General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Inspire Pharmacy, Unit 18, Croft Road, Newcastle Under Lyme, Newcastle, Staffordshire, ST5 0TW

Pharmacy reference: 9011381

Type of pharmacy: Closed

Date of inspection: 22/06/2023

Pharmacy context

The pharmacy is situated in an industrial unit on a business park. Members of the public do not usually visit the pharmacy in person. The pharmacy delivers medicines using its own drivers. The pharmacy mainly dispenses NHS prescriptions, and it supplies a large number of medicines to people in care homes. It has a website (www.Inspirepharmacy.co.uk) which provides information about the pharmacy.

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 adequately manages risks, and it takes steps to improve patient safety. The pharmacy team members keep people's private information safe. And they complete training, so they know how to protect children and vulnerable adults. The team generally completes the records that are needed by law. But controlled drug and private prescription records contain some inaccuracies, which could cause confusion in the event of a query and makes audit more difficult.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services provided, which were accessible electronically to pharmacy team members. Roles and responsibilities were set out in SOPs and team members were performing duties which were in line with their roles. The SOPs had not been reviewed to reflect the use of the automated dispensing robot which had been introduced around a year ago, so members of the pharmacy team might not fully understand the new ways of working. The delivery drivers were wearing uniforms and name badges which identified their role at the pharmacy. And the name of the pharmacy was displayed on the delivery vans. The name of the responsible pharmacist (RP) was displayed in the pharmacy as required by the RP regulations.

There was an electronic error recording system which was used to record both near miss incidents and dispensing errors. Learning outcomes to prevent re-occurrences were recorded and the errors were reviewed in a patient safety report. The pharmacist superintendent (SI) said that he aimed to conduct a review on a monthly basis. There was a report from February 2023 on display. The SI explained that he discussed all the monthly reviews with the pharmacy team, but he didn’t always display them. The patient medication record (PMR) system was integrated with the dispensing robot. It included a safety feature whereby the bar code on medicines were scanned, and if the incorrect medicine or strength had been selected by the robot, the dispenser would be alerted. One of the dispensers explained that efficiency had increased since the introduction of the robot, and errors were very rare.

The pharmacy submitted an annual complaints report to the NHS. The pharmacy’s complaint procedure and a ‘contact us’ form was generally available on the pharmacy’s website, but the website was currently being updated. The pharmacy team were in regular contact with the care homes and the SI acted on any feedback received from them. The dispenser explained how she referred any telephoned complaints from members of the public to the SI. She felt the most common complaint was about missing items, even though a note was added to their bag explaining that medication was owed, and the medicine would be delivered as soon as it was available.

Professional indemnity Insurance arrangements were in place. The electronic RP log appeared to be in order. But the SI sometimes worked late in the pharmacy after he had signed out as RP, which meant the record was not always accurate. Private prescriptions were recorded electronically but the prescriber details and date on the prescription were incorrect on some of the entries. Controlled drug (CD) registers were kept electronically and running balances were recorded. The SI aimed to check the CD running balances monthly but admitted that they were a couple of weeks behind. A selection of balances was checked, and some inconsistencies were found. Some of the discrepancies were due to missing entries, and these were resolved during the inspection, but others needed further investigation.

The SI agreed to conduct a full audit and investigate and report any discrepancies. The pharmacy recorded the return and destruction of patient returned CDs in the electronic register.

Members of the pharmacy team had read information governance (IG) SOPs and carried out training on data protection. A young person was carrying out work experience in the pharmacy. She said she had read and signed a document about confidentiality before she started work at the pharmacy, and she had a basic understanding about how to protect people's confidentiality. One of the trainee dispensers described the difference between confidential and general waste and explained the process for dealing with confidential waste. It was placed in a designated bin and then collected by a waste disposal company.

The SI had completed level 2 training on safeguarding. The dispenser demonstrated that she had completed training on safeguarding in October 2022. Other members of the team had a basic understanding of safeguarding and knew to report any concerns about children and vulnerable adults to the pharmacist. Guidance and contact numbers of who to report safeguarding concerns to in the local area were available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload and pharmacy team members have the right qualifications and training for the jobs they do. The team members work well together, and they are comfortable providing feedback to the pharmacist.

Inspector's evidence

The SI was working as the RP and he worked most days in the pharmacy. There was an NVQ2 qualified dispenser, two trainee dispensers, and two delivery drivers on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection, but the pharmacist had a heavy workload and often worked extra hours. There were two other dispensers on the pharmacy team. The dispenser was on an NVQ3 course, and she also acted as the team's supervisor. Team members worked set hours and planned absences were requested on a human resources (HR) App, so that not more than one person was away at a time. The young person carrying out work experience was clear which duties she was allowed to complete and didn't carry out any dispensing activities. The two trainee dispensers had been enrolled on dispensing assistant courses. The pharmacy provided induction training for new members of staff and a Disclosure and Barring Service (DBS) check was conducted before people started work at the pharmacy. Team members were given some protected training time although they also carried out training at home. They were able to access online training resources, covering professional issues such as Counter Excellence modules, as well as health and safety training such as fire and manual handling.

Day to day issues were discussed between the pharmacy team members as they arose, and team members discussed their performance and development informally with the SI. These communications were not generally recorded so there was a risk that issues raised might not be properly addressed. A member of the team said they would feel comfortable talking to the SI about any concerns they might have and would escalate these concerns to the GPhC, the MHRA or NHS England if necessary. There was a whistleblowing policy and team members had received training on this.

The SI was empowered to exercise his professional judgement and could comply with his own professional and legal obligations. For example, refusing to supply a medicine because he felt it was inappropriate. He said team members weren't under any pressure to achieve targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. It has a private consultation room that enables it to provide members of the public with the opportunity to receive services in private.

Inspector's evidence

The premises were clean, spacious and in a reasonable state of repair. There was a weekly cleaning rota on display. The lighting was adequately controlled. There were fans and a portable air conditioning unit to help with temperature control. The back door was fitted with a grill, so it was secure if left open to allow circulation of air. The pharmacy was fitted out to a good standard, and the fixtures and fittings were in good order. There was an office near the front door which was used as consultation room. This room was used when carrying out the blood pressure testing service. Staff facilities included a kitchen area and WCs. An external company provided sanitary bins and replaced toilet rolls, hand wash and paper towels on a regular basis. There was a separate dispensary sink for medicines preparation with hot and cold running water. The size of the dispensary was sufficient for the workload. The pharmacy's website was being updated and was not accessible. The SI said the work should be completed by the end of the month and the website would contain information about the pharmacy and its services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers healthcare services which are generally well managed, and people receive appropriate care. It gets its medicines from licensed suppliers and the team carries out some checks to ensure medicines are in suitable condition to supply.

Inspector's evidence

This was a closed pharmacy which usually provided its services to people at a distance. But people sometimes entered the pharmacy for services which took place in the consultation room. Information about the pharmacy's services was usually available on its website. People could contact the pharmacy by telephone or email.

The pharmacy had a delivery service with associated audit trails. Deliveries were recorded on electronic delivery software, although some deliveries were recorded on paper as a hard copy. Occasionally, some prescriptions were delivered nationally using a courier. Medicines were packed and sent using the courier's tracking software. Only medicines which did not require refrigeration or CD safe storage would be sent using a courier.

The PMR system recorded who had labelled the prescription, and this was usually the person who assembled it. But the pharmacy team did not initial dispensing labels to provide an audit trail, apart from controlled drugs, so there was no record of which pharmacist had checked the medication. There was a facility to record the clinical check on the PMR system, but this had been incorrectly recorded as a dispenser in the samples checked. This was because the pharmacist hadn't signed into the PMR system when carrying out the clinical check, so the check had been done in a dispenser's name which was inaccurate. This could cause confusion and limit learning in the event of an error. The pharmacy team used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing.

Team members encouraged people to take part in the new medicine service (NMS), and these telephone consultations were carried out by the SI. Team members were asking people from the surrounding businesses to have their blood pressure checked as part of the NHS hypertension case finder service. The numbers of people tested was recorded each month and 31 people were checked in May. But individual details, such as their name and consent were not recorded. If the person was found to have an issue with their blood pressure, they were told to contact their GP. Appropriate information was available to supply to patients when supplying higher-risk medicines including valproate. The SI said he had identified that one person who was prescribed valproate was in the at-risk group, and he confirmed he had a conversation with her about pregnancy prevention and updated the PMR to record the conversation.

The pharmacy had a new App which it was piloting. It was integrated with the NHS App and people could reorder their medicines on it. Other people telephoned or sent an email to the pharmacy with the details of the medicines they required ordering each month or they gave the delivery driver a completed repeat slip.

Some people received their medicines in multi-compartment compliance aid packs. An assessment was completed for new people requesting a pack to ensure it was appropriate for their needs. Information about their current medication was stored on the PMR system. Any medication changes were confirmed with the GP surgery before the PMR was updated. Medicine descriptions were not usually included on the packs so it might be more difficult for people to identify the individual medicines. Packaging leaflets were not included in the sample checked but a trainee dispenser was printing some off to supply with the packs. Disposable equipment was used to provide the service. Some people were provided with medicine administration record (MAR) charts and original packs as an alternative to compliance aid packs. Other people used the pharmacy's App which provided alerts and reminders about when to take their medicines.

The pharmacy supplied residents of around 30 care homes using an electronic system. The care homes were organised into separate groups which were set out on a calendar to help with the planning. Care home staff used an electronic tablet to update MAR charts and to re-order monthly prescriptions. The pharmacy was able to view the re-order information. When prescriptions were received the pharmacy uploaded them onto the system to enable the care home to view the prescriptions. Any queries could be highlighted on the system and the care home was informed. The pharmacy worked two weeks in advance, so the medicines could be delivered to the care home the week before they were needed. Medicines were supplied in their original packaging with packaging leaflets for this system.

Medicines were obtained from licensed wholesalers. Most of the stock was loaded automatically into the robot. The system could access the expiry dates of medicines from their bar codes, and date expired medicines were removed on a monthly basis. Split packs could be entered into the robot and their expiry dates were added manually. Some medicines could not go into the robot because their bar codes did not scan or because they were too large to fit. This stock was stored on dispensary shelves in an organised manner. It was date-checked, and this was recorded. Dates had not been added to some opened liquids with limited stability, which meant they might have passed their expiry date. The SI said he would remind the team to date them. Expired and unwanted medicines were segregated and placed in designated bins. There were two clean medical fridges in the dispensary. The minimum and maximum temperatures were being recorded daily and records showed that they had been within the required range throughout the last month. There was some stock in a fridge in the consultation room. Its temperature was not being monitored, but the SI said the stock would not be used as he was waiting to return or destroy it. A few medicines had been removed from their original containers and were not appropriately labelled with the batch number and expiry date. For example, there was a bottle of unlabelled methadone solution in the CD cabinet. The SI said he placed it there the day before and it would be used later that day, and the other unlabelled medicines would be removed from stock and disposed of. Date expired CD stock and patient returned CDs were clearly labelled and separated from current stock. Drug alerts were received electronically on the patient safety software. Details of alerts which had been actioned and by whom was electronically recorded, providing an audit trail.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacy team had access to the internet for general information. This included access to the British National Formulary (BNF) and BNF for children. There was a selection of glass liquid measures with British Standard and Crown marks. Separate measures were used for methadone solution. The pharmacy also had triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean. All electrical equipment appeared to be in working order. There was a service and maintenance contract in place for the robot. The team could contact dedicated helplines for the robot or the PMR service if problems occurred. Computers were password protected and it was not possible to see into the pharmacy from the outside. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call called for privacy.

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.