

Registered pharmacy inspection report

Pharmacy Name: Coast Road Pharmacy, 11 Coast Road, WALLSEND,
Tyne and Wear, NE28 9HP

Pharmacy reference: 1037719

Type of pharmacy: Community

Date of inspection: 21/10/2024

Pharmacy context

This is a community pharmacy in Wallsend in Newcastle. Its main activities are dispensing NHS prescriptions and providing people with their medicines in multi-compartment compliance packs to help them take their medicines safely. It provides a range of services including NHS Pharmacy First and provides a delivery service taking medicines to people in their 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 has written procedures which help guide team members to work safely and effectively. Team members record errors they make during the dispensing process and take suitable action to help prevent a recurrence of a similar error. They keep people's private information secure. And they know how to suitably respond to concerns about the welfare of vulnerable adults and children. The pharmacy keeps records required by law. But it does not maintain stock level records for all its higher-risk medicines. So, it may not identify errors in a timely manner.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to help team members to work safely and effectively. It had SOPs about dispensing processes, the responsible pharmacist (RP), and an SOP about its delivery service. The SOPs had been signed to confirm they had been reviewed in May 2024 by the company's superintendent (SI) pharmacist. Team members signed to say they had read and understood the SOPs. And they confirmed that they would only re-sign the SOPs after review if there had been any changes to them. The pharmacy's delivery SOP had not been updated since the previous inspection to include the process for delivering some people's deliveries through their letterbox. However, the pharmacy manager confirmed that the process had been changed and only a very small number of people had their medicines delivered in this way.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. The pharmacist recorded the details about the near miss and discussed it with the team member involved. Team members completed an informal review of the near miss data to identify any trends in mistakes made. And they made suggestions about changes that were required in the dispensary to help prevent the same or a similar mistake recurring. For example, they separated amlodipine 10mg tablets and atorvastatin 10mg tablets from each other and had separated allopurinol 100mg and 300mg tablets from each other on the dispensary shelves due to their involvement in near misses. The pharmacy recorded mistakes that were identified after a person had received their medication, known as dispensing errors. The details about the error were recorded on paper and were shared with the SI. Again, team members had separated the two medicines involved in the most recent dispensing error to help prevent a recurrence. The pharmacy had a complaints procedure which involved team members aiming to resolve any complaints or concerns informally. Any complaints that could not be resolved were escalated to the complaints manager. The pharmacy received feedback from people using its services via online reviews. Reviews seen were generally positive and this was shared with team members.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. The pharmacy had a roles and responsibility matrix which detailed the pharmacy activities team members were able to complete. This had not been completed when the SI had reviewed it in May 2024. Team members were observed asking the pharmacy manager which tasks they needed to complete that day. They knew which tasks could and could not take place in the absence of the RP. The RP notice was displayed in the retail area of the pharmacy and reflected the details of the RP on duty. The RP record was compliant. The pharmacy recorded the receipt and supply of its CDs in a paper-based register. The entries checked were in order, with some minor omissions in the wholesaler address for received medicines. Team members checked the physical stock levels of

tablets and capsules matched those in the register regularly, with the last check completed on 19th October. The pharmacy recorded details about CD medicines returned by people who no longer needed them. They recorded the details upon receipt and the destruction of the medicines was witnessed by a registrant. The pharmacy kept certificates of conformity for unlicensed medicines known as “specials”. A sample of certificates seen captured the details of who the medicines was supplied to which provided an audit trail. The pharmacy kept complete records of its supplies of private prescriptions and kept associated prescriptions.

Team members were aware of their responsibility to keep people’s private information secure. Team members had completed training either through training providers or at induction. They separated confidential waste for shredding on site. Team members were also aware of their responsibility to safeguard vulnerable adults and children. The pharmacy had a child protection and vulnerable adult policy which included telephone numbers for relevant contacts for team members to refer to. Team members would refer to the pharmacist in the first instance if they had any concerns.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough suitably skilled and qualified team members to support the delivery of services and manage the workload. Team members receive opportunities to develop their skills and knowledge. They support people and give appropriate advice when helping them with their healthcare needs.

Inspector's evidence

The RP at the time of the inspection was a locum pharmacist who worked frequently for the company. They were supported by the pharmacy manager who was also a qualified dispenser. The pharmacy had a resident pharmacist, two qualified dispensers and a trainee medicines counter assistant (MCA) who were not present during the inspection. Annual leave was planned in advance and arranged with a member of the company's management team. Team members from other pharmacies in the company were able to support periods of absence. The pharmacy manager had asked for support due to team member absence and two team members were sent to support from other pharmacies in the company. These team members included a dispenser and a trainee pharmacist.

Team members had either completed or were in the process of completing accredited training for their roles. The MCA's training was overseen by the SI pharmacist and the pharmacy manager confirmed that the SI had regular engagement with the MCA about their training. Team members ensured their skills and knowledge were kept up to date by completing additional training. Two team members had recently completed training about the smoking cessation service. The pharmacist had completed face to face training to be able to provide the NHS Pharmacy First service.

Team members were observed to work well together and were managing the workload. They had regular informal reviews with the pharmacy manager and a member of the management team to discuss their performance. And they had a review annually with the SI. Team members felt able to make suggestions and raise professional concerns with the pharmacy manager or SI. And the pharmacy had a whistleblowing policy for team members to use if necessary. They knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. They would refer to the RP who would have supportive conversations with people. The pharmacy set its team members targets; they did not feel under pressure to achieve them.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is generally clean, secure and suitable for the services it provides. It has adequate facilities to provide privacy for people accessing pharmacy services.

Inspector's evidence

The pharmacy had a retail area to the front of the premises which portrayed a professional appearance. And the dispensary was positioned to the rear of this. There was a barrier at the medicines counter which prevented unauthorised access to the dispensary. The dispensary was elevated so there was privacy for dispensing activities to take place without distraction. The dispensary was small and team members made good use of the space. There were different benches for the completion of different tasks. The pharmacist's checking bench was positioned so they could supervise the activity in dispensary and at the medicines counter. The dispensary had a sink which provided hot and cold water. Toilet facilities were slightly unclean and provided separate handwashing facilities. Team members had a rota for cleaning activities with a deep clean completed monthly.

The pharmacy had two consultation rooms for people to have private conversations with team members and access services. The consultation rooms were free from clutter and tidy. Both consultation rooms had sinks. There was space for consultations to be completed comfortably with a desk and two chairs in one room and a doctor's bed in the other. The pharmacy had suitable lighting throughout and the temperature was comfortable.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy generally manages the delivery of its services safely and effectively. And team members make them accessible to people. They provide people with the necessary information to take their medicines safely. They source medicines from licensed wholesalers and mostly complete regular checks on medicines to ensure they remain fit for supply. They respond appropriately to notifications about the safety of medicines.

Inspector's evidence

The pharmacy had level access from the street which provided ease of access to those with limited mobility and pushchairs. It had a range of healthcare leaflets for people to read or take away. Team members assisted those with hearing difficulties by providing them information in writing and they used translation applications for people whose first language was not English. They signposted people to other pharmacies to access services they did not offer. The NHS Pharmacy First service was provided via patient group direction (PGD) and there were current copies of the PGDs kept in the dispensary for the pharmacists to refer to if needed. The RP had access to flowcharts for each condition to help the pharmacist with their decision making. The pharmacist recorded consultations on an electronic platform and the information was shared with the person's GP.

The pharmacy supervised the administration of medicine for some people as part of the substance misuse service. The pharmacist managed the service and prepared the doses of medicines ahead of them being required by people, but they were not obtaining a second check of the volume poured. The pharmacy provided a delivery service, taking medicines to people in their homes. And the driver asked people to sign to confirm receipt of their CDs. They posted a small number of deliveries through letterboxes, the number had significantly decreased since the previous inspection. People had signed a consent form to show they agreed to this process. And if the driver was on annual leave this process did not occur at all. The pharmacy manager confirmed verbal checks were completed with people monthly to ensure that the procedure was still suitable.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines at the correct times. The pharmacy ordered prescriptions a week in advance so that any queries about a person's medication could be resolved in a timely manner. Each person had a medication record which showed the administration doses and times. Packs were dispensed and checked on the same day and team members provided the manufacturer's packs to the pharmacist, so they had all the necessary information to complete their checks. The pharmacy provided descriptions of the medicines in the pack so they could be easily identified. And they provided patient information leaflets once a month, so people had the necessary information about their medicines. Prescriptions for CDs were issued weekly by the GP surgery. Team members made up a month supply of packs containing CDs at a time. And these were checked again by the pharmacist once they had received a valid prescription. Packs containing CDs were stored securely in the CD cabinet. The pharmacy provided influenza and covid vaccinations. These were provided by the resident pharmacist and a dispenser. The dispenser provided the vaccinations under the national protocol. They had completed their training to administer influenza within the last two years and had completed annual covid vaccination training in September 2024. The pharmacy had an in-date adrenaline pen stored on the pharmacy shelves instead of the consultation room for use in an emergency. Team members were advised to ensure they had all the necessary equipment as per the service specification to ensure that

vaccination services were delivered safely.

Team members used baskets to keep people's medicines and prescriptions together and prevent them from becoming mixed up. They used stickers and stamps to highlight the inclusion of fridge items, controlled drugs and if the person had their medicines delivered. Team members signed to confirmed who had dispensed and who had checked the medicine so those involved in each stage of the process could be identified. They were observed asking appropriate questions when medicines were handed out to confirm they were provided to the correct person. They provided people with an owing slip or told them verbally if they were only able to be supplied with some of their medicine. And for any medicines that were out of stock they referred the patient back to their GP for an alternative.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were stored neatly behind the medicines counter which helped ensure that the sales of these were supervised by the pharmacist. There were various amber bottles containing tablets, which had been removed from the original manufacturer's packs. These had been annotated with the batch number and expiry date. Team members had a process for checking the expiry date of medicines which involved checking sections of the dispensary monthly. The pharmacy manager explained this had not been completed as per processes due to them being busier with providing winter vaccinations to people. Records showed date checking had been completed up to August 2024. Medicines expiring in the next few months were highlighted clearly with the expiry date. Not all liquid medicines had been marked with the date of opening or had passed their expiry date after opening. These were removed during the inspection. Team members checked the expiry dates of medicines when dispensing and checking medicines. This reduced the risk of supplying medicines past their expiry date. The pharmacy had two fridges to store medicines requiring cold storage. Team members recorded the temperatures of the fridges daily and records showed they were operating between the required two and eight degrees Celsius. The pharmacy received safety alerts and drug recalls about medicines via email. The pharmacy manager reviewed the information and actioned the alerts. And communicated the information to team members. They kept a folder on the computer for alerts about medicines they dispensed for people to refer to if necessary.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy generally has the equipment it needs for the services it provides. Team members use the equipment in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to online copies of the British National Formulary (BNF) and British National Formulary for children (BNFc). As part of the NHS Pharmacy First service, the pharmacy had equipment to provide the service including a blood pressure monitor and otoscope. The pharmacy manager confirmed it had been replaced two weeks previously.

The pharmacy had both glass cylinders and plastic measures used to measure liquid medicines and water. The cylinders were marked to indicate which were for water and which were for liquid medicines. The plastic measures were not stamped to confirm the accuracy of the volume poured and this was highlighted during the inspection. It had also been seen at the previous inspection. The pharmacy manager acknowledged this and confirmed replacement glass cylinders had already been ordered and were due to be delivered. The pharmacy had triangles used to count tablets. It stored medicines awaiting collection so that people's private information could not be seen by unauthorised people. And it had a cordless telephone so that conversations could be taken in a private area. The pharmacy computer screens were positioned in staff only areas so they could not be seen by unauthorised people. And the systems were password protected.

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.