General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Fawdon Park Pharmacy, 9 Fawdon Park Road, Fawdon, Newcastle upon Tyne, Tyne and Wear, NE3 2PE

Pharmacy reference: 9010826

Type of pharmacy: Community

Date of inspection: 11/03/2024

Pharmacy context

This is a pharmacy in Fawdon, Newcastle. Its main activities are dispensing NHS prescriptions and providing some people with medicines in multi-compartment compliance packs to help them take their medicines correctly. It provides a range of NHS services including Pharmacy First and provides a delivery service taking 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's written procedures help manage risk and guide team members to work safely and effectively. Team members record errors made during the dispensing process and make changes to help prevent a recurrence of the same or a similar error occurring. They keep records required by law and they know how to keep people's private information secure. They know how to respond to concerns for people accessing the pharmacy's services.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which assessed the risks of its services and helped guide team members to work safely and effectively. These included SOPs for controlled drugs (CD) management, dispensing and responsible pharmacist (RP). Team members had signed to confirm they understood and would comply with them. The superintendent (SI) pharmacist reviewed the SOPs every two years and had last completed the review in 2023.

The pharmacy recorded errors identified during the dispensing process known as near misses. The details of the error were recorded by the person who made the error. The pharmacist analysed the near misses for trends and had informal discussions with team members to help prevent a recurrence of the same or a similar error. There were some examples of stickers located throughout the dispensary which highlighted medicines that had been previously involved in near misses. This helped draw attention to these medicines when team members were dispensing them. The pharmacy completed electronic incident reports for errors that were not identified until after a person had received their medicines. The pharmacy had a complaints procedure for handling complaints or concerns. Team members aimed to resolve any complaints or concerns locally. And the SI pharmacist worked in the pharmacy full-time so was able to respond to complaints if needed. The pharmacy had good relationships with the local community and received regular positive feedback from those accessing the services.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. And there was a roles and responsibility SOP. The accuracy checking pharmacy technician (ACPT) had discussed with the SI as to what they felt comfortable to check. This included a discussion regarding checking multi-compartment compliance packs and as a result the SI checked packs that had many medicines in them as these were more difficult to check. The ACPT knew that prescriptions annotated with a black dot meant that these had been clinically checked and were suitable for them to complete the final accuracy check. Team members had some knowledge of the activities that could and could not take place in the absence of the RP. The RP notice was displayed prominently in the retail area and reflected the correct details of the pharmacist on duty. The RP record was compliant. The pharmacy kept certificates of conformity for unlicensed medicines and full details of the supplies were included to provide an audit trail. It kept electronic records for its supplies of private prescriptions and kept associated paper prescriptions. The pharmacy kept records of CD medicines returned by people who no longer needed them. These were compliant and destruction of these was witnessed. The pharmacy's records of its receipts and supplies of CDs were compliant. Team members checked the physical stock levels of medicines matched those in the CD register when they were being issued to people. This meant medicines that were being supplied frequently were checked frequently. And for medicines that were not supplied frequently balance checks were completed separately. The last recorded balance check for items not supplied frequently was completed in August 2023. The

pharmacists provided a locally commissioned NHS “walk in medicines service” where people could receive a small supply of medication. An example of the reason for a supply was seen recorded on an online platform and the persons patient medication record (PMR).

The pharmacy had an NHS data leaflet displayed in the retail area which informed people of how their data was used. Team members received training for information governance (IG) and general data protection regulations (GDPR) annually. The pharmacy separated confidential waste for shredding by a third-party company. The pharmacy provided the delivery driver with a list of people he was to deliver to. But it had not considered the risks of people’s private information being seen by unauthorised people when delivery drivers asked people to sign for their deliveries. Securing this information was discussed. Team members knew of their responsibilities to safeguard vulnerable adults and children and would refer any concerns to the pharmacist. The pharmacist gave an example of an occasion they had liaised with the appropriate authorities in response to concerns for a person’s welfare. And they had documented the concerns and actions taken on the person’s PMR.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and qualified team members to help manage the workload. Team members support each other with learning to help develop their skills and knowledge. They ask suitable questions and give appropriate advice when assisting people with their healthcare needs.

Inspector's evidence

The pharmacy had two pharmacists working at the time of the inspection, one of whom was the SI and RP. The SI worked in the pharmacy full-time alongside two locums who covered the pharmacy's opening hours so there was double cover every day. The pharmacy team further comprised of an ACPT, a recently qualified pharmacy technician, four dispensers, two medicines counter assistants and two delivery drivers. Team members had all completed accredited training for their roles except for the drivers who had read accredited driver training manuals and had not yet completed their assessments. Team members helped each other learn to help develop their skills and knowledge. One team member had shared their learning with team members that packs of sodium valproate contained a warning card that could be removed and given to people in the at-risk category. The pharmacists had completed training to deliver the NHS Pharmacy First service, including face to face training in the use of otoscopes and online clinical training.

Team members were observed working well together to manage the workload. Annual leave was planned in advance and part-time team members could increase their hours to support absences. The SI did not give the team members formal performance reviews but had informal conversations with team members about performance. Team members were not set targets. There was an open and honest culture amongst the team, and they felt comfortable to raise concerns if required.

Team members asked appropriate questions when selling medicines over the counter. They knew to be vigilant to repeated requests for medicines liable to misuse, for example medicines containing codeine. They referred such requests to the pharmacist or gave advice for people to contact their GP.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises portrayed a professional appearance. It was comprised of a large retail area to the front which sold various products including healthcare related items. The dispensary was spacious and had a consultation room that could be accessed from the dispensary for team members and from the retail area for people. There was a medicines counter which acted as a barrier and prevented unauthorised access to the dispensary. The dispensary was organised, clean and had different bench spaces for the completion of different tasks. There were two central islands which provided additional bench space for team members to complete tasks. One of the pharmacists checked prescriptions at a bench at the front of the dispensary which allowed them to effectively supervise the dispensary and medicines counter. And they were able to intervene in conversations at the medicines counter if necessary. The dispensary had a sink which had hot and cold water and was used for the preparation of medicines. And there was a storage area and staff break area to the back of the premises which was neat and tidy. The toilet and staff area were clean and had separate facilities for hand washing.

The pharmacy had a soundproofed lockable consultation room where people could have private conversations with team members and access services from the pharmacist. The room had a desk, a computer and chairs and was kept locked at the retail entrance to help prevent unauthorised access to the consultation room and dispensary. There had been a small ceiling leak which had been promptly fixed. The temperature was comfortable throughout and the lighting was bright.

Principle 4 - Services ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had an automatic door and level access from the street which allowed ease of access to those using wheelchairs or with prams. It had a range of healthcare leaflets for people to read or take away. And it signposted people to other nearby pharmacies for services it didn't provide such as palliative care medicines. The pharmacy provided some people with large print labels. And it provided the newly launched NHS Pharmacy First service which was underpinned by patient group directions (PGDs) which had been signed by the pharmacists and were available in paper form for easy referencing. If a person needed to be referred to the GP after being seen under the Pharmacy First service, the pharmacists completed the referral via an online platform and called the GP surgery to alert them.

Team members used baskets to keep people's prescriptions and medicines together and prevent them becoming mixed up. And they signed dispensing labels to confirm who had dispensed and who had checked a medicine so there was a full audit trail of those involved in each stage of the process. Stickers highlighted the inclusion of a CD or fridge line or if the pharmacist wanted to speak to a person at hand out. 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 medicines safely. They were aware of recent updated legislation for providing valproate in the original pack. People who received their medicines in multi-compartment compliance packs now received their valproate monthly to ensure original packs were dispensed. And this change had been supported by a local pharmacy hub which supported GP surgeries and pharmacies with medicines management. Team members were observed making suitable checks when handing out medicines to people to ensure they had been supplied to the correct person.

The pharmacy provided a delivery service, taking medicines to people in their homes. The deliveries were prepared and stored in a separate area of the pharmacy. And fridge items were dispensed on the day they were due to be delivered. The delivery drivers used a list of the people they were to deliver to. They asked people to sign for their deliveries. Any medicines that were unable to be delivered were returned to the pharmacy.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicine effectively. Team members received prescriptions approximately two weeks before they were required which allowed time to resolve any queries. Each person had a medication record file which detailed the medication taken and the dosage times. The SI was in the process of renewing these sheets, so they were clearer and easier to follow. The SI and ACT shared the checking of packs. The SI explained that packs with many medicines were filled by him after a dispenser had selected the stock and removed the medicines from the original packs. And he had a break before completing the final accuracy check. This was because some people received many medicines in their

compliance packs, and it was too difficult to check once sealed. Other packs were checked by the ACPT. Compliance packs were labelled with mandatory warnings and descriptions of the medicines so they could be easily identified. People were supplied with patient information leaflets (PILs) for new medicines but did not receive PILs for regular medication.

The pharmacy sourced its medicines from licensed wholesalers, and it kept medicines in original containers. Pharmacy (P) only medicines were stored behind the medicines counter which helped ensure the sales of these were supervised by the pharmacists. Team members had a process for checking the expiry date of medicines. They completed checks of the entire dispensary every three months. Medicines that were going out of date in six months were highlighted for use first. Team members checked the expiry dates of stock when putting the medicines delivery to shelf. This had been in response to an increase in short- dated medicines being sent in by the suppliers. Records showed date checking had last been completed in January 2024 and September 2023. And date checking was completed as part of the dispensing and checking process. The pharmacy had a medical grade fridge with a glass door which allowed the medicines to be viewed without opening the door. Team members recorded the temperatures of the fridge daily and records showed it was operating between the required two and eight degrees Celsius. Team members received notifications about drug alerts and recalls via email. The SI asked team members to action the alert and the details were captured on the PMR system including any actions taken if applicable.

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 in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to up-to-date electronic reference sources including the British National Formulary (BNF) and British National Formulary for children (BNFc). And the pharmacists accessed the National Pharmacy Association (NPA) medicines information line. The pharmacy had an otoscope used in the provision of the NHS Pharmacy First service. The pharmacy had crown stamped measuring cylinders used for liquid medicines and water. And there were brushes to ensure they were thoroughly cleaned between uses. It had triangles used to count tablets, including separately marked triangles used for cytotoxic medicines such as methotrexate.

The pharmacy had a cordless telephone so that conversations could be kept private. Medicines awaiting collection were stored in a way which prevented unauthorised access to people's private information. Confidential information was secured on computers using passwords, and team members used NHS Smart Cards. The PMR system was backed up daily. Screens were positioned within the dispensary and consultation room in a way that prevented unauthorised people from seeing 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.