General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: NewGen Pharmacy, St Mary's Medical Centre, Unit 4, 245 High Street, London, Stratford, E15 2LS

Pharmacy reference: 9012028

Type of pharmacy: Internet / distance selling

Date of inspection: 10/12/2024

Pharmacy context

The pharmacy is on a busy high street in a town centre in a largely residential area. It provides NHS dispensing services, the New Medicine Service, the Pharmacy First service and the NHS Hypertension Case Finding service. The pharmacy supplies medicines in multi-compartment compliance packs to people living in care homes. And it uses its registration to sell pharmacy-only medicines. The pharmacy provides most of its services at a distance. This is the pharmacy's first inspection since it opened in April 2023.

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	2.5	Good practice	Team members are comfortable about raising concerns about the pharmacy or other issues affecting people's safety. Team members suggestions are considered which means they can help improve the systems in the pharmacy.
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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce future risk. It protects people's personal information well. And it largely keeps its records up to date and accurate. Team members take appropriate action to help protect vulnerable people.

Inspector's evidence

Team members had signed to show that they had read, understood, and agreed to follow the pharmacy's standard operating procedures (SOPs). Team members knew which tasks should only be undertaken if there was a responsible pharmacist (RP) signed in. And they knew which tasks should not be undertaken if the pharmacist was not in the pharmacy. Team members' roles and responsibilities were specified in the SOPs.

The pharmacist said that she was not aware of any recent dispensing errors, where a dispensing mistake had happened and the medicine had been supplied to a person. She explained that she would record them on an incident report form and on the NHS online reporting tool. Items in similar packaging or with similar names were separated on shelves where possible to help minimise the chance of the wrong medicine being selected. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded and reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly during the regular team meetings. The pharmacy wrote an action plan following the reviews. Most of the near misses were where the incorrect quantity of a medicine had been dispensed into one pod in a multi-compartment compliance pack. Team members had been reminded to take care when dispensing medicines into the packs and to check the quantity of medicines in each pod.

The pharmacy had current professional indemnity insurance. The correct responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not routinely recorded. And there was some evidence of entries not always reflecting the prescribed amount. The pharmacist said that she would ensure that the address of the supplier was recorded in future. She confirmed that she would investigate the discrepancies and report any findings to the relevant authority if needed. The private prescription records were largely completed correctly, but the correct prescriber details were not routinely recorded. And there were several private prescriptions that did not have the required information on them when the supply was made, such as the prescriber's address. The pharmacist said that she would speak with the prescriber and ensure that all the required information was recorded on the prescriptions in future before supplies were made against them. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This may make it harder for the pharmacy to find this information if there was a query. The importance of maintaining complete records about private prescriptions and emergency supplies was discussed with the team.

People's personal information in the pharmacy could not be seen by people using the pharmacy. Confidential waste was shredded, computers were password protected and people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection.

The complaints procedure was available for team members to follow if needed and details about it were available on the pharmacy's website. Team members said that there had not been any recent complaints. The pharmacist said that she would attempt to resolve any complaints and refer them to the superintendent pharmacist if needed.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And team members had completed training about protecting vulnerable people. They could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The trainee pharmacy technician gave an example of recent action the pharmacy had taken in response to a safeguarding concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. Team members are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can raise any concerns or make suggestions and have regular meetings. This means that they can help improve the systems in the pharmacy. The team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, one trainee pharmacy technician and one trainee dispenser working during the inspection. Holidays were staggered to ensure that there were enough staff to provide cover. And there were contingency arrangements for pharmacist cover if needed. The team worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. And the pharmacy was seen to be up to date with its dispensing.

The pharmacist said that she spoke with people before selling over-the-counter medicines. And she explained the questions she asked people to establish whether the medicines were suitable for the person they were intended for. She was aware that there were restrictions on the sale of some over-the-counter medicines and would only sell one box of a medicine which could require additional care.

The trainee pharmacy technician was enrolled on an NVQ level 3 pharmacy course, and the trainee dispenser was enrolled on an NVQ level 2 pharmacy course. They said that they completed most of their training at home but could do it at the pharmacy during quieter times. Team members explained that the SI provided them with additional training on an ad hoc basis and they had recently completed training about safeguarding vulnerable people.

The pharmacist was aware of the continuing professional development requirement for professional revalidation. She explained that she had completed declarations of competence and consultation skills for the services offered and had done the associated training. And she had recently completed training for the Pharmacy First training and Discharge Medicines Service. She said that she was in the undertaking training for the contraception service. And she felt able to make professional decisions.

Team members explained that they had informal huddles each morning to discuss, prioritise, and allocate tasks. And they also discussed any issues. They said that the SI visited the pharmacy on a weekly basis. And they felt comfortable about discussing any issues with him. Team members had performance reviews twice a year with the SI. The pharmacist recently started working at the pharmacy and had suggested that the checking area be moved to a different workspace. This allowed her to have easier access to the patient's medication record which checking prescriptions.

Targets were set for the New Medicine Service, the Pharmacy First service and Hypertensive Case Finding service. Team members said that the services were provided for the benefit of the people using the pharmacy. And they would not let the targets affect their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured against unauthorised access. The door to the building was kept locked when not in use and people had to ring a bell to gain access to the building. The pharmacy was bright, clean, and tidy throughout. Air conditioning was available, and the room temperature was suitable for storing medicines. There was seating in the reception area for people to use while waiting for services. The pharmacy's consultation room was accessible to wheelchair users and was in the reception area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. And there were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. And the pharmacy provides its services safely and manages them well. It gets its medicines from licensed wholesalers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People who get their medicines in multi-compartment compliance packs receive the information they need to take their medicines safely.

Inspector's evidence

There was step-free access into the pharmacy through a wide entrance. Services and opening times were clearly advertised, and a variety of health information leaflets was available. The team explained that people could not purchase medicines from the pharmacy's online shop. They said that people usually contacted the pharmacy if they needed these items and purchased them in person at the pharmacy.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription. And team members initialled dispensing labels when they dispensed and checked each item to show who had completed these tasks.

There were signed in-date patient group directions available for the relevant services offered. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacist said that they would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacy dispensed these medicines in their original packaging. The pharmacist explained that she routinely screened prescriptions for higher-risk medicines and checked that they were having the relevant blood tests. She said that most people taking higher-risk medicines were residents in the care homes and she contacted the staff if she had any queries. Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being handed out when the prescription was no longer valid.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked monthly, and this activity was recorded. Items due to expire within the next several months were highlighted. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

CDs were stored in accordance with legal requirements and denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and it was not overstocked. The pharmacy used a cool box

when delivering medicines requiring refrigeration. And the pharmacist said that the pharmacy did not send fridge items through the postal system.

Part-dispensed prescriptions were checked daily. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected.

The pharmacy supplied medicines in multi-compartment compliance packs to some people. The pharmacist explained that people had a suitability assessment completed by their GP to identify which medicines needed to be dispensed into the packs. Prescriptions for people receiving their medicines in the packs were ordered in advance so that any issues could be addressed before people needed their medicines. And prescriptions for 'when required' medicines were not routinely requested. The pharmacist explained that people usually requested these if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. This meant people had up-to-date information about their medicines. Team members wore gloves when handling medicines that were placed in these packs.

The care homes requested prescriptions via an online portal. The pharmacist screened them before sending the requests to the surgery. And she messaged the prescribers with any queries. The pharmacy cross-referenced the prescriptions against the request and contacted the prescriber if prescriptions had not been received. Communication between the pharmacy and the care homes was via email or the messaging service. Packs provided to the care homes had a photo of the person and each pod in the pack had a list of the medicines printed on it. The medication batch number, expiry date and brand name were recorded on the backing sheets.

Local deliveries were made by the pharmacy's delivery driver. The pharmacy obtained people's signatures for deliveries where possible, and these were recorded in a way so that another person's information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery. The pharmacy used a 24-hour tracked service for delivering medicines via the postal system.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Triangle tablet counters were available and clean. And a separate counter was marked for cytotoxic use only which helped avoid any cross-contamination. Suitable equipment for measuring liquids was available. And separate liquid measures were used to measure certain medicines only. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor would be replaced in line with the manufacturer’s guidance. The shredder was in good working order. The phone in the dispensary was portable so it could be taken to a more private area where 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.