

Registered pharmacy inspection report

Pharmacy Name: J.T. Egginton Ltd., Abbey Road, Lower Gornal,
DUDLEY, West Midlands, DY3 2PG

Pharmacy reference: 1038325

Type of pharmacy: Community

Date of inspection: 05/11/2024

Pharmacy context

This community pharmacy is situated on a high street in the village of Gornal, Dudley. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including the NHS Pharmacy First service. The pharmacy supplies medicines in multi-compartment compliance packs to some people to help them take their medicines at the right time.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	3.1	Standard not met	The pharmacy premises are not used in a manner which enable services to be provided safely and effectively. This has led to a disorderly dispensary, and a lack of workspace to enable medicines to be dispensed at the volume sustained by the business.
		3.3	Standard not met	The premises are not cleaned to a standard expected of a healthcare setting.
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 have written procedures to follow, and this helps them to provide services in the correct way. And members know how to keep people's information safe. The pharmacy keeps the necessary records as required by law. Members of the team discuss when things go wrong, but they do not always document them. So they may not always be able to show how they learn from or review previous mistakes.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs). They were due to be reviewed in 2023, but the superintendent pharmacist (SI) admitted that they had not yet completed the review. Some members of the pharmacy team had signed training sheets. But there were a number of signatures missing for newer members of the team. So the pharmacy may not be able to show all team members had read and understood the SOPs.

The pharmacy had systems in place to identify and manage risk, such as the recording of dispensing errors and details of the subsequent learning outcomes. The pharmacist discussed near miss incidents with members of the team at the time they occurred to help identify potential learning points. But details of near miss incidents or the actions taken were not recorded. So the team were unable to conduct a thorough review to look for underlying trends, and the only example of action they had taken was no longer relevant as the medicine was no longer stocked. So the pharmacy may not be able to show it is doing all it can to improve its services.

The roles and responsibilities for members of the team were documented within SOPs. A dispenser explained what their responsibilities were and was clear about the tasks that could or could not be conducted in the absence of a responsible pharmacist. The correct responsible pharmacist (RP) notice was on display. The pharmacy had a complaints procedure. Any complaints were recorded and followed up by the pharmacist manager. A current certificate of professional indemnity insurance was available.

Records for the RP, private prescriptions and unlicensed specials appeared to be in order. Controlled drug (CD) registers appeared to be in order. And running balances were routinely recorded. But there were infrequent audits to check the balances against the physical stock being held. So the pharmacy may be slow to identify if there was a discrepancy. Two CD balances were checked, and one was found to be inaccurate. The SI confirmed the erroneous balance had been corrected following the inspection. A separate CD register was used to record patient returned CDs.

When questioned, team members described how confidential information was separated for it to be destroyed using a shredder. But not all members of the team had signed the information governance procedures, which formed part of the SOPs. So the pharmacy may not be able to show members of the team fully understood their role in protecting people's information. Safeguarding procedures were available and included the contact details for the local safeguarding team. The pharmacist had completed level 2 safeguarding training. Members of the team explained they would refer any concerns to the pharmacist in the first instance.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to manage the workload safely. And they complete the necessary training for their role. But ongoing learning is not routinely provided, so learning needs may not always be identified or addressed.

Inspector's evidence

The pharmacy team included four dispensers, a medicine counter assistant, a delivery driver, and a new starter who was due to be enrolled onto a dispenser training course. All members of the pharmacy team were appropriately trained, or in training. The workload appeared to be manageable. Staffing levels were maintained by part-time staff and a staggered holiday system.

Further training was not scheduled beyond core dispensing training courses. Members of the team explained they would sometimes discuss new medicines they had not encountered before to learn about them, but this activity was not recorded. So the pharmacy was unable to demonstrate whether the team's learning needs were being met. A dispenser provided examples of selling a pharmacy only medicine using the WWHAM questioning technique, refusing sales which they felt were not appropriate, and referring people to the pharmacist when needed.

Members of the team felt well supported by each other. They were seen working well together and assisted each other with any queries they had. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. There were no targets for professional based services.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy premises are not used in a manner which enable services to be provided safely and effectively. This has led to a disorderly dispensary, and a lack of workspace to enable medicines to be dispensed at the volume sustained by the business. The premises are not cleaned to a standard expected of a healthcare setting.

Inspector's evidence

This was a historical premises used by the same generational family business and it had been used as a pharmacy for many decades. But the volume of dispensing had grown faster than the layout of the dispensary. This meant medicines were stored in a disorderly fashion and could increase the risk of a picking error. The space was used ineffectively, resulting in both clutter and an increased workload on the team as they tried to cope with managing stock and space rather than dispensing prescriptions. There was a longer-term plan in place to move the premises into a new business unit which the team believed would resolve these issues, but it had yet to begin construction.

The team had fallen behind with cleaning the pharmacy, and a number of cobwebs were present throughout. This included above the storage and assembly space used for compliance packs. Some of the sinks were stained. And the carpet appeared unkept. A consultation room was available, and its availability was prominently displayed. But it was unkept and contained large cobwebs, which detracted from the professional appearance expected of a healthcare environment.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are easy to access. It gets its medicines from licensed sources. But the team do not always record when they carry out checks to help show that they remain in good condition. And members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might not always be able to check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

The pharmacy and consultation room were accessible by those with additional mobility needs. Information was on display about the services offered. The pharmacy opening hours were also on display.

Members of the team initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels to provide an audit trail for medicines dispensed in the pharmacy. They used baskets to separate individual patients' prescriptions to avoid items being mixed up.

Dispensed medicines awaiting collection were kept on collection shelves in alphabetical order. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Members of the team were seen confirming the patient's name and address when medicines were handed out. Medicines containing schedule 3 CDs were routinely highlighted to remind team members to check the expiry date of the prescription. But schedule 4 CDs were not, and so they may be overlooked. The pharmacist spoke to people regarding their medicines when they identified a clinical need during the final accuracy check. But there was no process to routinely provide counselling advice to people who took higher-risk medicines (such as lithium, and methotrexate), which was a missed opportunity. Members of the team were aware of the risks associated with the use of valproate-containing medicines and were providing counselling advice to those taking the medicines. But they were not aware about the counselling advice which needed to be provided to people taking topiramate. The updated guidance was discussed, and the team acknowledged they would review the drug safety updates to provide the correct information to people.

Some medicines were dispensed into multi-compartment compliance packs. Before a person was started on a compliance pack, the pharmacist checked the person's suitability. But this assessment was not recorded, which may be useful in the event of a query or a concern. An electronic record was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record was updated. Hospital discharge information was sought and kept for future reference. The compliance packs were supplied with patient information leaflets (PILs) and labelled with medication descriptions.

The pharmacy had a delivery service, and delivery records were kept. Unsuccessful deliveries were returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Members of the team confirmed that the expiry dates of medicines had been

checked, but they had not kept records. So there was a risk some medicines may be overlooked. Short-dated stock was highlighted with a highlighter pen. A spot check did not find any out-of-date medicines. But some liquid medications did not have the dates of opening written onto the bottle. The SI acknowledged they would assess the opened bottles to ensure they remained suitable for use. Controlled drugs were stored in the CD cabinets, with separation between current stock, patient returns and out of date stock.

There were two fridges, each equipped with a thermometer. The minimum and maximum temperatures were being recorded each day and had been within the required range for the past three months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA. But details about how the pharmacy had responded to these alerts were not kept which would help the pharmacy to show they had acted appropriately.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they keep the equipment clean in a manner expected of a healthcare setting.

Inspector's evidence

Team members accessed the internet for general information. This included access to the British National Formulary (BNF), BNFC and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were used for methadone to prevent cross contamination. The pharmacy also had counting triangles for counting loose tablets. Equipment appeared clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed team members to move to a private area if the phone call warranted privacy.

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.