General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Whitegate Pharmacy, 150-158 Whitegate Drive, BLACKPOOL, Lancashire, FY3 9ES

Pharmacy reference: 1101565

Type of pharmacy: Community

Date of inspection: 02/10/2024

Pharmacy context

This community pharmacy is situated inside a large medical centre. It is located on a major road in the town of Blackpool, Lancashire. 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 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 team follows written procedures, and this helps them to provide services safely and effectively. The pharmacy keeps the required records. And members know how to keep people's information safe. Members of the team record and discuss when things go wrong, but some of the details are no always captured. So they may not always be able to review previous mistakes or show how they have learnt from them.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) which were updated in June 2023. Members of the pharmacy team had signed training sheets to say they had read and accepted the SOPs.

A paper log was used to record near miss incidents. The pharmacist discussed the incidents with members of the team at the time they occurred to help identify potential learning points. At the end of each month, the pharmacist reviewed the records to look for common trends and potential learning points to help reduce similar mistakes. For example, the team had moved quinine and quetiapine away from each other to help prevent a picking error. Details of the learning points were recorded on a monthly patient safety review. The pharmacist had recorded dispensing errors within the near miss logs. The pharmacy team reviewed the dispensing error at the time they were made aware of the mistake, but they had not documented what they had investigated, and any actions taken to reduce the likelihood of a similar mistake. The pharmacist acknowledged they would ensure this is recorded on the correct form, with the relevant details, going forward.

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. Members of the pharmacy team wore standard uniforms. The correct responsible pharmacist (RP) notice was on display. The pharmacy had a complaints procedure, but information about it was not on display. Which would help to encourage people to provide feedback. Any complaints were recorded and followed up by the pharmacist manager. A current certificate of professional indemnity insurance was seen.

Records for the RP, private prescriptions and unlicensed specials appeared to be in order. Controlled drugs (CDs) registers were suitably kept. Running balances were recorded and frequently checked. Two random balances were checked and were found to be accurate. Patient returned CDs were recorded.

An information governance policy was available in a folder. Members of the team had completed GDPR training. When questioned, a dispenser described how confidential information was separated to be removed and destroyed by a waste carrier. A notice in the retail area provided information about how the pharmacy handled and stored people's information. Safeguarding procedures were available. Details for the local safeguarding team was on display within the dispensary. 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, or undertake 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 a pharmacist manager, six dispensers, one of whom was trained to perform the final accuracy check and another was training to become a pharmacy technician, a medicine counter assistant, and two delivery drivers. All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be well managed. Staffing levels were maintained by a staggered holiday system.

Members of the pharmacy team had completed some additional training. For example, they had previously completed training about the pharmacy first scheme. But ongoing training was not provided in a consistent manner, which would help to ensure learning needs were 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. They discussed their work each day and shared any learning points. Appraisals were completed twice a year. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the head office. There were no targets for professional based services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available for people to have a private conversation with a member of the team.

Inspector's evidence

The premises was clean and tidy, and appeared to be adequately maintained. People in the retail area were not able to view any patient sensitive information due to the position of the dispensary. The temperature was controlled using air conditioning units and lighting was sufficient. Team members had access to a kitchenette area and WC facilities.

A consultation room was available. It was tidy with a computer, desk, seating, wash basin, and adequate lighting. The patient entrance to the consultation room was clearly signposted. A separate room was available and contained a hatch for supervising consumption of some higher risk medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from licensed sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But members of the pharmacy team do not always provide advice to people taking topiramate-containing medicines, which would help to ensure they understand how to take them safely. And records of advice are not always kept which would help team members to demonstrate what was discussed in the event of a query.

Inspector's evidence

The pharmacy and consultation room were easily 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 inside collection drawers. 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. The computer software produced a list of dispensed medicines awaiting collection which were due to expire, so members of the team could remove them from the collection shelves. These included prescriptions containing schedule 3 or 4 CDs. The pharmacist routinely provided counselling advice to people who were taking higher-risk medicines (such as warfarin, lithium, and methotrexate). But the details of the advice were not recorded to share with other members of the team and help ensure key information was available in the event of a query. Members of the team were aware of the risks associated with the use of valproate-containing medicines, and the need to supply full packs. Educational material and counselling advice was provided with the medicines. But the pharmacist had overlooked the provision of counselling advice to people who were taking topiramate. The updated guidance was dicussed and the pharmacist acknowledged this was important and would review the requirements following the inspection.

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

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. A date checking record was available. The expiry dates of medicines were checked once every three months. Short-dated stock was highlighted using a sticker or highlighter pen. Liquid medications had the dates of opening written onto the bottle. Controlled drugs were stored in the CD cabinets, with clear separation between current stock, patient returns and out of date stock.

There were two medicines fridge, both equipped with a built-in 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 head office. These were printed, with the details of who actioned the alert, the action taken and when written onto the alert before being sent back to the head office to show how the pharmacy had responded.

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 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 was kept 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. The consultation room was used appropriately. People were offered its use when requesting advice or when counselling was 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.