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: 16/07/2024

Pharmacy context

This is a 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 NHS Pharmacy First and a substance misuse service. It delivers medicines to people in their homes.

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's written procedures help team members manage risk and provide services safely. Team members record mistakes made during the dispensing process to learn from them. And they make changes to help prevent the same mistake from happening again. They mostly keep the records required by law and they keep people's private information secure. They respond effectively to concerns for the welfare of 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 had been reviewed by the superintendent pharmacist (SI) in May 2024. Team members had signed to say they had read the SOPs.

The pharmacy recorded details of mistakes that were identified and rectified during the dispensing process known as near misses. The details of the mistake were recorded by the person who discovered it. Team members explained this could be a dispenser or the pharmacist. This was because team members had a process whereby one team member labelled prescriptions, another picked the medicines stock for the prescription, and another dispensed the medicine. This process was put in place to help identify mistakes made by team members before they were passed to the pharmacist for the final accuracy check. Team members discussed the details of the near miss at the time, and if the team member who made the mistake was not working, it was discussed with them upon their return. They took action to help prevent the same or a similar mistake from occurring again. For example, they had separated different strengths of the same medicine from each other on the dispensary shelves. And they put warning stickers about different quantities of a medicine where they were kept on the shelf to alert the dispenser to take extra care when dispensing these medicines. The pharmacy recorded details of mistakes that were identified after a person had received their medicine known as dispensing errors. These were recorded and shared with the SI. Team members discussed the error together and identified learnings. For an error that occurred in June involving medicine that was given to the wrong person, the team member involved reviewed the SOP for handing out medicines.

The pharmacy had a process for resolving complaints and concerns from people. Team members aimed to resolve any complaints or concerns informally with people. And for any that could not be resolved informally, team members escalated the details to the company's complaints manager. Team members sought feedback from people accessing the services and used an external company to analyse the data. And a report was produced annually and shared with team members. Team members now sent text messages to people to inform them their prescriptions were ready for collection as a result of feedback. The pharmacy had current professional indemnity insurance. Team members were aware of the tasks that could and could not be completed in the absence of the RP. And they had a SOP about the absence of the RP to refer to if necessary. The RP notice was displayed in the retail area and reflected the correct details of the RP on duty. The RP record was completed correctly. The pharmacy recorded the receipt and supply of its CDs. A sample of entries checked were mostly complete with the address of the wholesaler missing for received medicines. Team members checked the physical stock levels of medicines matched those in the CD register regularly. A sample of records for two CDs checked, showed that balance checks had been completed at different times over the last three months. The pharmacy

recorded details of CD medicines returned by people who no longer needed them at the point of receipt. The destruction of these was witnessed by two team members, one of whom was a pharmacist. And the returned medicines were kept separately and were highlighted as patient returned medicines to avoid them becoming mixed with regular stock medicines. The pharmacy kept certificates of conformity for unlicensed medicines and details of who the medicines was supplied to, which provided an audit trail. It kept paper-based records for its supply of medicines against private prescriptions. The records were completed with most of the required details but did not capture the date on the prescription. The pharmacy kept the associated prescriptions.

Team members understood their responsibility to keep people's private information secure. And team members in training received additional training on information governance and General Data Protection Regulation as part of their learning. The pharmacy separated confidential waste for shredding on site. Team members had previously undertaken training for safeguarding vulnerable adults and children. And they knew to refer any concerns to the pharmacist or pharmacy manager in the first instance. They were able to give examples of instances where they had assisted vulnerable people who needed help. The pharmacy displayed a chaperone policy in the consultation room informing people of their right to have a chaperone present if required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably qualified and team members in training to deliver its services safely. It supports its team members in training. Team members complete training to ensure their skills and knowledge are developed. They give appropriate advice when assisting people with their healthcare needs.

Inspector's evidence

The pharmacy team at the time of the inspection included a locum pharmacist who was the RP. They were supported by a dispenser who was also the pharmacy manager, an accuracy checking dispenser who was training to become a pharmacy technician, and an apprentice pharmacy assistant. An additional trained dispenser also worked in the pharmacy but was not present during the inspection. And there were two delivery drivers. The pharmacy's opening hours were covered by locum pharmacists and the pharmacy manager explained they had used the same locum pharmacists who were familiar with the pharmacy and provided some consistency.

The pharmacy's apprentice completed regular online training for their course outside of business hours. And their training was supervised by one of the locum pharmacists. The apprentice explained they had regular meetings with the supervising locum when they were working in the pharmacy to discuss their progress. Other team members received protected learning time every six months to develop their skills and knowledge. The company also conducted company-wide meetings outside business hours with all the pharmacy team members across all its pharmacies, with the last being in January 2024. The trainee pharmacy technician had recently restarted their course. The pharmacist had completed training through the Centre for Pharmacy Postgraduate Education and signed patient group directions (PGDs) to deliver the NHS Pharmacy First service.

There was an open and honest culture amongst the team, and they were observed supporting each other to complete the workload. Team members felt comfortable raising concerns with the pharmacy manager or SI if needed. Annual leave was planned in advance so that contingency arrangements could be made, with team members from the company's other pharmacies supporting periods of absence where needed. And team members planned workload when annual leave was approaching so they were able to manage the workload accordingly. Team members did not receive performance reviews but explained that the SI pharmacist checked in regularly with them. They were not set any targets by the company. Team members knew to be vigilant about repeated requests for medicines liable to misuse, for example medicines containing codeine. Team members felt comfortable to have supportive conversations with people or referred them to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services it provides. It has appropriate facilities where people can have private conversations with team members.

Inspector's evidence

The pharmacy comprised of a large retail area to the front with a large dispensary to the back. It portrayed a professional appearance, and was clean, tidy and free from clutter. There was a good workflow in the dispensary, with different benches used for completing different tasks. And the pharmacist’s checking bench was situated centrally which allowed for effective supervision of the dispensary and medicines counter. The medicines counter in front of the dispensary had a barrier which prevented unauthorised access to the dispensary. There were chairs in the retail area for people who were waiting while their prescriptions were prepared. The dispensary had a sink which provided hot and cold water. And toilet facilities provided separate hand washing facilities. Lighting provided good visibility throughout and the temperature was comfortable.

The pharmacy had a soundproofed consultation room which allowed people to have private conversations with team members and access services. It had a sink with hot and cold water, chairs and a desk for consultations to be completed comfortably.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages the delivery of its services well. Team members provide people with the relevant information to take their medicines safely. They obtain medicines from recognised sources and complete checks on medicines to ensure they remain fit for supply. They respond appropriately to alerts about the safety of medicines.

Inspector's evidence

The pharmacy had level access from the street which provided ease of access to those using wheelchairs or with prams. As the front door was not an automatic door, people who required assistance with access to the pharmacy rang a bell which alerted team members to their presence. Team members ensured that people who had hearing difficulties were assisted in a quieter area of the pharmacy, for example the consultation room. They used translation applications for people who did not speak English as their first language. And two team members spoke languages in addition to English.

Team members used baskets when dispensing to keep people's prescriptions and medicines together and prevent them becoming mixed-up. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Team members used stickers to highlight the inclusion of a CD, fridge line or if the pharmacist wanted to speak to a person when they were given their medicines. Team members were aware of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicines safely. People using the pharmacy who received valproate and were in the at-risk group had taken the medicine for many years. But team members did not always provide counselling when these people collected their prescription. The importance of ensuring that people always had the correct information and counselling to take their medicine safely was discussed. The pharmacy supervised the administration of medicine for some people as part of a substance misuse service. The medicines were prepared a day in advance of them being required.

The pharmacy provided the NHS Pharmacy First service for people. It had up to date versions of the PGDs for easy referencing. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicine at the correct times. Team members ordered the prescriptions in advance which allowed time for any queries regarding the medicines to be resolved. People were provided a sheet attached to the pack which was a record of the medicines in the pack. The sheets included descriptions of the medicines in the pack so they could be easily identified. And patient information leaflets were provided so people could read about their medicines. Any changes to a person's medication were communicated from the GP surgery or by hospital discharge letters. And messages related to medication changes were recorded in a communication diary for all team members to be aware of. The pharmacy received CD prescriptions for packs once weekly. To help with workload, four packs were dispensed and checked at a time. And before the packs were issued to a person, a team member ensured the pharmacy had a new valid CD prescription, and the pharmacist re-checked the CD in the pack. Team members left packs unsealed for the pharmacist to check. The dispenser assessed the pharmacist's remaining workload each day and stopped further dispensing when needed. This ensured the pharmacist had sufficient time to complete checks so that no

packs were left unsealed overnight.

The pharmacy provided a delivery service taking medicines to people in their homes. The drivers used a list of the deliveries to be made that day. And they were alerted to the inclusion of a fridge or CD by stickers on the prescription bags. The drivers asked people to sign to confirm receipt of their CDs. The pharmacy manager explained that for a small number of people who may not be able to answer the door, they had been given consent and keycodes so that the delivery drivers could leave their packs in the person's house. And on occasion, they were asked to deliver prescriptions to an alternative address by a person. The pharmacy manager explained this was done with pre-arranged consent and medicines were handed directly to the nominated person.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were stored behind the medicines counter which helped ensure that the sale of these was supervised by the pharmacist. Team members had a process for checking the expiry date of medicines. And records showed this was up to date. Medicines that were going out of date in the next three to six months were highlighted for use first. And liquid medicines with a shortened expiry date on opening were marked with the date of opening. A random selection of medicines checked were within their expiry date. The pharmacy had a fridge for medicines that required cold storage and team members recorded the temperatures daily. Records showed the fridge was operating between the required two and eight degrees Celsius. Team members received notifications about drug safety alerts and medicine recalls via their suppliers, the NHS or via the company's management team. They printed these alerts and signed to say action had been taken. Medicines returned by people who no longer needed them were kept separately in yellow waste bags for collection and secure destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had access to electronic reference resources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had equipment used to provide its NHS services, including blood pressure monitors used in the Hypertension Case Finding Service, and a thermometer, tongue depressors and an otoscope used in the NHS Pharmacy First service. The pharmacy had measuring cylinders used to measure water and liquids medicines. And they were highlighted to show which were for liquid medicines and which were for water. The current measuring cylinders were plastic, which were highlighted as potentially not measuring accurate volumes.
The pharmacy had acquired stamped glass cylinders after the last inspection, but these had smashed and the pharmacy had ordered replacements.

The pharmacy stored medicines awaiting collection behind the medicines counter in a way which prevented people from seeing other people's private information. The pharmacy had cordless telephones so that conversations were kept private. Confidential information was secured on computers using passwords and NHS smartcards. Team members were required to use their own NHS smartcards but used each other's. Computer screens were positioned within the dispensary in a way that prevented unauthorised access to confidential information.

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.