General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HBS Pharmacy, Newton Drive Health Centre, Newton Drive, Blackpool, Lancashire, FY3 8NX

Pharmacy reference: 1109046

Type of pharmacy: Community

Date of inspection: 02/10/2024

Pharmacy context

This community pharmacy is situated inside a medical centre. It is located in the residential area of Grange Park in 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 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 not all met	1.6	Standard not met	The pharmacy does not keep necessary records required. It has fallen behind with ensuring records are kept for private prescriptions, unlicensed specials, and controlled drugs.
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 not all met	4.3	Standard not met	The pharmacy fridge does not store medicines at the correct temperature.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy team generally follows written procedures, and this helps them to provide services effectively. And members know how to keep people's information safe. However, the pharmacy does not always keep records in line with legal requirements. So it cannot demonstrate that it always fulfils its legal obligations. 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) which had a stated date of review in June 2026. Members of the pharmacy team had signed training sheets to show they had read and accepted 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 the incidents or the actions taken were not recorded. So the team were unable to conduct a thorough review to look for underlying trends and demonstrate what specific action they had taken to improve. When questioned a team members explained they had moved different strengths of omeprazole away from one another to help reduce the risk of a picking error.

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 available.

Records for the RP appeared to be in order. But the pharmacy had fallen behind with recording private prescriptions and some had not been recorded since 16 September 2024. Records of unlicensed specials were kept, but they did not always contain the required details to show the source and supply of the medicines in the event of a query or concern. There were at least nine discrepancies in the controlled drug (CD) registers. And a number of patient-returned CDs were present which had not been recorded. So the pharmacy was unable to demonstrate that it kept accurate records of the CDs that it was storing.

Members of the team explained they had read an information governance (IG) procedure. When questioned, a dispenser described how confidential information was separated for it to be removed and destroyed using a shredder. But the IG policy could not be found. 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 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. But the contact details for the local safeguarding team were not immediately available, which may delay

concerns being reported in a prompt manner.

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, one of whom was the pharmacy manager, two medicine counter assistants (MCA), and two delivery drivers. The pharmacy was reliant upon regular locum pharmacists. All members of the pharmacy team were appropriately trained. 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 a training pack about Dementia Friends. But ongoing training was not provided in a consistent manner, which would help to ensure learning needs were met. An MCA 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. Appraisals had been previously completed by the previous pharmacist manager. 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, and adequate lighting. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not store medicines that require refrigeration at the corret temperature. So it cannot demonstrate that these medicines are still fit for use. The pharmacy's services are accessible, and it manages and provides them effectively. But members of the pharmacy team do not always provide advice to people taking valproate and topiramate-containing medicines which would help people taking these medicines understand how to take them safely.

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 pharmacy had completed an audit on people who were taking anticoagulant medicines to ensure people were provided with counselling advice and understood how to take their medicines safely. But other higher-risk medicines (such as lithium, and methotrexate) were overlooked, which was a missed opportunity. Members of the team were aware of some of the risks associated with the use of valproate-containing medicines in females, and the need to supply full packs. But they were not aware of the updated valproate guidance. And 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 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 patient information leaflets (PILs). But medication descriptions were not written on to the compliance packs, to help people to identify their medicines.

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. A separate record was kept for the delivery of CD medicines to provide a specific audit trail.

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 could not find the records. A copy of the records were sent following the inspection. Short-dated stock was highlighted using a sticker and liquid medications had the dates of opening written onto the bottle. A spot check did not find any out-of-date medicines. Controlled drugs were stored in the CD cabinets, with clear separation between current stock, patient returns and out of date stock.

There was a medicines fridge, 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. However, when checked the fridge temperature remained above nine degrees Celsius. So these medicines may no longer be suitable to use. 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 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.