

Registered pharmacy inspection report

Pharmacy Name: Neil Pharmacy, 95 Wenlock Road, SOUTH SHIELDS,
Tyne and Wear, NE34 9BD

Pharmacy reference: 1077013

Type of pharmacy: Community

Date of inspection: 22/02/2022

Pharmacy context

This is a community pharmacy in South Shields. It sells a range of over-the-counter medicines. It dispenses people's prescriptions. It delivers medicines to people who can't attend its premises in person. The pharmacy provides a range of services including a COVID - 19 vaccination service. People can also collect COVID-19 home-testing kits from the pharmacy when available. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

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 mostly identifies and manages risks with its services. It maintains the records it needs to by law and correctly secures people's private information. But team members don't always record all the details of mistakes they make while dispensing. So, they may miss the chance to learn from them to help prevent similar mistakes from happening again.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. It had several procedures in place to help manage the risks of the services it offered to people and help prevent the spread of coronavirus. The pharmacy had a large plastic screen placed at the pharmacy counter which acted as a protective barrier between team members and members of the public. It had markings on the floor of the retail area which helped people socially distance and keep to a one-way flow from their entrance to exit.

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The superintendent (SI) had updated these in 2021. All but one of the team members had read and signed the SOPs signature sheets to show they understood and would follow the SOPs.

The responsible pharmacist (RP) and the trainee ACT spotted near miss errors made by team members during the dispensing process. They informed the dispenser of the error and asked them to rectify the mistake. The trainee kept a separate logbook of near misses they had picked up and the RP recorded near miss errors onto near miss errors record sheets. Sections for possible causes and actions taken had not been completed on either records. So, the team may be missing opportunities to identify the cause of the error and make changes appropriately. The team recorded on average two or three near misses each month. The team had a procedure for recording dispensing errors that had not been picked up at the dispensing stage and had been supplied to people. The SI had recorded these in more detail on the significant error analysis record. A recent error record, shown to the inspector, had involved the supply of Amlodipine instead of Amitriptyline. The SI had contacted the GP and had made changes to reduce that risk of a similar error happening again.

The pharmacy had a procedure for the team to follow when a person raised a complaint. And a poster displayed near to the consultation room in the retail area provided information to people on how to give feedback about the pharmacy services or raise a concern. People had voiced their frustration with their prescriptions not always being ready when they called to collect them. The SI explained that sometimes local surgeries had not send the prescriptions through and the team had difficulty getting through to local surgeries because the telephone lines were constantly engaged.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The pharmacy's record showed that CD balances had been checked monthly and a line had been taken in the register to reflect this. A random balance check of two CDs in the cabinet tallied with the CD register balance. CD invoices and CD entries had been entered promptly. The team held records containing personal identifiable information in areas of the pharmacy that only team members could

access. And team members understood the importance of keeping people's private information secure. The team segregated confidential paperwork for shredding offsite. The pharmacy had safeguarding procedures for the team to follow and team members had access to contact numbers for local safeguarding teams. The team had completed safeguarding training. The team members who delivered medication to people at home reported any concerns to the pharmacist.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to manage the workload. Members of the pharmacy team work well together. And they know how to raise a concern if they have one. Some team members do not have appraisals. So, they may miss the chance to further develop their knowledge and skills. Members of the pharmacy team work well together.

Inspector's evidence

The pharmacy team on the day consisted of three dispensing assistants, one apprentice and two drivers. The SI worked most days and a regular locum assisted when the SI was vaccinating. The SI advised that the pharmacy had been busy during the pandemic. The workload and pressure on the team had increased as local surgeries referred people for blood pressure monitoring. Covid and flu vaccinations had also impacted on the workload. The SI thought they had enough staff to cover the workload. And numbers had been increased since the last inspection. Staff covered for each other's time off when possible. People were served promptly. The company didn't offer a formal training program as such. Team members had their own training records and all had done electronic training on look-alike sound alike (LASA) drugs, Asthma and Childhood obesity amongst others. The SI advised that newer members of the pharmacy team received on the job training when required. Some members of the team had completed training to provide the covid vaccination service and other services such as smoking cessation. The trainee and the apprentice had regular performance reviews. But more established members of the team had on the spot feedback if the need arose. The team members felt able to make suggestion for change and experienced team members supported the trainees.

The pharmacy did not have set targets. But it was something the SI had considered. Members of the pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. The company had a whistle blowing policy and team members knew who they should raise a concern with if they had one.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides a suitable and secure environment for people to receive healthcare. And its premises are clean. The pharmacy team members take some steps to reduce the risk of Covid 19 infection.

Inspector's evidence

The pharmacy had adequate lighting. The team used fans during hot days. The pharmacy had an adequately sized retail area, a consultation room with sink, computer desk and chairs. The vaccination team used the consultation room to provide covid 19 vaccinations. The pharmacy had been re-fitted to provide separate areas for dispensing and checking prescriptions. Clutter on some of the work benches made establishing a smooth workflow difficult. The pharmacy had a stock area to the rear where the team members stored overflow stock in blue boxes and in large totes. The SI explained that the waste contractor had been contacted to provide additional disposable boxes and to request collection of the overflowing boxes of obsolete and returned patient medicines. The pharmacy had a sink in the dispensary with a supply of hot and cold water. The team members cleaned the pharmacy when time allowed.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides a good range of services to support people's health needs. The pharmacy appropriately manages and delivers its services. It obtains its medicines from reputable sources. And it generally stores and manages them appropriately.

Inspector's evidence

The pharmacy had a step up at the front door into the pharmacy. The pharmacy team assisted with entry for wheelchair users or took medication out to them. The pharmacy had a back door that wheelchair users could also use to access the pharmacy. The pharmacy advertised its services and displayed information and advice prominently in the window. There were seats available in the retail area for people to use while they waited for their prescriptions to be dispensed. Team members had access to the internet which they used to signpost people requiring services that the pharmacy did not offer. The pharmacy provided a limited range of over-the-counter medication free of charge through the Pharmacy First Scheme. People appreciated the service and the pharmacy provided around 500 consultations each month. The pharmacy also supplied medication for a range of treatments for conditions such as Impetigo and Shingles through the 'GP to Pharmacy' scheme. Other services offered included smoking cessation, supply of EHC and a free delivery service on request. The pharmacy had a separate SOP file that had detailed procedures for the supply of such services. The pharmacy and the other pharmacy in the group provided a Covid 19 vaccination service. There had been good uptake before Christmas but demand had waned in January. The pharmacy provided a walk-in vaccination service three days each week. A second pharmacist covered the pharmacy when the covid vaccination service was running. The pharmacy supplied lateral flow tests. But these had been in short supply. People using the pharmacy did not understand that registering for test kits online and receiving a reference number did not guarantee that the pharmacy had the stock to supply. This had caused frustration for people and for the pharmacy team members. Team members used various stickers within the dispensing process as an alert before they handed out medicines to people. For example, they used fridge stickers to highlight that a fridge line needed added to the prescription before handing out. Team members used dispensing baskets to hold prescriptions and keep medicines together, this reduced the risk of them being mixed up. Team members gave owing slips to people on occasions when the pharmacy could not supply the full quantity prescribed. They gave one slip to the person and kept one with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy team members kept a record of the delivery of medicines to people. A separate record was kept for CD deliveries.

The SI advised that members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group prescribed valproate needed to be counselled on its contraindications. The pharmacy team had cards and leaflets that they handed out to patients when valproate was dispensed to them. The pharmacy team placed Pharmacy (P) medicines on shelving behind the counter so people could not self-select such medicines. The SI explained that she instructed the team to refer repeated requests for codeine-based medication, such as co-codamol to the RP. The pharmacy only supplied codeine linctus on presentation of a valid prescription. The team arranged medicines on the dispensary shelves in a tidy ordered manner. This helped to reduce the risk of a picking error. The SI explained that short dated stock had been removed at the quarterly stocktake in December 2021. The pharmacy team had a date checking matrix but this had not always been

completed. The team sometimes marked the date when a liquid medicine was opened. No out-of-date medicines were found after a check of around 15 randomly selected medicines in three different areas in the dispensary. The Pharmacy used recognised suppliers such as AAH, OTC and DE. The pharmacy received drug alerts electronically. A team member actioned them and a record of these were retained in a file in the pharmacy. Team members checked, and recorded fridge temperature ranges daily on an electronic record. During the inspection, the inspector checked the fridge temperatures, and they were seen to be within the correct range.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

Team members had access to up-to-date reference sources. The team stored medicines waiting to be collected in a way that prevented people's confidential information being seen by members of the public. The pharmacy used a range of CE quality marked measuring cylinders. They had a separate methadone measure. The pharmacy team stored these near to the sink for easy access. Members of the pharmacy team made sure they cleaned the equipment they used to measure, or count, medicines before they used it. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. The phone was positioned at the rear of the pharmacy So, its team could have confidential conversations with people when necessary. Some of the team members responsible for the dispensing process had their own NHS smartcard.

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.