General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Million Pharmacy, 187 Hylton Road, Sunderland, Tyne and Wear, SR4 7YE

Pharmacy reference: 9011314

Type of pharmacy: Community

Date of inspection: 06/08/2024

Pharmacy context

The pharmacy is in a row of shops in Millfield, Sunderland. It dispenses NHS prescriptions and sells some over-the-counter medicines. The pharmacy offers services including the NHS New Medicines Service 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 in the community take their medicines at the right time, as well as people in care homes. And the pharmacy 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 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, although these are due for review. 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. The pharmacy keeps the records required by law.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to help pharmacy team members manage risk with providing services. These were last reviewed in July 2021. The Superintendent Pharmacist (SI) explained that the SOPs were planned to be reviewed, but this had not yet been started. The current SOPs in use were held in an organised file so that team members could access them easily. There was also a reference page that made it clear which SOPs were applicable to the different roles within the team. All team members had read the SOPs and had signed to confirm they had understood them.

The pharmacy team recorded near miss errors, and from the records seen, this was done regularly throughout the month. These errors were mistakes identified before people received their medicines. The responsible pharmacist (RP) took responsibility for recording 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 pharmacy manager explained how these errors were reviewed monthly to produce learning points for the team. And they demonstrated instances where medicine boxes had been highlighted due to errors involving products that looked the same or had similar names. The pharmacy also had a recorded procedure for managing dispensing errors. These were errors that were identified after the person had received their medicines. But this was not always followed. A recent dispensing error which the inspector was aware of was discussed. The SI and members of the team were aware of the error and the actions taken to prevent it happening again but did not have written records of this. The importance of having written records for these types of incidents was discussed with the SI during the inspection.

The pharmacy had a procedure for dealing with complaints. People could raise these in person, or via the pharmacy's website. The team aimed to resolve any complaints themselves but knew to escalate when necessary to the pharmacy manager or SI, who worked most days at the pharmacy as RP. The pharmacy manager provided an example of how they had responded to a complaint relating to the pharmacy's delivery service and how the team now try to set appropriate expectations around this.

The pharmacy had current professional indemnity insurance. The Responsible Pharmacist had their RP notice on display which meant people could see details of the pharmacist on duty. Team members knew what activities could and could not take place in the absence of the RP. And they knew what their own responsibilities were based on their role within the team. An accuracy checking dispensing assistant followed a clear protocol for the dispensed items they checked. And they had developed their confidence and competence over time to include the accuracy checking of higher-risk medicines.

A sample of RP records checked during the inspection were completed correctly. And a sample of

private prescription records and CD registers checked during the inspection met legal requirements. The team completed weekly checks of the running balance in the CD register against the physical stock. Random balance checks against the quantity of stock during the inspection were correct. The pharmacy kept a register of CDs returned by people, but some entries were found to be lacking full details. The importance of completing all details in these registers was discussed with the SI during the inspection.

Pharmacy team members understood what to do to keep people's personal information safe and they separated confidential waste from general waste, into a designated bin. A third-party company collected the confidential waste every two weeks for destruction. The pharmacy had a procedure for the safeguarding of vulnerable people. And the members of the pharmacy team had received training around safeguarding, so were aware of signs and situations that would be a cause for concern. Key safeguarding contact information was displayed within the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

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

Inspector's evidence

At the time of the inspection, the RP was the SI pharmacist of the company. They were supported by a large team that consisted of a trainee pharmacist, seven qualified dispensers, two pharmacy technicians and two medicines counter assistants. Other team members that were not present during the inspection were five qualified dispensers and two medicines counter assistants, one of which was in training. Another regular pharmacist usually covered the end of the day, as the pharmacy operated extended hours. Team members worked overtime to cover periods of absence within the team. Within the dispensary, the pharmacy team functioned as two separate smaller teams, with one half focusing the provision of multi-component compliance packs for people in the community and in care homes. The other half of the team covered the rest of the dispensary services. Both teams had a designated area of the dispensary where they mainly worked and a team member that was responsible for co-ordinating the work of their small team. The team were observed to be managing the workload throughout the inspection. The skill mix of the team appeared appropriate for the nature of the business and the services provided.

A delivery driver worked five days a week for the pharmacy. They had received some training during their induction but had not been enrolled on a recognised training course. This was highlighted during the inspection and the SI acted after the inspection to provide evidence that the driver had been enrolled on a recognised training course. Other team members had their learning and development needs considered on an individual basis. The pharmacy manager explained that all team members completed some company-provided training to supplement any recognised courses. Team members enrolled on training courses were routinely given protected time to facilitate their learning. Some team members also accessed additional training to allow them to provide additional services. Examples of these were the provision of rescue kits to prevent overdoses and the NHS Hypertension Case Finding Service.

Pharmacy team members asked appropriate questions when selling medicines over the counter and referred to the RP at appropriate times. They were comfortable challenging requests for over-the-counter medicines that they deemed inappropriate. The team used a communications book behind the pharmacy counter to share information on any sale requests that they had intervened on, to ensure there was a consistent approach to the sale of medicines across the pharmacy’s full opening hours. Team members knew how to raise concerns if necessary. And they were confident that any concerns raised would be listened to and appropriate actions taken to improve the services the pharmacy was providing. Although the pharmacy team did not have targets to achieve, team members explained that they were enthusiastic about continuing to develop the business.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and 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 was clean and tidy and had a suitably professional appearance. It had an open retail area with some seating for people to use when waiting. The pharmacy counter provided a barrier to prevent unauthorised access to staff-only areas of the pharmacy. The dispensary was an appropriate size for the workload being undertaken. There were two large island units for team members to work. And there was more bench space around the edge of the dispensary. Walkways were kept as clear as possible to minimise trip hazards. There was sufficient storage space for stock, assembled medicines and medical devices. The layout of the dispensary 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.

Team members completed daily cleaning tasks to maintain a standard of hygiene in the pharmacy. And this was supplemented by the once weekly visit of a professional cleaner. The pharmacy had a private consultation room which was accessed via a lockable door from the retail area. It was large enough for two seats, a desk, and a sink. And it was suitably constructed for the purpose it served.

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 level access from the street and a power assisted door to help people with mobility issues to enter the pharmacy. 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. The assembled bags of medicines for delivery were stored separately, and the driver scanned barcodes on each bag to enter them onto an online delivery application. This then organised their route and provided an audit trail for the deliveries made. For deliveries that contained higher risk medicines, a signature was captured from the recipient. 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. Team members ordered people's prescriptions in advance of the compliance pack being due, which allowed enough time to receive the prescriptions back, order any necessary stock and deal with any queries. They also kept an audit trail of which ordered prescriptions had been received back to easily highlight if any were outstanding. 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. And patient information leaflets were routinely supplied with these packs.

The pharmacy team dispensed prescriptions using baskets, which kept prescriptions and their corresponding medicines separate from others. Team members used different coloured baskets to prioritise work, so that more urgent prescriptions were acted on first. They 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 that further advice and counselling was needed from the RP.

When the pharmacy could not entirely fulfil the complete quantity required on a prescription, 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 managed these well. The pharmacy had a procedure for checking expiry dates of medicines. Evidence was seen of medicines highlighted due to their expiry date approaching or because the shelf life was reduced after being opened. It was noticed during the inspection that a number of the dispensary shelves contained medicines stored as partial blister strips outside of the original manufacturer's container, alongside full boxes of stock medicines. This meant that the team could not refer to the medicine's full information such as batch number and expiry date. No evidence of these partial blister strips being used for dispensing was seen during the inspection. But the appropriate storage and packaging of medicines on the shelf was discussed with the team during the inspection, who took action to remove these. The

pharmacy kept unwanted medicines returned by people in segregated containers, while awaiting collection for disposal.

The pharmacy team showed a good understanding of the requirements for 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 for these medicines in the manufacturer's original packs. And it had patient cards and stickers available to give to people if needed. The RP provided counselling on a range of higher-risk medicines when supplying them to people. But they did not make records of these types of interventions to support them in providing continual care.

The pharmacy obtained medicines from licensed wholesalers and specials manufacturers. Team members transferred some stock of a higher-risk liquid medicine to larger bottles for use with the pharmacy's automated dispensing machine. They kept records of the batch numbers and expiry dates of the medicine transferred to the larger bottles. This allowed the team to demonstrate how it safely monitored this process and could take appropriate action in the event a safety alert was issued for the medicine. The pharmacy held medicines requiring cold storage in two medical fridges equipped with a thermometer. Team members monitored and recorded the temperatures of the fridges regularly. These records showed cold-chain medicines were stored at appropriate temperatures. A check of the thermometer during the inspection showed temperatures were within the permitted range. The pharmacy held its CDs in legally-compliant cabinets. It had a documented procedure for responding to drug safety alerts and manufacturer's recalls. It received these via updates from software it used to order stock. And it had records of alerts received and any actions taken in response.

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 keeps people safe and protects private information.

Inspector's evidence

Pharmacy team members had access to a range of hard-copy reference materials and access to the internet for up-to-date information and further support tools. There was equipment available for the services provided which included an otoscope and a digital thermometer and a 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. They used personal protective equipment, such as disposable gloves when handling medicines and performing some other tasks. The pharmacy had a service contract for its automated dispensing machine. The team completed cleaning and calibration checks of the machine regularly.

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 quieter areas. 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.