

Registered pharmacy inspection report

Pharmacy Name: G. Whitfield Ltd., 1a Church Street, HOUGHTON LE SPRING, Tyne and Wear, DH4 4DN

Pharmacy reference: 1037488

Type of pharmacy: Community

Date of inspection: 22/08/2024

Pharmacy context

The pharmacy is in a retail area in the town of Houghton-le-Spring. It dispenses NHS prescriptions and sells over-the-counter medicines. The pharmacy offers many 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

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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 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. These SOPs were held in an organised file so that team members could access them easily. There was a column in each documented SOP that made it clear which roles within the team were responsible for a stage in the process. This helped members of the team to work safely within their remit. 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. The responsible pharmacist (RP) took responsibility for recording these errors and the team member who made the error corrected the mistake. This meant they had the opportunity to reflect on what had happened. The RP completed a documented analysis of these errors monthly to produce learning points for the team. These were shared with the team in informal meetings. The pharmacy also had a recorded procedure for managing dispensing errors. These were errors that were identified after the person had received their medicines. A dispensing error had occurred approximately one month prior to the inspection, involving the incorrect strength of a medication being supplied. Records of this error were seen on internal documentation as well as the NHS incident reporting tool. And the pharmacy team were aware of this and knowledgeable about the actions put in place to prevent similar errors occurring in future.

The pharmacy had a procedure for dealing with complaints. And it advertised this to people using its services, with a notice in the pharmacy retail area. The team aimed to resolve any complaints or concerns locally. If they were unable to resolve the complaint, they escalated it to the business owner or superintendent pharmacist (SI). 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 RP records checked during the inspection were completed correctly. The pharmacy kept its private prescription records electronically within the dispensing system. These did not always have the correct prescriber details recorded. The importance of maintaining accurate records was discussed during the inspection. The RP and another team member jointly completed weekly checks of the running balance in the CD register against the physical stock. Random balance checks against the quantity of stock during the inspection were correct. 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 and general waste separate. Team members used a shredder to destroy confidential waste. They completed this activity daily to ensure a backlog did not build up. The pharmacy had a procedure for the safeguarding of vulnerable people. The RP had also completed level 3 safeguarding training to allow them to deliver some services. And other members of the pharmacy team were able to give examples of signs and situations that would be a cause for concern and what action they would take to protect vulnerable people.

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 a team who consisted of two qualified dispensers, two apprentice dispensers and a pharmacy student from a local pharmacy school. Other team members who were not present during the inspection were three qualified dispensers. Another company-employed pharmacist would regularly work as RP one day per week. Team members worked overtime to cover periods of absence within the team. The team were observed to be calmly managing the workload throughout the inspection even during busy periods. Although several members of the team were in training positions, the competence and skill mix of the team appeared appropriate for the nature of the business and the services provided.

A delivery driver worked five days a week for the pharmacy. They had received some training during their induction but had not been enrolled on a recognised training course. This was highlighted during the inspection and the RP acted after the inspection to provide evidence that the driver had been enrolled on a recognised training course. Other team members completed various training to support their development. The RP explained that all team members completed training related to the recognised courses on which they were enrolled. And they were routinely given protected time to facilitate their learning. Some team members also accessed additional training to allow them to provide additional services. Examples of these were the provision of a smoking cessation service and the NHS Hypertension Case Finding Service.

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 healthcare professionals.

The pharmacy team felt comfortable discussing when things went wrong openly with the wider team. The RP explained there were internal channels for sharing such instances with the other pharmacies in the company. This was so all pharmacy teams had the opportunity to learn and avoid repeating mistakes. Team members knew how to raise concerns. This would typically be with the pharmacy manager, but they also had access to the superintendent 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. Although the pharmacy team was not set targets to achieve, it was encouraged to take opportunities to deliver services. Team members explained that they set their own standard that they were motivated to maintain.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are clean, secure, and provide a suitable environment for the services provided. And the pharmacy has consultation rooms to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy was in a large premises. It consisted of a good-sized retail area and spacious dispensary. The pharmacy had an overall appearance which was suitably professional. The retail area of the pharmacy was open plan and had seating for people to use when waiting. The pharmacy counter provided a barrier to prevent unauthorised access to the dispensary. Access to other staff-only areas of the pharmacy were secured by lockable doors. The dispensary was a good size for the workload being undertaken. There was a large open area of the dispensary with bench space around the edge. This was where most of the dispensing activity was performed. And there was a large island unit toward the back of the dispensary, where multi-compartment compliance packs were assembled and checked. Walkways were kept as clear as possible to minimise trip hazards. And there was sufficient storage space for stock, assembled medicines and medical devices. The layout of the dispensary supported the supervision of medicines sales and queries. 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 two private consultation rooms which were in a more private area of the premises, away from the main retail section. Both consultation rooms were large enough for two seats and a desk. And they were suitably constructed for the purpose they served. The main consultation room also had a sink.

The pharmacy team kept the hygiene of the premises to an adequate standard, with team members completing cleaning tasks as required. However, there was an untidy area at the back of the dispensary where several bins were waiting to be emptied. These appeared to contain only cardboard and other dry materials from the dispensing process. This was fed back to the team during the inspection.

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 stepped access from the street via its two main entrances. The pharmacy team explained how they supported people with mobility issues to access the pharmacy's services. This included the option to allow supervised access via a step-free side door, which also led directly into the area adjacent to the pharmacy's consultation rooms. 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 name and address of the person due to receive a delivery that day. The driver kept an audit trail of the deliveries completed, including the time of the delivery attempt. 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 confirm the contents with the recipient at the point of delivery. The driver returned any failed deliveries back to the pharmacy on the same day.

The pharmacy provided a large number of people with their medicines dispensed in multi-compartment compliance packs. 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. Due to the large number of compliance packs provided by the pharmacy, team members followed a process for dispensing these packs that included an extra check to help ensure accuracy. This process involved one team member obtaining all stock required for a compliance pack and a second team member checking the medicines and quantities were correct before dispensing could start. This was in addition to the clinical and accuracy checks that the RP would perform on the assembled compliance packs. From a sample of packs checked, the full dosage instructions, warnings, and medication descriptions with images were included. And patient information leaflets were routinely supplied with these packs.

The pharmacy team dispensed prescriptions using baskets, which kept prescriptions and their corresponding medicines separate from others. 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 RP provided counselling on a range of higher-risk medicines when supplying them to people. They attached notes to prescriptions and filed them in a designated area if they contained medications that required further advice and counselling. This meant that these prescriptions could only be handed out

after the RP had the opportunity to 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. And it had patient cards and stickers available to give to people if needed.

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. 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, a digital thermometer, and a blood pressure monitor. 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 public reach 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.