General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Witton Pharmacy, 6 Preston Old Road, Blackburn, Lancashire, BB2 2SS

Pharmacy reference: 9012269

Type of pharmacy: Community

Date of inspection: 11/10/2024

Pharmacy context

This community pharmacy is on a main road in a residential area of Blackburn, 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 and travel vaccinations. 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 has written procedures to help them to provide services safely and effectively. The pharmacy keeps the required records. And team members know how to keep people's private information safe. They discuss when things go wrong, but they do not make any records. 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 a historic set of written standard operating procedures (SOPs) which belonged to the previous ownership and were due to be updated in December 2021. Members of the team acknowledged they had read a newer set of SOPs but could not be found during the inspection. An electronic copy was sent subsequently to the inspection. But there were no training sheets to show they had read and understood the SOPs.

The pharmacy used electronic computer records to record investigations of dispensing errors. This included any learning outcomes. A paper log was available to record near miss incidents, but it had not been used. The pharmacist discussed any incidents with members of the team at the time they occurred to help identify potential learning points. For example, the team had placed a reminder label next to boxes of aspirin to alert team members to the different pack sizes present on the shelves. But the details of any action taken were not recorded, and the lack of records meant there were no further reviews to look for underlying trends. So the pharmacy may not to be able to show they are doing all they can to learn from their mistakes.

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, 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, but infrequently used CDs were not audited often. So there may be a delay before the pharmacy identified a mistake and was able to act on it. Two random balances were checked and were found to be accurate. Patient returned CDs were recorded.

Historical information governance procedures had been read by members of the team. When questioned, a dispenser described how confidential information was separated and destroyed using a shredder. But there were no details on display to inform people about how their personal information was used. 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 suitable skilled team members to manage the workload safely. But the pharmacy does not routinely provide ongoing learning for the team, so their learning needs may not always be fully identified and addressed.

Inspector's evidence

The pharmacy team included two pharmacists, six dispensers, one of whom was training to become a pharmacy technician, and a delivery driver. 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 and part-time staff.

Members of the pharmacy team had completed some additional training. For example, they had previously completed training about infection control. 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 yearly. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to their line manager. 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 were 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 range of fizzy drinks and confectionary, which were high in sugars, were available to purchase in the retail area. This was not fitting of a healthcare premises providing healthy living advice.

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.

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 and counselling to people taking some higher risk medicines, which would help to ensure they 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. The pharmacy had a medicines 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.

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 put inside medicine bags and kept inside alphabetic storage boxes on collection shelves. 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 prescription tokens were attached to medicine bags when they contained schedule 3 or 4 CDs to remind team members to check the prescription expiry date. But prescription forms were not routinely attached, to enable team members to review what medicines were being handed out. The pharmacist used reminder stickers if they identified a need to provide counselling. For example, to people who were commenced on higher-risk medicines (such as warfarin, lithium, and methotrexate). But the team did not routinely counsel people who had been taking these medicines for some time. This was a missed opportunity to ensure people continued to take their medicines safely and were up to date with blood tests. 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 discussed, 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 started taking their medicines from 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).

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. 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 recorded using electronic software for one of the fridges. But there were gaps in these records, and the temperature of the second fridge had not been recorded. So the pharmacy may not be able to always show they are effectively monitoring the temperatures each day to ensure they had been within the required range. Throughout the inspection the fridge temperatures remained within the required range. The pharmacist acknowledged the record keeping of fridge temperatures had been an oversight and these would be kept going forward. Patient returned medication was disposed of in designated bins located away from the dispensary. Medicine recalls and patient safety alerts were received by email. But details of the action taken by the pharmacy were not kept which would show whether the pharmacy 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, including a designated counting triangle for cytotoxic medicines. 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 telephone was available in the pharmacy which allowed team members to move to a private area if the telephone 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.