General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Finney Pharmacy, 84 Ryhope Road, Sunderland, Tyne and Wear, SR2 9QE

Pharmacy reference: 9011651

Type of pharmacy: Internet / distance selling

Date of inspection: 02/03/2022

Pharmacy context

This is a distance selling pharmacy in the Sunderland Tyne and Wear. It dispenses NHS and private prescriptions. People do not access the pharmacy premises for services, so the pharmacy delivers medicines to people to their homes. It supplies some people with their medicines in multi-compartment compliance packs to help them with taking their medicines. The inspection was completed during the COVID-19 pandemic.

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. And it effectively manages the risks with infection control during the pandemic to help keep members of the public and team members safe. It maintains the records it needs to by law and correctly secures people's private information.

Inspector's evidence

This was a new distance selling pharmacy that was run by the Superintendent (SI) with assistance from a part time dispenser. The layout of the pharmacy helped the team to socially distance during the COVID-19 pandemic. The SI wore a face mask and had hand sanitiser for people to use. The driver, when delivering peoples medicines, leaves the bagged prescription on the step, rings the doorbell and retreats to 10 feet away. He waits until the person takes the medication in doors.

The pharmacy had a set of standard operating procedures (SOPs), that had been written in August 2021. The SI hadn’t signed these. The SOPs covered various processes such as dispensing and the requirements of the Responsible Pharmacist regulations. Both members of the pharmacy team had read and signed the SOPs. The pharmacy had a process in place to record and report near miss errors made during dispensing. The SI kept a near miss record and advised the inspector that because of the numbers dispensed there had only been one near miss recorded since August 2021. The SI explained that extra care was taken when dispensing look alike sound alike medicines and demonstrated a good understanding of risk. The SI had a procedure to record dispensing errors that had been supplied to people. There had been no dispensing errors to date. The SI described how he would deal with an error. And the steps he would take to mitigate the risk of a similar error occurring. The pharmacy had a complaints procedure this wasn’t displayed on the website but they had a Pharmacy Leaflet which described how people could make a complaint. The pharmacy had received no complaints and the SI brought up people’s online reviews and ratings. All complimented the pharmacy for their quick and efficient service.

The pharmacy displayed a valid NPA indemnity insurance certificate. An RP notice clearly displayed the name and registration number of the RP on duty. The pharmacy kept an electronic RP record, and it was complete. The SI demonstrated that the system was secure and entries could not be deleted or amended retrospectively. The SI checked CD balances on each dispensing. The controlled drug (CD) cabinet held a small range of four of five CDs. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. And team members understood the importance of keeping people’s private information secure. The SI segregated confidential paperwork for shredding in the pharmacy. The pharmacy had safeguarding procedures for the team to follow and team members had access to contact numbers for local safeguarding teams should they need them. The SI and dispenser had completed Level 2 training on safeguarding vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). The team member who delivered medication to people at home reported any concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload. Members of the pharmacy team work well together. And the dispensing assistant knows how to raise a concern if they have one.

Inspector's evidence

The pharmacy team on the day consisted of the SI, one dispensing assistant and a delivery driver who part time hours. The SI worked most days alone and had assistance from the dispensing assistant one day a week. He managed the workload comfortably. The dispenser also worked at another pharmacy and shared ideas and learning from errors for example. The dispenser had completed training on LASA drugs and Asthma. They discussed the day ahead and the tasks that needed completing. The pharmacy had a white board for the days deliveries and to communicate any changes for the patient packs. The dispensing assistant advised that the SI was approachable and they worked well together. The SI hadn’t set targets as such but he was striving to increase the business and to introduce new services. The dispenser advised that if she had any concerns, she would discuss it first with the SI and then with another pharmacist. She found the SI approachable and felt comfortable about making suggestions on how to improve the pharmacy and its services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, tidy, and well organised and support the safe and effective delivery of its services. The pharmacy team members take steps to reduce the risk of Covid 19 infection.

Inspector's evidence

The pharmacy had been fitted out to a high standard. The pharmacy was well lit and had air conditioning. The pharmacy had a well laid out dispensary with a sink with hot and cold running water for the team to use. A reception area to the front of the pharmacy led onto the good-sized consultation with sink, desk, and chairs. The premises had an upstairs with a series of rooms. These weren't in use. The pharmacy roof had been significantly damaged following the recent storms. And the pharmacy ceiling had water damage and was drying out. Workmen were onsite repairing the damage.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a basic range of services that suitably support people's health needs. The pharmacy appropriately manages and delivers its services. It obtains its medicines from reputable sources. And it stores and manages them appropriately.

Inspector's evidence

The pharmacy advertised its services through its website. And people could access the pharmacies services by telephone or from the information on their website. The pharmacy had a tamper proof letter box for people to post their repeats with clear instructions that prescriptions posted before 12am would be delivered after 4pm the same day. The SI expressed his disappointment that the pharmacy didn't appear on the NHS website for pharmacies in the area. So, it meant that some people were not aware of the pharmacy or its services. And people were not able to nominate the pharmacy because it was not visible on GP surgeries system. The pharmacy website outlined the pharmacy's opening hours. The website had a section for displaying information on health conditions such as Menopause and Breast Cancer awareness.

The SI and dispensing assistant used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. They used separate areas of the benches to carry out the dispensing process and final checks of prescriptions. The SI used a bench to the side for deliveries. The SI worked alone most days, so to reduce risk of errors he printed the labels and checked them against the prescription. He then selected the medicines from the shelf and attached the labels, leaving a mental gap by doing an unrelated task before doing the final check. A check of completed prescriptions confirmed that the dispensing labels had been initialled. This provided an audit trail of to indicate who had dispensed and checked the item. The SI contacted people via telephone to give people more information about their medicines if they had new medicines or had been prescribed high risk medicines that required ongoing monitoring. For example, a new warfarin patient had been contacted to check their INR and check if they were stable on their current dosage regime. The SI recorded the details on the patient medication record (PMR). The SI and dispensing assistant demonstrated their understanding of the pregnancy prevention programme for people who were prescribed valproate. The SI kept patient leaflets and patient cards on the shelf near the sodium valproate and the SI provided these on every dispensing.

The pharmacy supplied medicines dispensed into multi-compartment compliance packs on request. People received their packs either weekly or monthly depending on their needs. The SI or the dispenser checked prescriptions against people's personal record sheet. And checked any anomalies with the surgery. The master sheets detailed which medicines went in the packs. And at what time of the day they were to be taken. The SI supplied patient information leaflets with the packs monthly. They didn't usually include table descriptions.

The pharmacy obtained medication from reputable sources such as AAH, OTC and DE. The pharmacy retained CD invoices. The SI explained that they didn't hold a lot of excess stock because they received two deliveries a day. The dispenser checked dates on the medicine at the selection stage. They didn't have a date checking matrix but any short, dated items would be marked with highlighter pen. They

didn’t keep a note of such items. The inspector didn't find any out-of-date medicines after a check of around 15 randomly selected medicines. The pharmacy received electronic notifications of drug alerts and recalls. So far none of the alerts had been applicable to the stock they held. But the SI intended to print alerts off and mark the date and any actions taken. The pharmacy had a marked file ready to file appropriate alerts. The pharmacy used a pharmacy grade fridge to store medicines that needed cold storage. The medicines inside were tidily stored. The SI checked fridge temperatures every morning. There had been odd accessions when the SI had forgotten to record the fridge temperatures. But overall, the records were well kept.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people’s private information.

Inspector's evidence

The pharmacy had reference resources such as the BNF and BNF for children. And had access to the internet for up-to-date information. It had password-protected computers, with individual log-in. The SI had invested in IT and maintenance support for the pharmacy computer system. The pharmacy had an issue while demonstrating the systems functions and website, one phone call sorted the issue quickly. The SI had an NHS smartcard. The pharmacy team had three glass measure to help with accurate measuring. It had a range of consumables to dispense medicines in compliance packs and used large baskets to keep people’s medicines and compliance packs separate.

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.