General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Parkside Pharmacy, Front Street, Bellingham, HEXHAM, Northumberland, NE48 2AA

Pharmacy reference: 1035853

Type of pharmacy: Community

Date of inspection: 25/03/2024

Pharmacy context

This is a pharmacy in the rural area of Bellingham, Hexham. Its main activities are dispensing NHS prescriptions, and it supplies some people with their medication in multi-compartment compliance packs to help them take their medicines correctly. It provides services such as NHS Pharmacy First, emergency contraception and delivers medicines to people in their homes.

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 has written procedures to help identify and manage risk so team members can provide services safely and effectively. Team members record mistakes they make during the dispensing process to help prevent the same mistake occurring. They mostly keep records required by law, and they keep people's private information secure. They have appropriate training to help them respond correctly to support vulnerable people.

Inspector's evidence

The pharmacy had some standard operating procedures (SOPs) to help manage the risk of its services. The pharmacy owners were in the process of reviewing and updating the SOPs which meant that some, including delivery service SOPs, were unavailable on the day of the inspection. The pharmacy had SOPs about the responsible pharmacist (RP), controlled drug (CD) management and dispensing. The SOPs were prepared in July 2023 and were marked for review by the owner and superintendent pharmacist (SI) in July 2025. The CD SOPs had not been signed by team members.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. Team members felt comfortable discussing their mistakes. The person who made the near miss recorded the details about it such as it being the incorrect quantity or strength dispensed. The data produced from the near misses was analysed to produce a monthly patient safety report which was completed by the owner pharmacist. And the information produced was shared with team members. Team members had separated medicines in the dispensary that had been involved in previous near misses, including metformin. And they had highlighted areas where medicines that looked-alike and sounded-alike were kept. The pharmacy completed incident reports for mistakes that were not identified until after a person had received their medicine, known as dispensing errors. A recent incident report included the details of the mistake but did not include any learnings which meant that opportunities to learn from the incident may have been missed. The pharmacy displayed a complaints and feedback procedure in the retail area. Team members aimed to resolve complaints informally. If they were unable to resolve a complaint, they escalated it to the SI. The pharmacy received feedback from reviews posted by people accessing the services on a NHS website and this was positive. Team members had received a notification of a positive review the previous week.

The pharmacy had current professional indemnity insurance. Team members had some knowledge of the tasks they could and could not complete in the absence of the RP. For example, they knew they could not hand out completed prescriptions or sell pharmacy only (P) medicines, but they were unaware they could not dispense medication. The RP notice was displayed in the retail area and reflected the details of the pharmacist on duty. The RP record was completed correctly, with two minor omissions over six weeks missing the time the RP ceased responsibility. The pharmacy kept paper records for the receipt and supply of its CDs. The records of supplied CDs were in order, but the address of the supplying wholesaler was generally missing from the record. Team members checked physical stock levels of CDs matched the running balance in the CD register on a monthly basis. The pharmacy recorded details of CD medicines returned by people who no longer needed them. And the destruction of the medicines was witnessed. The pharmacy kept complete records for its supply of medicines made against private prescriptions and kept associated paper prescriptions. It kept certificates of conformity for unlicensed medicines and full details of the supplies were kept to provide an audit trail.

The pharmacy displayed a privacy notice and a NHS data processing notice in the retail area which informed people of how their data was used. The pharmacy had policies about information governance and the General Data Protection Regulation, which team members had signed. The pharmacy separated and shredded confidential information. Team members had received training about safeguarding vulnerable adults and children. And they explained they would refer any concerns to the pharmacist or the person's GP. This included the delivery driver who knew to report any concerns to back to the pharmacy. And the pharmacist would report concerns to the GP. The accuracy checking pharmacy technician (ACPT) and the RP had completed level 2 and 3 safeguarding training respectively.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to provide its services safely. Team members who are working towards the completion of accredited qualification training are suitably supported and supervised by the pharmacist. Team members receive ongoing training to further develop their skills and knowledge. And they support each other to help complete the workload. They ask appropriate questions when helping people with their healthcare needs. And they feel comfortable to raise concerns if required.

Inspector's evidence

The pharmacy team at the time of the inspection, included a locum, who was the RP, an ACPT who was the pharmacy manager, two dispensers, a trainee medicines counter assistant (MCA) and a delivery driver. Other team members not present were a dispenser, a locum dispenser, and second delivery driver. The trainee MCA's training course was overseen by one of the owner pharmacists. And the trainee was progressing through the course in a timely manner. Other team members developed their skills and knowledge through training provided by the owner pharmacist. Team member's most recent training involved the re-classification of codeine linctus and updated legislation for supplying valproate in original packs. The locum pharmacist had completed administration and clinical training provided by the Centre for Pharmacy Postgraduate Education (CPPE) to provide people with influenza vaccinations. And they completed CPPE training every two years for the provision of emergency contraception. Other pharmacists working in the pharmacy had signed patient group directions (PGDs) declaring their competency to give advice and treatment under the NHS Pharmacy First service.

Team members were observed working well together to manage the workload. And they supported each other and asked each other questions to help resolve queries. The owner pharmacist usually worked in the pharmacy on Saturdays and would share information about learnings, recalls or other important information. Team members who worked alongside the owner pharmacist ensured the information was briefed to other team members on a Monday morning. Annual leave was planned in advance, so contingency plans were made. Part-time team members increased their hours to support during periods of absence. Team members felt comfortable to raise professional concerns with the pharmacy's management team. And there was a whistleblowing policy. Team members felt able to make suggestions for change. For example, the ACPT discussed changes about the layout of the dispensary and sought opinions from team members as to whether it would be beneficial. There was an open and honest culture amongst the team and the pharmacy manager had informal performance discussions with team members.

Team members asked appropriate questions when selling medicines over the counter. And they knew to be vigilant about repeated requests for medicines liable to misuse, for example medicines containing codeine. They referred such requests to the pharmacist who had supportive conversations with people and refer them to their GP if necessary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and suitable for the services it provides. It has appropriate facilities for people requiring privacy when accessing the pharmacy's services.

Inspector's evidence

The pharmacy premises portrayed a professional appearance. There was a front retail area and a dispensary to the rear. Additionally, there were two upstairs rooms used for storage and for the preparation of multi-compartment compliance packs. The pharmacy had a medicines counter which acted as a barrier to help prevent unauthorised access to the dispensary. The dispensary was very small, but team members managed the limited space well. There was an organised workflow and there were separate areas for the dispensers and pharmacist to complete tasks. As the dispensary was small, the pharmacist was able to supervise the dispensary and medicines counter easily. And they were able to intervene in conversations at the counter if necessary. The dispensary was up a small step and was screened to allow dispensing activities to take place without distraction. The dispensary shelves were kept neat and tidy, and the pharmacy was cleaned daily as per a rota. The dispensary had a sink which provided hot and cold water and was used for professional use and handwashing. A separate bathroom upstairs provided further facilities for handwashing. The upstairs room used to prepare multi-compartment compliance packs was spacious and organised. The temperature was comfortable, and lighting was bright throughout.

The pharmacy had a consultation room which was situated up a flight of stairs on the first floor. It allowed people to have private conversations or access services from the pharmacist. It had a desk, chairs and computer.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages the delivery of its services safely and effectively. And it makes them accessible to people. Team members generally supply people with the information they need to help them take their medicines. They complete checks on medicines to ensure they remain fit for supply. And they respond appropriately when they receive alerts about the safety of medicines.

Inspector's evidence

The pharmacy had level access from the street to help those using wheelchairs or with prams. It advertised a range of services it provided in the window of the pharmacy. Team members provided large print labels for those with visual difficulties. For those who were unable to access the consultation room, team members asked people to return when the pharmacy closed at lunchtime so a conversation could be completed privately on the ground floor. Team members managed services such as the administration of influenza vaccinations in the same way. As the pharmacy had large glass windows, team members maintained people's privacy by asking them to wear clothing that allowed access to their upper arm. And they had screens which could be used to further maintain people's privacy. The NHS Pharmacy First service was provided by some of the pharmacists. The PGDs for the service were kept in paper form in a folder for easy referencing.

Team members used baskets to keep people's prescriptions and medicines together to prevent them becoming mixed up. They highlighted the inclusion of a fridge line or CD using stickers on prescriptions. And the pharmacist used "speak to pharmacist" stickers if pharmacist input was required when handing out prescriptions to people. Team members were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicine effectively. Records showed that a person receiving valproate had been counselled on the risks by the pharmacist. Team members informed people when the full quantity of their prescription could not be provided. For any medicines that were out of stock, team members referred to the surgery for an alternative. The pharmacy supplied some people with their medicines using the repeat dispensing service. It maintained separate records of people's medicines and doses. Any communications about changes to peoples medicines were kept in the person's folder so there was a clear audit trail.

The pharmacy supervised the administration of a medicine as part of a substance misuse service. Team members prepared the medicine in advance, so it was ready for when it was required. The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. Team members ordered the prescriptions in advance. Most people were provided with their packs one week in advance due to the rural nature of the pharmacy. Each person had a medication record sheet which detailed the medicines taken and dosage times. Any changes to people's packs were communicated via email from the persons GP. The packs contained a sheet which included information as to the medicines in the pack. Team members provided descriptions of the medicines so they could be easily identified. And they provided patient information leaflets (PILs) every four weeks. Warning labels for medicines were sometimes omitted. When checking on the pharmacy's patient medication record (PMR), a label preview showed the warning information included, but it was not transferred to the provided sheet. For other patients the warning label was included for the same medicine. The dispenser confirmed they would check the settings to ensure all information sheets would be issued with the relevant warnings. CDs were added to packs on the day they were due to be

delivered.

The pharmacy provided a delivery service, taking medicines to people in their homes. Due to the rural nature of the pharmacy and the population it served, some people in remote locations had an agreement in place for their medicines to be left in a safe place. Consent was captured on the person's PMR and bag label so that delivery drivers knew who had given consent for their delivery to be left. And this only occurred if the person was not available to receive their delivery. A note was posted through the person's letterbox informing them of where the medicine had been left. The risks had been considered and fridge lines or CDs were never left unattended and were returned to the pharmacy. The pharmacy asked people to inform them of any changes to their circumstances and did not review people's circumstances themselves. Patients signed for the receipt of the CD medications.

Team members stored medicines in the original manufacturer's containers. Pharmacy only (P) medicines were stored behind the medicines counter which helped ensure the sales of these were supervised by the pharmacist. Team members had a process for checking the expiry date of medicines. They completed different sections of the dispensary weekly. And any medicines going out of date in the next three months were highlighted for use first. A random selection of several medicines found all to be within their expiry date. The pharmacy had two fridges to store medicines that required cold storage. Team members recorded the temperatures daily. The current temperature for both fridges was within the required two and eight degrees Celsius but their maximum temperatures were above 8 degrees. Team members reset the thermometers in response. Team members received notifications about drug safety alerts and recalls via email. These were printed, actioned and recorded on the patient safety report. Medicines returned by people who no longer needed them were kept separately for destruction by a third-party company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had access to up-to-date electronic resources including the British National Formulary (BNF) and BNFc (for children). It had crown marked glass measuring cylinders which were marked to identify which were for water and which were for liquid medicines.

The pharmacy had cordless telephones so that conversations could be kept private. And it stored medicines awaiting collection to the side of the medicines counter. Team members ensured peoples private information was protected by storing the bags so the labels were not visible. Initials for people were written on the bottom of the bag, which helped team members locate the correct person's medicine. Confidential information was secured on computers using passwords. Screens were positioned in the dispensary and prevented unauthorised access to confidential information.

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.