

Registered pharmacy inspection report

Pharmacy Name: Pharmacy Express, 105 Linthorpe Road,
Middlesbrough, North Yorkshire, TS1 5DD

Pharmacy reference: 9012312

Type of pharmacy: Community

Date of inspection: 12/11/2024

Pharmacy context

The pharmacy is in a busy retail area in Middlesbrough. It dispenses NHS prescriptions and sells some over-the-counter medicines. The pharmacy offers many services including the NHS New Medicines Service and the NHS Pharmacy First Service. And it offers some private services, including travel vaccinations. The pharmacy team provides medicines in multi-compartment compliance packs to help some people in the community take their medicines at the right time. And the pharmacy delivers medicines to people's homes.

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 suitably identifies and manages risks with its services. It has written procedures relevant to its services and team members follow these to help them provide services safely. Pharmacy team members learn and improve from mistakes. They keep people's confidential information secure. And they know how to identify situations where vulnerable people need help. The pharmacy mostly keeps the records required by law.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs) to help pharmacy team members manage risk with providing services. These included for dispensing, Responsible Pharmacist (RP) regulations and controlled drug (CD) management. These SOPs were held in an organised file so that team members could access them easily. The SOPs had not been signed by all team members to confirm they had understood them. However, the team members who had not signed them explained that they had read and were following them. The working processes described by the team, and observed during the inspection matched the content of the SOPs.

The pharmacy team recorded near miss errors, and from the records seen, this was done regularly throughout the month. Near miss errors were mistakes identified before people received their medicines. The responsible pharmacist took responsibility for recording these errors and the team member who made the error corrected the mistake. This meant they had the opportunity to reflect on what had happened. The RP explained how they and the pharmacy manager regularly reviewed near miss records and highlighted any trends and learning points with the rest of the pharmacy team during informal meetings. The pharmacy had a recorded procedure for managing dispensing errors. These were errors that were identified after the person had received their medicines. The pharmacy kept records of errors that had previously occurred. And the pharmacy team demonstrated changes that had been put in place to prevent similar errors occurring in future. Examples included separating medicines with similar sounding names to different locations in the dispensary.

The pharmacy had a procedure for dealing with complaints. The team aimed to resolve any complaints or concerns locally. If they were unable to resolve the complaint, they escalated it to an area manager who was also a pharmacist. A team member explained that feedback and reviews about the pharmacy posted online were monitored by the area manager. They shared any significant feedback with the pharmacy team and responded to the people that left the feedback, where necessary. The pharmacy had current professional indemnity insurance. At the start of the inspection, the Responsible Pharmacist notice of the previous day's RP was still displayed, which meant that people using the pharmacy would not have correct details of the pharmacist on duty. This was highlighted to the RP who corrected this. Team members knew what activities could and could not take place in the absence of the RP. And they knew what their own responsibilities were based on their role within the team. The RP explained how the pharmacy operated safely with an accuracy checking technician. They followed a clear protocol for the dispensed items they checked, to ensure prescriptions had undergone a professional check firstly by the RP. And they had developed their confidence and competence over time to include the accuracy checking of higher-risk medicines.

The pharmacy kept its RP log electronically. A sample of RP records checked were found to be regularly

lacking RP sign out times. The importance of maintaining accurate records was discussed during the inspection. The pharmacy also kept its private prescription records electronically and these were generally found to be compliant. The RP completed monthly checks of the running balance in the CD register against the physical stock. Random balance checks against the quantity of stock during the inspection were correct. The pharmacy kept a register of CDs returned by people, and there were recent records of these returns being destroyed.

The pharmacy had a policy for keeping people's personal information safe and it kept confidential waste in designated bags, separate from general waste. The bags were sealed when full and collected periodically by a waste disposal contractor for secure destruction. The pharmacy had a procedure for the safeguarding of vulnerable people. Some team members had completed formal safeguarding training to allow them to deliver some services. And other members of the pharmacy shared an example of a recent situation where they had taken action to protect a vulnerable person, they had a concern for.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough people in its team with an appropriate range of skills and experience to deliver safe and effective care. Team members work well together and within the scope of their competence. They are comfortable about giving feedback to help the pharmacy do things better.

Inspector's evidence

At the time of the inspection, the RP was one of the regular pharmacists who worked at the pharmacy. They were supported by a team that consisted of three qualified dispensers and a medicines counter assistant. Two pharmacy students on placement from a local pharmacy school were also present. Other team members who were not present during the inspection were two pharmacy technicians, one of which held accuracy checking accreditation, and two qualified dispensers. Another company-employed pharmacist regularly worked as RP three days per week. The pharmacy managed any periods of absence within the team by offering regular team members overtime, or by bringing in colleagues from other local branches within the company. The team were observed to be calmly managing the workload throughout the inspection and demonstrated some instances where they were completing work a week in advance. The competence and skill mix of the team appeared appropriate for the nature of the business and the services provided. The pharmacy had two delivery drivers working during weekdays. They were managed by the pharmacy's head office.

Team members completed various training to support their development. They accessed learning materials via an online learning platform. The area manager directed the team to mandatory modules to complete. The RP had completed some specific training to gain the competence required to carry out some of the services that the pharmacy delivered through private patient group directions (PGDs). These services included the provision of travel vaccines and period delay medication. And other pharmacies in the group signposted people interested in these services to this pharmacy. Pharmacy team members asked appropriate questions when selling medicines over the counter and referred to the RP at appropriate times. They were confident challenging requests for over-the-counter medicines that they deemed inappropriate.

Team members felt comfortable discussing when things went wrong openly with the wider team, as well as making suggestions to improve ways of working. Team members knew how to raise concerns. This would typically be with the pharmacy manager, but they also had access to the area manager and Superintendent pharmacist (SI) if necessary. The team provided examples of where feedback had been acted on to reduce the amount of retail items the pharmacy offered for sale. The pharmacy owners set performance related targets for the team. The RP did not think that these targets compromised the health or safety of the people using the pharmacy.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are clean, secure, and provide a suitable environment for the services provided. And the pharmacy has a consultation room to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy was a suitable size for the services it delivered. It had an overall appearance which was modern and professional. The retail area of the pharmacy was small but had seating for people to use when waiting. A combination of the pharmacy counter and a freestanding 'no entry' signpost provided a barrier to prevent unauthorised access to the dispensary. The dispensary was a good size for the workload being undertaken. It provided the team with adequate bench space to work. And there was sufficient storage space for stock, assembled medicines and medical devices. Pharmacy team members kept the pharmacy, including the work benches, clean and tidy. And they mostly kept floor spaces clear of obstructions, to help reduce the risk of trip hazards. The layout of the dispensary supported the supervision of medicines sales and queries from the RP's workstation. The lighting and temperature were suitable to work in and to provide healthcare services. The dispensary had a sink with access to hot and cold water for professional use and hand washing. There were staff and toilet facilities that were hygienic.

The pharmacy had a suitably soundproofed consultation room which had access from the retail area and dispensary. And team members used this room to provide services and have private conversations with people. The pharmacy had a second dispensing area on the first floor, which team members used for storage and to prepare medicines in multi-compartment compliance packs. The pharmacy team kept the hygiene of the premises to an adequate standard, with team members completing cleaning tasks daily.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy sources its medicines from recognised suppliers. And it generally stores and manages them appropriately. Pharmacy team members complete regular checks to ensure medicines are suitable for supply. And they respond appropriately when they receive alerts about the safety of medicines. Team members adequately manage the delivery of services safely and effectively. And they take opportunities to provide people with advice on higher-risk medications.

Inspector's evidence

Access to the pharmacy was via a small step. Pharmacy team members explained how they supported people who may have difficulties entering the pharmacy by meeting them at the entrance. The pharmacy's large windows and transparent glass door was conducive to this. The pharmacy team used the patient medication record (PMR) system to produce large-print labels to help people with visual impairments. And they demonstrated how people's records were flagged to ensure that they received their labels this way. The pharmacy provided a medicines delivery service. Team members stored assembled bags of medicines waiting for delivery in a separate area at the back of the dispensary. They sorted these according to postcode and delivery day. This was to ensure the large number of deliveries provided by the pharmacy were kept organised. The delivery drivers kept an audit trail of the deliveries completed in case of any queries. They provided people with a note when deliveries could not be completed. And they returned any failed deliveries back to the pharmacy on the same day.

The pharmacy provided some services via private PGDs. These were delivered by the RP, and they recorded details of the consultation and any medicines or vaccines supplied to people. The pharmacy provided many people with their medicines dispensed in multi-compartment compliance packs. Team members ordered people's prescriptions in advance of the compliance pack being due, which allowed enough time to receive the prescriptions back, order any necessary stock and deal with any queries. They also kept an audit trail of which ordered prescriptions had been received back to easily highlight if any were outstanding. The pharmacy used a record for each person that listed their current medication, dosage, and dose times. This was referred to throughout the dispensing and checking of the packs. The pharmacy team used a standard form for recording any contact received about the compliance packs it dispensed. This meant that there were clear audit trails for medication changes. From a sample of compliance packs checked, the full dosage instructions, and medication descriptions were included. And patient information leaflets were routinely supplied with these packs. However, the necessary warnings for the medicines contained were not always included. The pharmacy team explained that the decision to not include medicine warnings was to help lists of people's medicines fit on one page to reduce the risk of any extra sheets of paper being misplaced. The importance of including appropriate warnings and precautions on dispensed medicines was discussed with the RP during the inspection, who agreed that the pharmacy would include these for all compliance packs. The pharmacy team used an organised system for the safe storage of the large number of assembled multi-compartment compliance packs.

The pharmacy team dispensed prescriptions using baskets, which kept prescriptions and their corresponding medicines separate from others. Pharmacy team members signed dispensing labels during dispensing and checking. This maintained an audit trail of the team members involved in the process. They used stickers to indicate a prescription that contained a fridge item, to ensure correct storage temperatures were maintained. And they highlighted dates on prescriptions that contained CDs

to ensure they were not handed out beyond their legal expiry.

The pharmacy had written procedures that covered the supply of a range of higher-risk medicines. The RP explained how the team set up alerts in people's records in the PMR system. These alerts helped ensure prescriptions were flagged during dispensing of any medicines that required further advice and counselling. The pharmacy team showed a good understanding of the requirements for dispensing valproate for people who may become pregnant and of the recent safety alert updates involving other medicines with similar risks. The team dispensed prescriptions for these medicines in the manufacturer's original packs. And team members took care to place labels on appropriate parts of the box. The pharmacy provided some higher-risk medicines to people in regular instalments throughout the week. And the RP supervised the consumption of these supplies privately in the consultation room. The pharmacy team prepared batches of these medicines in advance. They did this on the pharmacy's typically quieter days. Team members used glassware that was clearly marked for the measuring out of doses of higher-risk liquid medicines. The RP confirmed the quantity while referring to the prescription, before the doses were transferred to appropriate, labelled containers. These were stored securely in an organised way which kept people's medicines separate.

When the pharmacy could not entirely fulfil the complete quantity required on a prescription, team members created an electronic record of what was owed on the PMR system. And they gave people a note detailing what was owed. This meant the team had a record of what was outstanding to people and what stock was needed. The team checked outstanding owings daily and were managing these well. The pharmacy had a procedure for checking expiry dates of medicines. Team members checked defined sections of the dispensary and recorded when the expiry dates of medicines in a section had been checked. This ensured that the team had an audit trail of expiry dates checked. The team was up to date with its date-checking activities. There was some evidence seen of medicines highlighted due to their expiry date approaching, but the team explained that any stock found to be short dated is offered to other branches in the company who are more likely to use it before expiry. There were no instances of expired medicines found on the shelf during the inspection, and most opened liquid medications had been marked with the date of opening to highlight that it's shelf life may be reduced as a result. During the inspection, a selection of amber bottles containing stock were removed from shelves by the inspector. These bottles had labels attached but with insufficient information about the product contained. The importance of adhering to good practice principles of stock storage in terms of both patient safety and product stability, was discussed during the inspection. The pharmacy kept unwanted medicines returned by people in segregated containers, while awaiting collection for disposal.

The pharmacy obtained medicines from licensed wholesalers and specials manufacturers. It held medicines requiring cold storage in medical fridges equipped with a thermometer. Team members monitored and recorded the temperatures of the fridges daily. These records showed cold-chain medicines were stored at appropriate temperatures. The pharmacy held its CDs in secure cabinets. It had a documented procedure for responding to drug safety alerts and manufacturer's recalls. It received these via email and had records of alerts received and any actions taken in response.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and resources it needs to provide its services. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

Pharmacy team members had access to a range of hard-copy reference materials and access to the internet for up-to-date information and further support tools. The RP accessed some specialist resources, like the National Travel Health Network and Centre, to support the delivery of the pharmacy's travel vaccine service. There was equipment available for the services provided which included an otoscope, a digital thermometer, and a blood pressure monitor. Electrical equipment was visibly free from wear and tear and appeared in good working order. The pharmacy had a range of clean counting triangles and CE marked measuring cylinders for liquid medicines preparation. The team had access to personal protective equipment, such as disposable gloves when handling medicines.

The pharmacy's computers were password protected and access to people's records was restricted by the NHS smart card system. Computer screens were protected from unauthorised view and a cordless telephone was available for private conversations in quieter areas. The pharmacy stored completed prescriptions and assembled bags of medicines away from public reach and view in a restricted area.

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.