General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Whitworth Chemists Ltd, 38 Front Street, Cockfield, BISHOP AUCKLAND, County Durham, DL13 5DS

Pharmacy reference: 1029364

Type of pharmacy: Community

Date of inspection: 19/09/2019

Pharmacy context

The pharmacy is on a main road of the village and it has a Post Office within it. It dispenses NHS and private prescriptions and sells over-the-counter medicines. It provides advice on the management of minor illnesses and long-term conditions. And offers a private independent prescribing service for minor conditions. The pharmacy delivers medicines to people's homes. And supplies medicines in multi-compartmental compliance packs, to help people remember to take their medicines. It offers a range of services including seasonal flu vaccinations, various travel vaccinations and other vaccinations such as chicken pox and polio.

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	4.1	Good practice	The pharmacy is involved in the local community. And works in partnership with the other healthcare professionals. It promotes and advises on services with good displays and information to assist people.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures that the team follows. The team members have a clear understanding of their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. The pharmacy provides people using the pharmacy with the opportunity to feedback on its services. It looks after people's private information. And the team members know how to protect the safety of vulnerable people. They discuss mistakes they make during dispensing. But the detail they record is sometimes limited. So, they may be missing out on some learning opportunities to prevent similar mistakes from occurring. The pharmacy generally keeps all the records as required in compliance with standards and procedures.

Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs) which the pharmacy team members have read. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as the dispensing prescriptions and controlled drugs (CD) management. The SOPs had signature sheets and the team had read and signed the sections relevant to their role. The pharmacy workflow provided different sections for dispensing activities with dedicated benches for assembly and checking, with a separate area for compliance pack preparation. The team utilised the space reasonably well. Although it was a little untidy. The team were reviewing the workflow due to the introduction of electronic prescriptions which was changing the ways of working. The local surgery had only commenced with electronic prescriptions two weeks ago. And they were adapting to the change. They were also aware that they would likely review the workflow when they adopted the scanning for the Falsified Medicines Directive (FMD). The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used different colours of baskets with red for people waiting, white for call back and electronic and blue for delivery to distinguish people's prescriptions by degree of urgency and this helped plan workload.

The pharmacy recorded near misses found and corrected during the dispensing process. The team recorded these directly on to the computer system. And the dispenser knew how to record on the system. The dispenser advised that the system allowed them to record any near misses that colleagues had done, if they were not present when the checker had identified it. Examples included hypromellose 0.5 percent instead of 0.3 percent. The dispenser advised she had made this near miss a few times but now she had learnt from recording it a few times. They had noticed that ramipril and lisinopril were in very similar packaging and had shared this with each other. The online form had reasonable detail on some entries but on others there was not much detail completed, with blank fields. Other near misses included Seretide with 250mcg instead of 125mcg and latanoprost but the combined latanoprost and timolol given. The team had completed some actions taken. The pharmacy completed a monthly patient safety report using the data on the computer. And this showed the top five near miss errors for the month. There was various other learning which the pharmacy could take from the report. Such as there being more near misses in the afternoon. So, the team had discussed this and not being distracted. The company shared some learning from other branches such as the Look Alike Sound Alike (LASA) drugs, including prednisolone and propranolol.

The pharmacy had a notice displayed at the counter which explained the complaints process. The pharmacy gathered feedback through the annual patient satisfaction survey. And they had highlighted

to people to check before they ordered any items to reduce waste. They were also checking with people that they were ordering the correct inhalers and not overusing the relief inhalers. And using preventative ones. There was a procedure to record and report dispensing errors. The team recorded this online and discussed any learning from errors. They had not had many errors and the company shared learning from any errors throughout the pharmacies. The team discussed learning from errors. The pharmacy had current indemnity insurance with an expiry date of 31 October 2019.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records on the computer. The pharmacy completed the CD registers as required with headings completed. The pharmacy maintained running balances and the register indicated the team undertook weekly stock audits. Physical stock of an item selected at random agreed with the recorded balance. There was some out of date stock with an expiry date of over a year waiting to be destroyed. The pharmacy kept a record of CDs which people had returned for disposal. They were not clearly segregated from the out of date stock in the CD cabinet. But were away from current stock. The pharmacy had few private prescriptions (two to three a month) but some of these had not been suitably entered at the time. There was one from December 2018, two from January 2019, one from June 2019, two from July 2019 and one from September 2019. These had not been entered. The prescriptions were in the folder with the others which they had entered. The others had been hole-punched but the ones not entered had not. The folder was bulging with private prescriptions which were over two years in date. And required to be cleared. The pharmacy kept special records for unlicensed products with the certificates of conformity completed.

The pharmacy displayed information on the confidential data kept and how it complied with legislation. It had leaflets on ‘How we look after and safeguard information about you’. It had a privacy notice and provided details of the Data Protection Officer. The team had completed General Data Protection Regulation (GDPR) training and had certificates in their folder which confirmed passing the course. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions and patient sensitive information securely and safely. The pharmacy team shredded confidential waste.

Safeguarding information including contact numbers for local safeguarding were available for the team. The pharmacist had undertaken level 2 CPPE training. And the team had all completed the mandatory training on safeguarding. And they kept the certificate for completion of the training in their training folder. The team members advised they would raise any concerns they had with the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe and effective services. The pharmacy team members are competent and have the skills and qualifications they need for their role. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. And they feel comfortable raising any concerns they have.

Inspector's evidence

There was one pharmacist and two dispensers working in the pharmacy. In addition, there was another dispenser who worked part-time. The pharmacist worked four days and the Saturday half-day. A regular company locum generally covered the pharmacy on the pharmacist's day off. This provided continuity. The previous dispenser had left. And they had replaced her 19 hours but then that person had left for a full-time position. So, the pharmacy was advertising again. The pharmacy had an advert on the door and had several people interested. The pharmacy was in the process of interviewing. And hoped to get someone to start soon. They would train the person if they did not get a qualified dispenser. All the team were working additional hours to cover. The team, including the pharmacist, received training to work in the Post Office. But the pharmacist seldom undertook tasks relating to the Post Office. One of the team had undertaken the full training course for the Post Office. And they all completed any required ongoing training such as compliance procedures. The team had a rota for covering the Post Office. This allowed dedicated time in the dispensary.

Certificates and qualifications were available for the team in their folders. The team followed the General Pharmaceutical Council (GPhC) revalidation model for ongoing learning, with four topics. Some training was mandatory such as 'Slips, trips and falls', 'Fire safety' and 'Health and Safety'. They completed Continuing Professional Development (CPD) cycles. They chose their own topics and undertook most of the training at home as there were less distractions. And they preferred to do this. One member had recorded learning on cannabis oils. They used information from magazines and leaflets from suppliers and other third parties. The pharmacist discussed any items that the team required to know which kept them up-to-date. The pharmacist attended a two-day conference and shared learning from this with the team. The company booked locums to cover the pharmacies, so all the pharmacists could get together for the conference. The pharmacist had completed training for the next health campaign, on Sepsis. And undertaken refresher training for the vaccines. The team worked well together and were all getting used to the electronic prescriptions from the surgery which had just commenced in the area. They were also working with the doctors to share understanding on how the system worked.

The team received performance reviews six monthly and yearly appraisals which gave the chance to receive feedback and discuss development needs. The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacist, area manager or the superintendent (SI). The team carried out tasks and managed their workload in a competent manner discussing any issues which arose and dealing with any telephone queries. There was a whistleblowing policy and telephone numbers were available, so the team members could easily and confidentially raise any concerns outside the pharmacy if needed. The pharmacy team had targets for services such as Medicine Use Reviews (MUR) and the New Medicines service (NMS) and undertook these when they met the

patient’s needs. The pharmacy focused on private services which it felt would benefit the community.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are of a suitable size for the services it provides. And people can have private conversations with the team in a consultation room.

Inspector's evidence

The pharmacy was clean, reasonably tidy and hygienic. And fitted out to an acceptable standard with suitable space for dispensing, storing stock and medicines and devices waiting collection. The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The benches, shelves and flooring were all clean and the team kept a cleaning rota to ensure tasks were undertaken as required. The room temperature was comfortable, and the pharmacy was well lit.

The pharmacy had a reasonable sized, signposted, sound proofed consultation room which the team promoted for use. There was a notice about the chaperone policy asking patients if they would like a family member or chaperone present. The pharmacist advised that he received several children attending for travel vaccinations for school trips and he encouraged a parent or other person to attend as chaperone. Most people attended with their child. The pharmacy team kept the consultation room locked when not in use. And they left no confidential information in the room .

Members of the public could not access the dispensary as there was a gate across the entrance. The counter was clearly observed from the dispensary and the staff were aware of customers in the premises. They attended to people as they entered the pharmacy. Several people attended for the Post Office services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy actively promotes the services it provides to the local community to help people improve their health and wellbeing. It advises on services with good displays and information to assist people. The pharmacy provides its services using a range of safe working practices. It takes the right action if it receives any alerts that a medicine is no longer safe to use. The pharmacy team members take steps to provide more information for certain medications. This helps ensure that people understand how to take or use their medication, most effectively. The pharmacy team members dispense medicines into multi-compartmental compliance packs to help people remember to take them correctly.

Inspector's evidence

The pharmacy had steps outside and a ramp which allowed easy access for people. There was a bell which rang when people opened the door to alert the team that there was someone in the premises. The consultation room and pharmacy counter were accessible to all. And there was some customer seating. The pharmacy had a Post office which was in the corner at the end of the medicines counter. The pharmacy displayed its services in the window and within the pharmacy. The hours of opening were on the door. The pharmacy had a defined professional area. And it kept pharmacy only medicines behind the counter and assisted people if they wished to purchase any of these items. The team members asked appropriate questions when making these supplies. The pharmacy had a list of other services provided by other healthcare professional and provided people with details of these. The list included a foot clinic, dentist, out of hours service and smoking cessation clinic.

The pharmacy was part of the local community and was taking part in the Macmillan coffee morning at the end of September. They were using this event to raise awareness to the local population of Healthy Living. They had information displayed for a taster session through ‘age uk’ for kurling and seated exercise. The pharmacy had a table with information promoting mental health. This included an information leaflet ‘Take care of your wellbeing’ produced in association with Mind. And raising awareness about this, with an emphasis for men. The pharmacy had a map displayed on the wall with certain areas marked. These marked areas gave an indication to people what vaccinations they would require if they were going to these areas. The visual display was a good reminder to people to get ready for their holiday. And the pharmacist used the map when people said where they were going on holiday. He advised them of the vaccinations they required. And any which were mandatory. The map provided a good talking point and focus for health requirements when on holiday.

The pharmacy provided an independent prescribing service called Whitworth Independent Prescribing Service (WHIPs). And displayed information on the services available such as period delay, pain and acne. This service occurred either when a pharmacist prescriber was present. Or it was undertaken through a video link to a pharmacist prescriber within the company. A pharmacist prescriber generally attended the pharmacy every two weeks. If they were not present, the pharmacy team set up the video link in the consultation room. The room contained no confidential material. The team left the person in private for their consultation. At the end of the consultation the pharmacist spoke to the person. If the prescribing pharmacist had prescribed something, then they sent a prescription by fax and electronically. The pharmacist then dispensed the item, made the appropriate charge and entries. The original prescription was then sent to the pharmacy. If the person was not prescribed anything there was no charge. If not, there was an administration charge plus the cost of any item. The items

prescribed followed the company guidelines and were for minor conditions such as urinary tract infections, pain relief, respiratory infections and erectile dysfunction. The service required the person to give consent for the prescriber to share the information their doctor. The pharmacy had promoted the service and there had been some interest. But the service had limited uptake with two supplies in January 2019 for amoxycillin and doxycycline respectively. The team advised some people had used for convenience, but most people were able to get an appointment with the doctor so used that instead.

The pharmacy undertook Medicine Use Reviews (MURs) and referred people to the surgery if required. The pharmacy carried out a MUR with a patient who advised he was not feeling so good. The pharmacy checked his blood pressure which was high. They phoned the surgery and got an appointment that day for him. The doctors reviewed his blood pressure medication and they increased his dose of medication. The pharmacy had called NHS 111 and following this the man had been admitted to hospital. He later thanked the team for their help and action taken. The pharmacy had been part of an atrial fibrillation trial and following on from this, continued to review people. It had been part of a research study with York University for depression with one person who was later referred directly to the university. The pharmacy undertook the New Medicines service (NMS) and followed these up with people to ensure they were taking their new medicine correctly. The pharmacy promoted the flu vaccination service with an eye-catching company leaflet and poster. They booked some appointments but generally people preferred to walk in and wait a short while. The pharmacy provided travel vaccinations with some people referred from the surgery as they did not provide this service. The pharmacy carried out appropriate risk assessments for the service. It also provided vaccinations through an occupational health service for an engineering company, usually for hepatitis B, with the assessment carried out by the company before being referred to the pharmacy. The pharmacy used Patient Group Directions (PGDs) for vaccinations such as MMR, chickenpox and polio. It processed the vouchers for the smoking cessation scheme. It provided some items through the minor ailments scheme and condoms through, C-card. The pharmacy undertook very few supplies for Emergency Hormonal Contraception (EHC) as there were other local providers people used.

The pharmacy received referrals from NHS 111 through the NHS Urgent Medicines Supply Advanced Service (NUMSAS). This was usually on a Saturday morning. The patient had contacted NHS 111 for advice and NHS 111 determined they required urgent access to a medicine or appliance that they had been previously prescribed on an NHS prescription. The pharmacy then processed the request to ensure the suitability and appropriateness for the patient. Most referrals led to the pharmacy making a supply. And on some occasions the pharmacy directed the patient to another healthcare service such as their general practitioner. The pharmacy received referrals through the Digital Minor Illness Referral service (DMIRS). The digital minor illness referral service (DMIRS) referred patients from NHS 111 or NHS 111 online, straight to their nearby pharmacist, rather than to services like doctors or hospitals. On most occasions the pharmacy could assist the patient, and, on some occasions, it referred people to other providers for further assistance. The pharmacist had undertaken the training for this and had provided one or two. But the surgery already referred people to the pharmacy for minor illnesses and the pharmacy referred to the surgery when the person required further treatment. The pharmacy could book appointments, so people could be seen promptly.

The pharmacy supplied medicines to around 50 people in multi-compartmental compliance packs to help them take their medicines. The doctors carried out the initial assessments on people. On occasion the doctors did not think a pack was suitable and did not allow one. This was mostly if the patient had frequent changes of medication. The team members prepared four weeks at a time. And most people received packs weekly. All patients had profile sheets. And the team noted any changes in medication on these. They recorded any special instructions such as ‘lansoprazole orodispersible must go in the pack in the foil’. They kept notes of any documents from hospitals with changes. The pharmacy team

members prepared these in the dedicated area. And left the empty boxes and any foils used for the pharmacist to see when checking. They provided people with patient information leaflets (PILs) on the first week of four. The pharmacy offered a substance misuse service to seven people who received methadone. Most of the people collected daily. The pharmacist generally made up the supplies as people came in for them. On occasions some people phoned shortly before they came to collect to alert the pharmacist, so he could have it ready for them.

There was a clear audit trail of the dispensing process. The team completed the 'dispensed by' and 'checked by' boxes which showed who had performed these roles. And a sample of completed prescriptions looked, at found compliance with this process. The team used appropriate containers to supply medicines. And used clear bags for dispensed CDs and fridge lines so they could check the contents again, at the point of hand-out. There were some alerts stickers used to apply to prescriptions to raise awareness at the point of supply. These included 'speak to pharmacist' and 'book flu'. They attached stickers to inhalers to remind people of the technique with 'hard and deep' and 'slow, steadily and deeply'. These ensured patients received additional counselling. And used their medicines correctly and raised awareness of services.

The team members used CD and fridge stickers on bags and prescriptions to alert the person handing the medication over that there was an item required to be added. The team members recorded the last date for supply for a CD, on the prescription, to make sure it was within the 28-day legal limit. This prevented supplies when the prescription was no longer valid. When the pharmacy could not provide the product or quantity prescribed, patients received an owing slip. And the pharmacy kept one with the original prescription to refer to when dispensing and checking the remaining item and quantity. The pharmacy contacted prescribers and gave suggestions of possible alternatives which could be obtained if there were significant delays. The pharmacy and local surgery worked well to resolve any supply issues. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. They had undertaken an audit and had two people who were both on pregnancy prevention plans. They could explain the information they provided to the 'patients in the at-risk' group.

The pharmacy had just started receiving electronic prescriptions. And the surgery was moving towards putting suitable people on to Repeat Dispensing. The pharmacy only ordered for people who received their medication in compliance packs. The pharmacy used a company 'CitySprint Health' to undertake its deliveries. The pharmacy provided deliveries two afternoons a week. The company generally provided the same driver which people liked. The driver signed in at the pharmacy. And the pharmacy provided him with a list of all the deliveries. And CD and fridge lines were marked. The driver undertook the fridge items at the beginning of the delivery route. The pharmacy provided a separate sheet for the CD deliveries. The driver reported back any issues with deliveries. The company's drivers had all undertaken the required confidentiality training.

The pharmacy obtained medicines from its own warehouse and other recognised wholesalers such as AAH, Alliance, Phoenix and Rokshaw. The pharmacy stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. The pharmacy had a refrigerator from a recognised supplier. This was appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings daily and they checked these to ensure the refrigerator remained within the required temperature range. The pharmacy team checked expiry dates on products and had a rota in place to ensure all sections were regularly checked. The team members marked short-dated items and they took these off the shelf prior to the expiry date. The out of date stock in the CD cabinet was on a shelf, away from current stock but not clearly separated from patient returned CDs. The team members marked liquid medication with the date of opening which allowed them to check to ensure the liquid was still suitable for use.

The pharmacy team were aware of the requirements of the Falsified Medicines Directive (FMD). The manager had received an update at the company's conference. The pharmacy had scanners but had not started scanning. The team used appropriate medicinal waste bins for patient returned medication. These were uplifted regularly. The pharmacy had appropriate denaturing kits for the destruction of CDs. The pharmacy had a process to receive drug safety alerts and recalls. The team actioned these and kept records of the action taken. They recorded these on their monthly patient safety report.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people's privacy.

Inspector's evidence

The pharmacy team members had access to a range of up-to-date reference sources, including the British National Formulary (BNF). They used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It had a separate range of measures for measuring methadone. It also had a range of equipment for counting loose tablets and capsules. The team members had access to disposable gloves and alcohol hand washing gel. And they used disposable wipes which they had in a holder in the consultation room. The water in the consultation room was cold water only. The blood pressure machine appeared in good working order and the team checked it. And replaced it when required.

The pharmacy stored medication waiting collection on shelves and in drawers where people could not observe any confidential details if they were waiting in the pharmacy. The pharmacy had developed the collection area to improve this. The team attached the prescriptions to the bags, waiting collection. The computer in the consultation room was screen locked when not in use. The computer screens in the dispensary were out of view of the public. The team used the NHS smart card system to access to people's records. The team used cordless phones for private conversations. And took calls in the consultation room for extra privacy, if required.

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.