General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Berwick Pharmacy, 4-6 Castlegate, Berwick-upon-Tweed, Northumberland, TD15 1JS

Pharmacy reference: 9012385

Type of pharmacy: Community

Date of inspection: 11/12/2024

Pharmacy context

The pharmacy is in a parade of shops in Berwick-upon-Tweed, Northumberland. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy offers a variety of services including the NHS New Medicines Service and the NHS Pharmacy First Service. And it offers seasonal 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. And the pharmacy delivers medicines to people's homes.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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 suitably 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. 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 up-to-date standard operating procedures (SOPs) to help pharmacy team members manage risk with providing services. These included for dispensing, Responsible Pharmacist (RP) regulations and controlled drug (CD) management. As well as holding these SOPs in an organised file, the pharmacy also had quick reference summaries of key procedures and services displayed around the dispensary, so team members could access them easily. 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. Team members took responsibility for recording these errors when they were highlighted to them, as well as correcting the mistake. This meant they had the opportunity to reflect on what had happened. To support team members recording these in real time, they could use their mobile device to scan a printed barcode on the wall of the dispensary to directly access the pharmacy's online recording system. This meant that team members did not have to wait for one of the dispensary computers to become free and those using the computer didn't feel rushed to complete their task. The RP advised that they reviewed these errors with the team regularly and they jointly considered any learning points that could be taken from these. Team members provided several examples of where alert stickers had been placed on the dispensary shelves as a result of reviewing near miss errors. The pharmacy also had a recorded procedure for managing dispensing errors. These were errors that were identified after the person had received their medicines. The RP described learning and improvements which had been implemented following a recent dispensing error, which involved the incorrect strength of pain medication being supplied. They explained that the team have adopted an extra accuracy check immediately prior to the same or similar medicines being handed out.

The pharmacy had a procedure for dealing with feedback and complaints. The team aimed to resolve any complaints or concerns locally. If they were unable to resolve the complaint, they escalated it to the superintendent pharmacist (SI). Team members explained that, following the pharmacy's relocation to a new premises, they had received some complaints about the lack of parking immediately near the pharmacy. The pharmacy responded to this by offering its delivery service more widely. During the inspection, team members were observed offering this service to people they thought it may benefit. 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.

A sample of records from the RP log and private prescription register checked during the inspection

were completed correctly. The RP completed weekly checks of the running balance in the CD register against the physical stock. Three random balance checks were carried out and found to match the quantities of stock present. The pharmacy kept a register of CDs returned by people, and there were recent records of these returns being destroyed.

The pharmacy had a procedure for keeping people's personal information safe and it kept confidential waste in designated bags, separate from its general waste and recycling bins. The confidential waste bags were sealed when full and collected periodically by a waste disposal contractor for secure destruction. The pharmacy had a procedure for the safeguarding of vulnerable people. And the RP had completed level 3 safeguarding training to allow them to deliver some services. Other members of the pharmacy team shared examples of situations where they've acted on a concern they had for vulnerable people using their services. The pharmacy advertised its chaperone policy to people with a notice on the outside of the consultation room. And team members were well-informed about the circumstances where this may be needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a 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 regular pharmacist and manager of the pharmacy. They were supported by two qualified dispensers. Other team members who were not present during the inspection were a qualified dispenser and a pharmacy technician. The RP worked at the pharmacy three days a week, and regular locum pharmacist covered the two remaining days. Team members worked overtime to cover periods of absence within the team. The team were observed working well together to calmly manage the workload throughout the inspection. And the competence and skill mix of the team appeared appropriate for the nature of the business and the services provided. A trained delivery driver worked five days a week for the pharmacy.

Team members completed training ad hoc by reading various materials that the pharmacy regularly received. And they completed training modules that were required as part of NHS services. The RP had completed training modules which were a requirement for some of the services they provided at the pharmacy. Pharmacy team members asked appropriate questions when selling medicines over the counter and referred to the RP at appropriate times. They were confident challenging requests for over-the-counter medicines that they deemed inappropriate. They shared information on any sale requests that they had intervened on with other team members and sometimes with other local pharmacies.

The pharmacy team understood the importance of reporting mistakes and acting in an open and honest way when mistakes were identifed. The RP shared the example of the recent dispensing error, which became known following a routine stock check. The pharmacy contacted the person who had received the incorrect medicines to inform them of the error. And they reported it to other necessary parties, including the person’s GP. Pharmacy team members knew how to raise concerns. This would typically be with the RP, but they also had access to the SI and company directors 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. The pharmacy team was not set any performance targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, organised, 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 had a good-sized dispensary and retail area. It was clean, organised and had a professional appearance. The pharmacy counters provided a barrier to prevent unauthorised access to the dispensary. The dispensary was divided into two sections and was a good size for the workload being undertaken. There was sufficient bench space throughout. The main part of the dispensary looked out onto the retail area, and this allowed for the supervision of medicines sales and queries. The part of the dispensary toward the rear of the premises was where multi-compartment compliance packs were assembled and checked. Walkways were kept clear to minimise trip hazards. And there was sufficient storage space for stock, assembled medicines and medical devices. 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.

The pharmacy had a private consultation room which was large enough for two seats, a desk, and a sink. And it was suitably constructed for the purpose they served. The pharmacy team kept the hygiene of the premises to an adequate standard, with team members completing cleaning tasks as required.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy sources its medicines from recognised suppliers. And it 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. And they take opportunities to provide people with advice on higher-risk medications.

Inspector's evidence

The pharmacy had a stepped access from the street with grab bars fitted at the entrance to help people enter the pharmacy safely. Pharmacy team members advised that where people had difficulty with entering the pharmacy, they would routinely go to the front door to help them access services. The pharmacy provided a medicines delivery service. The assembled bags of medicines for delivery were stored separately. And the team provided the delivery driver with a sheet detailing the names and addresses of people due to receive a delivery that day. Examples seen also included notes on any items that were stored elsewhere, such as the fridge. This meant that the driver could be sure they had all the assembled bags of medicines that were due for delivery that day. The driver kept an audit trail of the deliveries completed. For deliveries that contained higher-risk medicines, a summary sheet of the higher-risk medicines being delivered was also produced. This allowed the driver to capture the name and signature of the recipient at the point of delivery. The driver returned any failed deliveries back to the pharmacy on the same day.

The pharmacy provided medicines in multi-compartment compliance packs for a large number of people. 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 compliance packs checked, the full dosage instructions, and medication descriptions were included. And patient information leaflets were routinely supplied. However, the recommended warnings for the medicines contained were not always included which meant people may not always know about precautions they may need to take. The SI understood the importance of these warnings and agreed to make sure they would always be included in future. The pharmacy team used a designated area of the premises for the storage of the large number of assembled multi-compartment compliance packs.

The pharmacy team dispensed prescriptions using baskets, which kept prescriptions and their corresponding medicines separate from others. Different colour baskets were used to help the team prioritise work, so that the more urgent prescriptions were acted on first. Pharmacy team members signed dispensing labels during dispensing and checking. This maintained an audit trail of the team members involved in the process. 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 prescriptions that contained CDs to ensure they were stored appropriately and not handed out beyond the prescription's legal expiry.

The pharmacy team provided counselling on a range of higher-risk medicines, for example Methotrexate, when supplying them to people. There were several aide memoires printed within the dispensary to remind team members of the points to check with people to ensure they were handed out safely. And the RP attached stickers to assembled bags of medicines if they contained medications that required further advice and counselling, so they could speak to the person collecting. 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.

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 daily and were managing these well. The pharmacy had a procedure for checking expiry dates of medicines. Team members checked defined sections of the dispensary and recorded when the expiry dates of medicines in a section had been checked. This ensured that the team had an audit trail of expiry dates checked and the details of any medicines that were expiring soon. This allowed the team to remove the stock they knew to be expiring at an appropriate time to avoid it being used. Evidence was seen of medicines highlighted due to their expiry date approaching or because the shelf life was reduced after being opened. The pharmacy kept unwanted medicines returned by people in segregated containers, while awaiting collection for disposal.

The pharmacy obtained medicines from licensed wholesalers and specials manufacturers. The pharmacy held medicines requiring cold storage in a medical fridge 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 secure cabinets. It had a documented procedure for responding to drug safety alerts and manufacturer's recalls. It received these via email and 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 safely. Team members use the equipment in a way that protects people’s 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 blood pressure monitor. The blood pressure monitor had been marked to show when it was first used. And the RP was aware that this needed to be serviced or replaced in the near future. 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'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 the public 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.