General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: PCH Chemist, Unit A1, Derwenthaugh Industrial Estate, Derwenthaugh Road, Swalwell, Newcastle upon Tyne, NE16 3BQ

Pharmacy reference: 9012022

Type of pharmacy: Internet / distance selling

Date of inspection: 29/02/2024

Pharmacy context

This is a distance selling pharmacy on a small industrial estate close to Gateshead. It mainly dispenses NHS prescriptions for people living across the local area. It supplies some medicines in multi-compartment compliance packs to help people take them properly. And it provides medicines to some people living in local care homes. People do not directly access the premises. And so, the pharmacy delivers people's medicines to their 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	2.2	Good practice	The pharmacy fully supports its team members whilst they complete training. And it provides a good amount of protected learning time for all team members to complete ongoing learning while they are at work. Team members are encouraged to develop their skills and have a variety of opportunities available for progression.
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 appropriately manages the risks associated with the services it provides for people. It has a complete set of written procedures which help the team carry out tasks consistently and safely. Team members record and learn from the mistakes they make when dispensing. And they keep the records they need to by law. Team members have knowledge and experience to help support vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) relevant to the pharmacy's services and mandatory SOPs such as for responsible pharmacist (RP) regulations. The SOPs had been updated by the superintendent pharmacist (SI) in April 2023. Team members had read the SOPs and had signed a record of competence to indicate they understood and would follow the procedures. Team members had distinct roles, for example, dispensing in the main dispensing area, or completing workload associated with dispensing of medicines into multi-compartment compliance packs. And they were observed working within the scope of their roles. There was a SOP detailing roles and responsibilities for the team. Team members were aware of the responsible pharmacist (RP) regulations and what tasks they could and couldn't do in the absence of an RP.

Pharmacy team members recorded any mistakes they identified during the dispensing process, known as near misses, on a paper near miss record. They explained that an error would be highlighted to them by the pharmacist, and it was their responsibility to enter it onto the record. This allowed them to reflect on the mistake. Team members explained that after an error, they would implement actions to reduce the likelihood of a similar error happening again. Recently there had been an increase in errors which looked alike, or names sounded alike (LASA), for example amitriptyline and amlodipine. The team had separated the medicines to reduce the recurrence of this type of error. The team also completed a monthly patient safety report. This was led by a key dispenser who shared the outcome of the analysis with all team members. And team members read the analysis report and signed the front to record that they had done so. Team members also recorded details of any errors which were identified after the person had received their medicines, known as dispensing incidents. These incidents were recorded and were then reviewed by the SI. The team aimed to resolve any complaints or concerns informally. But if they were not able to resolve the complaint, they would escalate to the SI.

The pharmacy had current indemnity insurance. The RP notice displayed contained the correct details of the RP on duty, and it could be seen clearly from the retail area. The RP record was compliant. The pharmacy had a paper-based controlled drug (CD) register and the entries checked were in order. Team members checked the physical stock levels of CDs against the balances recorded in the CD register regularly. The pharmacy held certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. Accurate records of private prescriptions were maintained.

The pharmacy had written information relating to General Data Protection Regulation (GDPR) and confidentiality. And it had a privacy notice on the website. Team members were aware of the need to keep people's confidential information safe. And they were observed separating confidential waste into separate waste bags for secure collection and destruction by a third-party supplier. Pharmacy team

members had completed learning associated with their role in protecting vulnerable people. They understood their obligations to manage safeguarding concerns well and were familiar with common signs of abuse and neglect. And they had access to contact details to relevant local agencies.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a good team, who work well together and manage its services safely. Team members have the qualifications and knowledge they need. They complete regular ongoing training to keep their skills up to date. And they work in an environment that supports the sharing of ideas and learning from mistakes.

Inspector's evidence

The pharmacy employed a full-time pharmacist who was also the owner and SI. Other team members included two full-time dispensers who were completing their accuracy checking dispenser qualification (ACD), a full-time dispenser who also made deliveries, a part-time dispenser and two part-time trainee dispensers. And the pharmacy had support from a second locum pharmacist for at least two days per week. The pharmacy staffing levels had recently been reviewed by the SI and due to an increase in workload a part-time vacancy was being recruited for. Team members had all completed accredited qualification training or were enrolled on an accredited qualification training course for their role. They had regular reviews with the pharmacist who was their course supervisor. All team members enrolled on an accredited training course received regular weekly protected learning time. Team members completed ongoing training that was relevant to their roles, and they were provided with protected learning time to complete this training. The team had recently completed online training relating to data awareness, safeguarding and sepsis. Certificates of formal qualifications and additional online training were displayed in the pharmacy.

The team were observed working well together and managing the workload. Planned leave requests for the pharmacy team were managed so that only one or two team members were absent at a time. Team members were able to rotate tasks so that all tasks could be completed effectively during absence periods. Part-time staff members were also used to help cover absences. Team members were comfortable asking the SI any questions to improve their knowledge, and there was a variety of information relating to their roles available to read, for example relating to healthy living advice. The pharmacy had some informal team huddles, following dispensing incidents and they had discussions as they worked relating to issues such as workload and stock issues.

The pharmacy had appraisal forms, and team members had received a recent appraisal. The appraisal provided team members to identify individual learning needs. For example, one team member was in the process of being enrolled on the pharmacy technician course. And a second team member was being enrolled in a business management course to allow them to progress to a team leader role in the pharmacy. Team members described how approachable the SI was and how they felt they would listen and act on any concerns raised. The pharmacy had a suggestion box at the staff notice board area. Recently team members had approached the SI to ask for an additional computer monitor at each dispensing terminal. This was to enable them to work more efficiently between different operating systems when managing people’s prescriptions. The SI approved the idea and team members had found the additional computer screen improved time efficiency. There were no targets set. The pharmacy did not sell any medicines.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. They are clean and hygienic. And the pharmacy is secure when closed.

Inspector's evidence

People did not physically access the pharmacy premises due to its NHS distance selling contract. There was a car park for the businesses on the small industrial estate but no throughfare for the public. The door to access the pharmacy was locked with a keypad entry system for team members. The premises were clean and there were no maintenance issues seen. There was little natural light, but the lighting was sufficient. The pharmacy had heating and the temperature throughout the premises was acceptable. The pharmacy's website clearly displayed both the pharmacy and superintendent's details and registration numbers.

The pharmacy had a main dispensing area, including an area to the rear to dispense multi-compartment compliance packs and a stock storage area. A bench used by the RP to complete the final checking process was at the front of the main dispensary. And there was a completed prescription storage area used by delivery drivers to sort medicines for deliveries. This kept different tasks separate. There was enough bench and storage space for the busy workload. There was an additional storage area, office space and a training room. The pharmacy was tidy and the shelves storing stock were tidy in all areas of the pharmacy. Different strengths of medicines were clearly separated. The team kept benches mainly clear from clutter and it kept floors and aisle ways clear to avoid slips and trip hazards. The pharmacy had toilet facilities with hot and cold running water and separate staff facilities, which were kept clean. It had a separate sink for medicines preparation.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy organises its services well and it delivers them safely and efficiently. People easily access its services and speak with team members to get suitable advice about their medicines. Team members obtain medicines from reputable sources. And they manage and store them appropriately.

Inspector's evidence

The pharmacy provided access to its services through its website and by telephone. Team members were observed answering queries and providing advice to people on the telephone. There was a modern telephone system used, with calls directed through several handheld devices. And team members could identify the call type prior to answering. People's calls were seen to be answered quickly and efficiently. People could access a healthy living advice webpage and self-care advice webpage for common ailments on the pharmacy's website. And they could contact the pharmacy via telephone for more advice. The pharmacist maintained a log of all advice calls to people and referral details if they made a referral for further care from another healthcare professional.

The pharmacy supplied people with their medicines using a full-time delivery service. People using the pharmacy filled in an electronic delivery consent form and then completed a paper version on receipt of their first delivery. The pharmacy stored medicines awaiting delivery in a clearly defined separate area of the pharmacy. Urgent, same day deliveries were kept separate and were stored in a different coloured basket to enable them to be identified. The drivers used a handheld device which helped them allocate delivery workload by geographical location. This helped delivery drivers plan their route. People signed the handheld device when they received their medicines. This enabled the team to keep a record of completed deliveries. And it meant they could answer queries from people expecting deliveries. The pharmacy posted a small number of people's medicines, for example if they had moved out of the delivery radius. It did not post high-risk medicines such as CDs or medicines requiring cold chain storage. Medication was delivered in discreet packaging using postal tracked services. The pharmacy could track the status of each delivery and confirmation that it had been received. Any medicines not delivered were returned to the pharmacy for secure disposal.

The dispensary had separate areas for labelling, dispensing, and checking of prescriptions. The pharmacy team organised the dispensing process so that prescriptions were downloaded from the NHS spine throughout the day. And team members contacted the prescriber via telephone or secure email if there were any queries. Team members used baskets to store medicines and prescriptions during the dispensing process to prevent them becoming mixed-up. Team members signed dispensing labels to maintain an audit trail. They provided owing's slips to people when they could not supply the full quantity prescribed. And they contacted the prescriber when a manufacturer was unable to supply a medicine. Team members demonstrated a good awareness of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate, and of the associated risks. And they had read the recent National Patient Safety Alert. The pharmacy supplied patient information leaflets and patient cards with every supply. And they always supplied valproate in the original manufacturer's pack. The pharmacist had recently completed an audit, identifying people prescribed valproate. They contacted people who had been prescribed valproate and other higher risk medicines such as warfarin prior to their delivery. This enabled them to counsel people and make any interventions prior to delivery.

A large proportion of the pharmacy's workload involved supplying people's medicines in multi-compartment compliance packs. This was to help people better manage their medicines. Team members used medication record sheets that contained a copy of each person's medication and dosage times. They were responsible for managing the ordering of people's repeat prescriptions and matched these against the medication record sheet. They documented any changes to people's medication on the record sheets. This ensured there was a full audit trail should the need arise to deal with any future queries. The packs were annotated with detailed descriptions which allowed people to distinguish between the medicines within them. The pharmacy supplied people with patient information leaflets, so they had access to up-to-date information about their medicines. The compliance packs were signed by the dispenser and RP so there was an audit trail of who had been involved in the dispensing process. A small number of dispensed multi-compartment compliance packs were left unsealed to allow for additional medicines to be added to the packs at the point of delivery. So, there was a risk to the stability of these medicines. This was highlighted to the RP who advised they would cease the activity immediately.

The pharmacy supplied medicines in their original packs to people living in ten local care homes. And it provided accompanying medication administration records. The care homes were responsible for ordering the medicines and the pharmacy team checked the prescriptions against the order requests on receipt of the prescriptions. The SI visited the homes regularly to complete an audit of the service provided.

The pharmacy obtained its stock medicines from licensed wholesalers and stored them tidily on shelves. Team members had a process for checking expiry dates of the pharmacy's medicines. Short-dated stock which was due to expire soon was highlighted and rotated to the front of the shelf, so it was selected first. The team advised that they were up to date with the process and a log of medicines close to their expiry dates was completed by team members. And they had a signed date checking matrix to confirm completion. A random selection of medicines were checked and no out-of-date medicines were found to be present. The pharmacy had medical grade fridges to store medicines that required cold storage. The team recorded daily checks of the maximum and minimum temperatures. A sample of the records seen showed the fridges were operating within the correct range of between two and eight degrees Celsius. The pharmacy received notifications of drug alerts and recalls via the internet. A key team member checked this daily and kept a record of actioned recalls. Team members carried out the necessary checks and knew to remove and quarantine affected stock. The pharmacy had medical waste bins and CD denaturing kits to manage pharmaceutical waste.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It uses its equipment in a way to help protect people's confidential information.

Inspector's evidence

The pharmacy had reference resources and access to the internet for up-to-date information. It had password-protected computers and the team used NHS smart cards. There were consumables for the multi-compartment compliance pack dispensing service and these were stored appropriately. The pharmacy had a range of CE marked measuring cylinders which were clean and safe for use. And it had a set of clean, well-maintained tablet counters.

People didn't access the premises and the windows in the dispensing areas were blacked out to prevent unauthorised access to people's confidential information on the computer screens. Team members used cordless telephones, and this allowed them to have private conversations with people out of earshot of others if needed.

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.