager and had recently started the role. They worked in the dispensary alongside another dispenser, whilst the third dispenser worked mainly at the medicines counter. Additionally, there was a fourth part-time dispenser and two part-time delivery drivers. Team members were observed to be working under pressure but were managing to complete the workload. There had been a significant increase in reported number of items processed since the last inspection. Team members were mainly focussing on dispensing prescriptions and sometimes struggled to complete other tasks. The pharmacy was cluttered and untidy, which showed a degree of pressure they worked under.

Team members received periodic training with a third-party company, with the last training event covering medicines sold over the counter. They were given some opportunities for development. This included a dispenser restarting their pharmacy technician training and another expressing an interest in being enrolled on the course. The pharmacist had completed training for services they provided via patient group directions (PGDs). Following the previous inspection, the pharmacy had implemented a weekly review of two SOPs. However, records showed that this had not been maintained since April.

Team members asked appropriate questions when selling medicines over the counter. And they knew how to respond to repeated requests for medicines liable to misuse, with any such concerns referred to the pharmacist. Team members felt able to raise suggestions for change within the pharmacy and felt comfortable raising concerns. The pharmacy did not set targets for its team members.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is excessively cluttered in some areas and this creates a risk of errors. It has suitable rooms where people can have private conversations with team members.

Inspector's evidence

The pharmacy had a front retail space which was free from clutter and portrayed a professional appearance with medicines stored neatly on shelves. However, the dispensary was cluttered and untidy. Benches were cluttered with stock and other items, including empty bottles of medicines used for people who had their medicine supervised and were not yet disposed of. There was a separate bench used for the pharmacist to complete checks on prescriptions. This was also untidy, increasing the risk of mistakes. The medicines on shelves in the dispensary were stored untidily, further increasing risk.

The pharmacy had three consultation rooms and two of these were in use, with the third used a a storeroom. It had an additional room with an external door, where the supervision of some medicines took place. The rooms were used for people to have private conversations with team members and access services with the pharmacist. The medicines counter acted as a barrier to the dispensary preventing unauthorised access. The pharmacist's checking bench was positioned so they could intervene in conversations at the medicines counter if necessary. There was a sink in the dispensary and in the toilet which provided hot and cold water for hand washing. Lighting was bright throughout, and the temperature was comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And it generally manages them well. It mostly stores its medicines as it should. But team members do not record the temperature of the fridge to help provide reassurance that it is working properly.

Inspector's evidence

The pharmacy had level access from the street which provided ease of access to those with limited mobility or with prams. It provided services such as the hypertension case finding service, advice and treatment for urinary tract infections (UTIs) and covid vaccinations. The pharmacist accessed patient group directions (PGDs) for NHS services such as treatments for UTIs on an electronic platform and records for these services were captured there. The pharmacy provided covid vaccinations which were administered by vaccinators external to the company. Team members were unable to provide further information regarding the provision of the service. The pharmacy provided a delivery service, taking medicines to people in their homes. A small number of people had an arrangement whereby their deliveries could be left if they were not available to receive them. There were no reported issues, but team members confirmed this arrangement had not been reviewed to ensure the procedure remained appropriate. The drivers asked people to sign for the receipt of the CD deliveries.

Team members used baskets to keep people's prescriptions and medicines together to help reduce the risk of mistakes. And they initialled dispensing labels which provided an audit trail to identify individuals involved in the dispensing process. Team members were aware of the requirements of the valproate Pregnancy Prevention Programme (PPP). But they were not aware of the recent legal changes to the supply of valproate in original packs. The pharmacist confirmed that they highlighted bags with stickers indicating that referral to the pharmacist was required, including for higher risk medicines.

The pharmacy kept most of its medicines in manufacturer's packs, but some medicines had been transferred into amber bottles. This had been seen during the previous inspection. The amber bottles were labelled with the batch number and expiry date of the medicines. One pack of medicine contained numerous foil cuttings of tablets. These cuttings did not contain batch numbers or expiry dates and team members confirmed they were in use. During the inspection, a controlled drug was transferred to an amber bottle. The dispenser annotated the label with an expiry date and batch number, and although the original packs were in the CD cabinet the dispenser was confident the expiry date and batch number on the label was correct. The dispenser gave assurances that if there was any doubt the medicines would not be used.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines. Team members generated lists so they knew when people's medicines were due. The pharmacy had records for each person which detailed the medicine they took and when. People were provided with patient information leaflets, so they had the necessary information to take their medicines. Team members did not supply people with the descriptions of the medicines in the packs, which may make it difficult to identify them. Team members felt changes to medication in people's packs were not always communicated effectively to the pharmacy. For example, during the inspection, team members discovered a change made to a person's medication when the most recent prescription was downloaded. This created a risk that people may not receive the most recent medication prescribed by the GP.

The pharmacy supervised the administration of medicines for some people. The pharmacist prepared these the day prior to them being required to help manage workload. They were observed pouring the medicines and having a dispenser confirm the volume poured.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only medicines were stored behind the medicines counter which helped ensure the sales of these were supervised by the pharmacist. There was a record for date checking dispensary stock which showed some sections had been checked in August. Team members confirmed that medicines identified as going out of date in three months were highlighted for use first. Some examples of this were seen on the shelves however a medicine due to expire in November had not been highlighted. And random sampling of medicines found one out-of-date medicine, which was removed from use. Team members confirmed they checked expiry dates of medicines as part of the dispensing process. Medicines with a shortened expiry date on opening were not always marked with the date of first use. A date checking record for over-the-counter medicines and records of monthly date checking were not seen. The pharmacy did not keep fridge temperature records. The temperature of the fridge was in range when checked during the inspection, but the maximum temperature was out with range and had not been reset. Team members did not know how the fridge was reset.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has suitable equipment to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had reference resources, including paper copies of the British National Formulary (BNF) and British National Formulary for children (BNFc). There were measuring cylinders for measuring liquid medicines and for water. They were marked to show which were used for medicines and which were for water. Some of the measuring cylinders were dirty. There was a blood pressure machine in the consultation room that was used in the hypertension case finding service. It was not marked to indicate when it was due to be calibrated and this was highlighted during the inspection.

The pharmacy had a cordless telephone so that conversations could be kept private. And it stored medicines awaiting collection so that people could not see people's private information. Confidential information was secured on computers using NHS smart cards and passwords. Screens were positioned within the dispensary so that only authorised people could see them.

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.