General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Whickham Pharmacy, Rectory Lane, Whickham, Newcastle upon Tyne, NE16 4PD

Pharmacy reference: 9011778

Type of pharmacy: Community

Date of inspection: 26/03/2024

Pharmacy context

This is a busy pharmacy in Newcastle. Its main activities are dispensing NHS prescriptions and providing some people with their medicines in multi-compartment compliance packs to help them take their medicine correctly. The pharmacy provides both NHS and private services and it 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 and mitigate risk so that team members can work safely and effectively. It suitably considers the risks of its prescribing services. And it has a protocol for ensuring that incidents relating to prescribing are responded to appropriately. Team members record mistakes made during the dispensing process to help prevent the same or a similar mistake occurring. They keep the records required by law and know to keep people's private information secure. They respond appropriately to concerns for the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were prepared in July 2021 and reviewed in July 2023 by the company's pharmacists. They included SOPs about dispensing activities, the responsible pharmacist (RP), controlled drug (CD) management and the pharmacy's NHS and private services. A sample of the SOPs seen had not been signed by all team members, but team members were experienced in their roles and were observed completing tasks effectively. The pharmacy had an extensive risk assessment (RA) which considered the risks and mitigations of pharmacist independent prescribers (PIP) providing prescribing services. The RA considered the risks about prescribing higher-risk medicines and completing remote consultations. And it contained appropriate actions put in place by the pharmacy to address the risks identified. The RA had been prepared by the superintendent pharmacist (SI) in January 2024 and was due to be reviewed annually. The RA was supplemented by a prescribing protocol to ensure that prescribing services were delivered safely and consistently by all PIPs. The pharmacy used a services checklist when introducing new prescribing services within the pharmacy. The checklist included considerations about a PIPs competency and the training required to provide the service and how the pharmacy would communicate any prescribing decisions taken with the person's GP.

The pharmacy recorded mistakes identified and rectified during the dispensing process known as near misses. The person who was responsible for the mistake recorded the details about it when it was identified by the pharmacist or accuracy checking pharmacy technician (ACPT). A sample of records seen showed that team members recorded learning points from the mistakes made. Pharmacists had conversations with team members about the mistakes and any identified trends monthly. The pharmacy completed incident reports for mistakes that were not identified until after a person had received their medicine, known as dispensing errors. These were recorded on the pharmacy's patient medication record system. The pharmacy had a prescribing incident protocol which provided clear instructions for team members to follow in the event of a prescribing incident and included direction to share any learnings about prescribing incidents both with the immediate pharmacy team and with other pharmacies in the company if necessary. Team members had a procedure for dealing with complaints. They aimed to resolve any complaints or concerns informally. If they were unable to resolve the complaint, they directed it to the pharmacy's operations manager. The SI reviewed any feedback submitted by people through online search engines.

The pharmacy had current professional indemnity insurance. Team members were observed working within the scope of their roles. And they knew which daily tasks they were responsible for by direction from the ACPT manager. The RP notice was prominently displayed in the retail area and reflected the correct details of the RP on duty. Team members knew which tasks could and could not take place in the absence of the RP. The RP record was completed electronically and included the details of the RP,

but it did not always indicate what time the RP ceased duty. The pharmacy recorded the receipt and supply of its CDs. The entries checked were in order, with some minor omissions of the address of the supplying wholesaler. Team members checked the physical stock levels of medicines matched those in the CD register on a weekly basis. The pharmacy kept certificates of conformity for unlicensed medicines and full details of the supplies were kept to provide an audit trail. It kept complete records for supplies of medicines made against private prescriptions and retained corresponding prescriptions.

The pharmacy displayed a privacy notice in its main consultation room, informing people of how their private data was used. Team members knew to keep people's private information secure and some team members who were completing accredited qualification training had received additional training regarding information governance and the General Data Protection Regulation as part of their course. The pharmacy kept confidential waste separately for destruction by a third-party company. Team members were aware of their responsibilities about safeguarding vulnerable adults and children. And they confirmed if they had any concerns for the welfare of a vulnerable person, they would refer them to the pharmacist. The pharmacy displayed a chaperone policy in its main consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a large team with the appropriate training and skills to manage the workload and deliver services safely. Team members in training are supported to complete their training courses and develop their skills and knowledge. Pharmacists complete additional training to ensure they have the appropriate knowledge to provide services. Team members ask appropriate questions when helping people with their healthcare needs.

Inspector's evidence

At the time of the inspection, the RP was one of the company's full-time employed pharmacists. Another pharmacist was present, alongside an ACPT, a pharmacy technician, a trainee pharmacist, two dispensers, an apprentice, and a hospital trainee pharmacist who was completing a week-long placement in the pharmacy. Other team members not working included two pharmacists, three dispensers, another apprentice, another trainee pharmacist, three delivery drivers, a pharmacy student and a retail assistant. The pharmacy's owners were pharmacists, and one of the owners was the SI pharmacist.

Team members had either completed accredited training or were completing accredited training for their roles. The ACPT confirmed that the assistant who worked on Saturdays completed tasks such as cleaning the pharmacy and organising stock and was therefore not required to be enrolled on an accredited course. The two apprentices were completing an integrated pharmacy technician course which trained them to become accuracy checkers. The ACPT was a training supervisor for one of the apprentices. Team members in training received protected learning time to complete their training in a timely manner. The pharmacists had completed training for its additional services including travel vaccinations and weight loss. This had been provided by an online platform and directly from the medicines manufacturer respectively. PIPs attended regular training events to develop their skills and knowledge. And they attended monthly meetings for prescribers to discuss prescribing and case studies. And this was an opportunity for the PIPs to receive peer support and improve their prescribing quality.

Team members were observed supporting each other to manage the workload. They assisted each other with ongoing learning and queries. For example, one of the trainee apprentices had produced an end of month task sheet with step-by-step instructions for ensuring team members were supported to complete the tasks correctly. And they had produced other guides to assist team members when ordering medicines from wholesalers. Annual leave was planned in advance and part-time team members could increase their hours to support periods of absence. Team members in training received regular reviews with their designated supervisor as part of their learning. For other team members reviews were last completed in November. There was an open and honest culture amongst the team, and they felt comfortable to raise professional concerns with management if required. The pharmacy did not set its team members targets.

Team members asked appropriate questions when selling medicines over the counter. They knew to be vigilant about repeated requests for medicines liable to misuse, for example medicines containing codeine. They felt comfortable to have supportive conversations with people or would refer to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was a large modern premises set over two floors. The ground floor had a medicines counter, waiting area for those accessing services, a small dispensary and consultation room. The pharmacy portrayed a professional appearance and medicines were arranged neatly on shelves behind the medicines counter. Upstairs comprised of the pharmacy's main dispensary and three consultation rooms. The downstairs dispensary was mainly used for the processing and labelling of prescriptions which were sent to the main dispensary to be dispensed. Both dispensaries were clean and tidy and had different bench spaces for the completion of different tasks. The pharmacist worked in the upstairs dispensary and the checking bench was positioned to provide effective supervision of the dispensary. The main dispensary had a sink which provided hot and cold water. And a sink in a staff only area downstairs also provided hot and cold water. There were toilet facilities with separate hand washing facilities. The temperature was comfortable throughout and lighting was bright. Team members disinfected the pharmacy daily and performed a deeper clean at the weekend.

The pharmacy had four consultation rooms in total. Two of these were used by other healthcare professionals including an audiologist and a physiotherapist. The consultation rooms were soundproofed and allowed people to have private conversations with team members or access services. The pharmacy primarily used one of the consultation rooms and this room had a sink with hot and cold water. Both consultation rooms used by the pharmacy were spacious and had a desk and chairs.

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 provide people with the necessary information to take their medicines safely and effectively. They complete checks to ensure that medicines remain fit for supply. And they respond appropriately when they receive alerts about the safety of medicines.

Inspector's evidence

The pharmacy had automatic entry and ramped access which provided ease of access to those using wheelchairs or with prams. It had an accessible toilet for people to use. The consultation rooms primarily used by the pharmacy were upstairs, and one of its consultation rooms was situated on the ground floor. Although the ground floor consultation room was primarily used by the audiologist, team members used it when required by those requiring an accessible consultation room. The pharmacy provided a range of PIP-led private prescribing services including for travel vaccinations and weight loss. People wishing to access these services did so by contacting the pharmacy directly and an appointment was arranged for them. A pharmacist confirmed that consultations were mostly completed face to face with some remote consultations occurring occasionally. The NHS Pharmacy First service was underpinned by patient group directions (PGDs) which were available in paper form for easy referencing.

Team members used baskets to keep people’s prescriptions and medicines together and prevent them becoming mixed up. They highlighted prescriptions which included CDs and fridge lines. And the pharmacist could use “speak to pharmacist” stickers to highlight additional information which was required when the prescription was handed 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 medicine safely. And they were aware of recently updated legislation about providing valproate in the original manufacturer’s packs. The pharmacy provided a delivery service taking medicines to people in their homes. The delivery drivers used an electronic device to record when deliveries were made to people. And records were kept so that any queries could be resolved. For any deliveries where a person was not available to receive their medicine, a notice of the attempted delivery was left and the medicines were returned to the pharmacy.

Team members provided some people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. They ordered the prescriptions in advance which allowed time to resolve any queries. Each person had a medication record form detailing the medicines and the dosage times. Any changes to a person’s medication were communicated from the GP surgery and documented on a medication change sheet. This sheet included the type of change and medication involved, who had informed the team of the change and who had updated the person’s medication record, to provide a full audit trail. The pharmacist who clinically checked the change also signed and dated to say this had been completed. The clinical check recorded on people's record sheets applied for future prescriptions, as long as no changes had been made to the medication. The ACPT completed the final accuracy check for the compliance packs. Team members involved in the dispensing of the packs provided the original manufacturer’s packs for the final check. And descriptions of the medicines in the packs were provided so that people could easily identify them. Patient information leaflets were provided every four weeks, so people had the necessary information to take their medicines effectively.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were stored behind the medicines counter. Team members checked the expiry dates of medicines. They had last completed date checking in February. Medicines that were going out of date in the next six months were highlighted for use first. A random selection of medicines checked found none were out of date. The pharmacy had two fridges and team members recorded the temperatures daily. Records showed that the fridges were operating between the required two and eight degrees Celsius. Team members received notifications about drug safety alerts and recalls via email. These were printed and given to the pharmacist to action and file. And any relevant information was cascaded to team members. For example, a recent alert highlighted the reclassification of codeine linctus to a prescription only medicine. The information was shared with team members who then removed the medicine from the P shelves and moved it to the dispensary. 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 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, the British National Formulary for children and National Institute for Clinical Excellence guidelines. It had a blood pressure monitor used in the hypertension case finding service but there was no record of the date of first use or last calibration. And it had equipment including single-use lancets used for a blood lipid testing service. The pharmacy had crown marked measuring cylinders for measuring liquid medicines and water. And it had two medical grade fridges for the storage of medicines between specific temperatures. One of the fridges had a glass door so that medicines could be viewed without prolonged opening of the fridge.

The pharmacy's telephones were used in staff only areas so that conversations could be kept private. And it stored medicines awaiting collection away from public view to protect people's private information. Confidential information was secured on computers using passwords, and NHS smartcards were in use. Screens were positioned in the dispensary and consultation room in a way that 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.