

Registered pharmacy inspection report

Pharmacy Name: Whiteleas Pharmacy, 176 Whiteleas Way, SOUTH SHIELDS, Tyne and Wear, NE34 8HF

Pharmacy reference: 1037660

Type of pharmacy: Community

Date of inspection: 01/02/2024

Pharmacy context

This is a community pharmacy in South Shields. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy provides substance misuse services and dispenses private prescriptions. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via patient group directions (PGDs).

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 team members work to professional standards to keep services safe and effective. But the pharmacy does not keep its policies and procedures under review. And it does not always provide assurance that its services are safe and effective. Team members discuss mistakes that happen when dispensing. But they do not keep records to identify patterns in the mistakes. And they do not always take the opportunity to improve and reduce the risk of further errors. The pharmacy mostly keeps the records it needs to by law, and it protects confidential information to keep it safe and secure. Team members understand their roles in protecting vulnerable people. And they complete regular training to ensure they are up to date with safeguarding requirements.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define the pharmacy's working practices and they were available for team members to read. The superintendent pharmacist (SI) worked on-site at the pharmacy, but they had not reviewed the SOPs since 2016. This meant there was a risk they did not reflect the pharmacy's safe working practices. Team members were expected to read and sign the SOPs to confirm they understood them. But the SI had not reviewed the signature audit trail, and not all team members who worked at the pharmacy had signed them. Team members signed medicine labels to show who was responsible for dispensing. This meant the pharmacist and the trainee accuracy checking dispenser (ACD) were able to identify and help team members learn from their dispensing mistakes. The pharmacy did not keep records of the near miss errors that team members identified. And this meant they were not always able to conduct near miss reviews to identify patterns and trends to make safety improvements. Team members discussed some of the errors at the time they happened. And they provided a few examples of actions they had taken to manage the risk of a recurrence in the future. For example, they had separated the different strengths and pack sizes of codeine containing medicines to manage the risk of selection errors. And they had separated medicines that look alike and sound alike such as prochlorperazine and procyclidine. Team members had introduced annotations on prescription bag labels to alert colleagues to take extra care. For example, when people had the same or similar names.

Team members knew to manage complaints appropriately and they discussed them in private in the consultation room. They knew to refer dispensing mistakes that people reported after they left the pharmacy. And the SI conducted investigations to identify the root cause and introduce safety improvements if necessary. They documented the incidents using a template report and provided information about the improvement action they had taken. Team members maintained the records they needed to by law. And the pharmacy had current professional indemnity insurances in place. The pharmacist displayed a responsible pharmacist (RP) notice, but it was not visible from the waiting area. The RP record was mostly up to date but there were some missing entries, and the time the RP finished for the day was not always recorded. Team members maintained controlled drug (CD) registers and kept them up to date. But they did not always complete the headers on each page of the registers to show the CD records they referred to. The pharmacy used a CD destruction register to record CDs that people returned for destruction. And team members kept a signature audit trail to confirm destructions had taken place. Team members filed prescriptions so they could easily retrieve them if needed. They kept records of supplies of unlicensed medicines and private prescriptions that were up to date. Team

members knew to protect people's privacy and they used a shredder to dispose of confidential waste securely. They knew to discuss safeguarding concerns with the pharmacist to protect vulnerable people. And team members provided some examples of when they had raised concerns. For example, when people tried to buy over the counter (OTC) medicines that were not appropriate for them to take. They had a list of relevant contacts and their details for ease of access.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy reviews its staffing levels to ensure it has the right number of suitably skilled pharmacy team members working when it needs them. Team members have the right qualifications and skills for their roles and the services they provide. And the pharmacy provides some support to help team members learn and develop.

Inspector's evidence

The SI owned the pharmacy and had worked there for over 20 years. They kept staffing levels under review to ensure there were sufficient team members to provide the pharmacy's services which had increased over the previous year. Regular locum pharmacists worked at the pharmacy and provided extra cover when required. Minimum staffing levels provided service continuity with only one team member permitted to take leave at the one time. And part-time staff sometimes worked overtime to provide cover when necessary. The following team members worked at the pharmacy. One pharmacist, one part-time trainee ACD, one full-time dispenser, one part-time dispenser, one full-time trainee dispenser, two part-time medicine counter assistants (MCAs) and one delivery driver.

The SI supported team members with qualification training which included providing protected learning time during working hours. They were currently supporting a dispenser who was training to conduct final accuracy checks. And they were in the process of introducing a SOP for all team members to read and adhere to. This included information about the annotation that was needed to show team members which prescriptions were suitable for the ACD to check. The pharmacist supported team members to keep up to date in their roles. This included recent discussions about the introduction of the new NHS Pharmacy First service. The pharmacist had attended off-site training and had read and understood the patient group directions (PGD) for the new service. This ensured they had the necessary skills to deliver it. The SI had ongoing discussions about medicine shortages so that team members could provide people with the appropriate advice. And the SI provided updates following PGD changes which had recently included the treatments for urinary tract infections (UTIs) and the inclusion criteria. Team members understood their obligations to raise whistleblowing concerns, and they knew when to refer concerns to the pharmacist. The SI encouraged the pharmacy team to suggest improvements to the pharmacy's working arrangements. And one of the dispensers had recently suggested the introduction of a communications diary to manage repeat prescriptions.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are secure, clean, and hygienic. The pharmacy has adequate facilities for people to have private conversations with pharmacy team members.

Inspector's evidence

The premises were secure and provided a professional image. The pharmacy team managed the available workspace to ensure dispensing procedures were conducted in a safe environment. They had designated workstations and used a separate dispensing bench for multi-compartment compliance pack dispensing. A sound-proofed consultation room was available for use. And it provided a confidential environment for people to speak freely with the pharmacist and other team members during private consultations. It also provided a clinical environment for the provision of services such as for vaccination services. There was a clean, well-maintained sink in the dispensary which was used for medicines preparation. And team members cleaned and sanitised all areas of the pharmacy on a regular basis. This ensured the pharmacy remained hygienic for its services. Lighting provided good visibility throughout, and the ambient temperature provided a suitable environment to store medicines and to provide services.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it provides its services in accordance with safe working practices. The pharmacy gets its medicines from reputable sources, and it mostly stores them appropriately. The team conducts checks to make sure medicines are in good condition and suitable to supply. And they identify and remove medicines that are no longer fit for purpose.

Inspector's evidence

People accessed the pharmacy via a step-free entrance which helped with mobility difficulties. The pharmacy opened on weekdays and did not open at weekends. Team members purchased medicines and medical devices from recognised suppliers. And they conducted monitoring activities to confirm that medicines were fit for purpose. They checked expiry dates at the time of dispensing. But they did not have a schedule in place for regular date checking so they could highlight short-dated items and remove them before they expired. Sampling showed that items were within their expiry date. The pharmacy used a fridge to keep medicines at the manufacturers' recommended temperature. Team members could not show they had checked the temperatures as they were expected to on a daily basis. And records showed they had only checked the fridge on eight occasions in January 2024. Records showed it had remained in the accepted range of between two and eight degrees Celsius. The fridge was organised with items safely segregated. This helped team members manage the risk of selection errors. Team members used three secure cabinets for some of its items. Medicines were well-organised and items awaiting destruction were kept segregated from other stock. The pharmacy kept an audit trail of drug alerts and recall notifications and team members checked the notifications and acted when necessary. They could show they acted on a recent notification for Nutramigen in January 2024. The pharmacy had medical waste bins and denaturing kits available. This helped team members to manage and dispose of pharmaceutical waste.

Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew about the warning labels on the valproate packs, and they knew to apply dispensing labels so people were able to read the relevant information. They also knew about legislative changes which required them to provide supplies in the original manufacturer's pack. The pharmacist had conducted a risk assessment and continued to make supplies to someone who received their medicines in a multi-compartment compliance pack. The pharmacy used containers to keep individual prescriptions and medicines together during the dispensing process. This helped team members to manage the risk of items becoming mixed-up. The containers were colour coded and this helped them with dispensing tasks, for example to prioritise prescriptions according to when they were needed. Team members used a separate dispensing bench to dispense multi-compartment compliance packs to help people with their medicines. The pharmacist monitored the number of people they provided packs to. This helped to manage the risk of congestion on benches and to ensure dispensing remained safe and effective. Team members referred to records that provided a list of people's current medication and the time of the day it was due. They checked new prescriptions for accuracy and kept the records up to date. Team members sometimes provided descriptions of medicines on the medicines label on the pack. And they provided patient information leaflets (PILs) with the first supply or when there were changes to people's medicines. The delivery driver delivered most of the packs, but some people arranged collection either by themselves

or by a representative. Team members monitored the packs to confirm they had been collected on time and they contacted the surgery when people failed to collect them.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including online access to the British National Formulary (BNF). Team members used crown-stamped measuring cylinders, and they used separate measures for substance misuse medicines. They had highlighted the measures, so they were used exclusively for this purpose. The pharmacy used a blood pressure monitoring machine. But team members were unable to confirm that they calibrated the machine to provide assurance it recorded accurate measurements. The pharmacy stored prescriptions for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Team members could conduct conversations in private if needed, using portable telephone handsets.

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.