

Registered pharmacy inspection report

Pharmacy Name: Scott-Chem Ltd, Unit 3 Roseberry Shopping Centre,
Roseberry Road, REDCAR, TS10 4NY

Pharmacy reference: 1092378

Type of pharmacy: Community

Date of inspection: 25/09/2019

Pharmacy context

The pharmacy is in Redcar, Cleveland. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy offers a prescription collection service from local GP surgeries. And it delivers medicines to people's homes. It supplies medicines in multi-compartmental compliance packs. These help people remember to take their medicines. And it provides NHS services such as flu vaccinations and a smoking cessation service.

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 adequate processes and written procedures in place to protect the safety and wellbeing of people using its services. It keeps the records it must have by law and keeps people's private information safe. The pharmacy equips the team to help protect the welfare of vulnerable adults and children. The pharmacy team members respond when mistakes happen. And they discuss what happened and act to prevent future mistakes. But the reviews do not have all the information needed to allow the team to identify patterns and learn from them.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. These provided the team with information on how to perform tasks supporting the delivery of services. The SOPs were in the process of being reviewed. And the pharmacy team members were working to the 2016 version. The pharmacy had a process in place to report and record errors that were made while dispensing. The pharmacist explained the procedure. The pharmacist having spotted the error let the team member know that they had made an error. The prescription was handed back to the dispensing assistant responsible to correct. And the checker recorded the error. Usually the pharmacist discussed the errors as they occurred. The pharmacist last completed a risk review in February. And look alike sound alike drugs were separated. For example, allopurinol and atenolol were separated following a number of picking errors. The pharmacist had discussed this with the pharmacy team to raise awareness. The pharmacist advised that there are always three people involved in the dispensing process, the labeller, the dispenser and the checker. There was a procedure in place for recording dispensing incidents. Errors were recorded on the Numark incident reporting form. The pharmacist advised that they had very few errors. But showed the inspector one that occurred last year and involved the supply of memantine 10mg when donepezil 10mg was required. A contributing factor was that the pharmacist had self-checked. The pharmacy had been busy, and the pharmacist did not follow the procedure. The pharmacy had a complaints procedure. The pharmacist would deal with the complaint initially and if they were unable to resolve the complaint then it would be referred to the superintendent (SI). A person had expressed concerns that a medicine was missing from their multi-compartmental tray. An investigation was launched, and it was found that the person had not been receiving the medicine for months. The surgery had omitted the item from the prescription in error. The pharmacy had changed the procedure to ensure that medicines stopped without notification were followed up with the surgery. The investigation and report were detailed and addressed all the issues raised by the complainant.

Appropriate professional indemnity insurance was in place. The responsible pharmacist (RP) notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries made in chronological order. Running balances were maintained. And they were checked on each dispensing. A CD destruction register for patient returned medicines was correctly completed. The pharmacy retained records of private prescription and emergency supplies. Private prescriptions had a reference number on them which corresponded with the entry in the private prescription book. The pharmacy retained completed certificate of conformities following the supply of an unlicensed medicine. The team held records containing personal identifiable information in staff only areas of the pharmacy. Confidential

waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed off site. The pharmacist had done information governance training with the pharmacy team members. The registered team members had completed Level 2 training on safeguarding. The rest of the team were due to complete training next month. A pharmacy team member said that they would discuss any concerns with the manager at the time.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to safely manage the services it provides. The pharmacy team members have the right qualifications and skills for their roles. And for the services they provide. The team members openly discuss how to improve ways of working. And they can raise professional concerns if necessary.

Inspector's evidence

At the time of the inspection there was the manager who was also SI. An additional pharmacist. Four dispensing assistants and two medicines counter assistants. The manager thought that they managed with the current level of staff. Holidays were planned in advance. And members of the pharmacy team worked extra hours if necessary. There was a steady stream of customers waiting at the counter. And these were dealt with in a friendly, efficient manner.

The pharmacy team members involved the pharmacist when offering advice to people who were purchasing over-the-counter products. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The pharmacy team members do not have appraisals, so training needs were not discussed. And there were no training plans in place. Pharmacy team members had received healthy living pharmacy training. And had completed training on dementia and oral health.

The team usually had discussions about near misses and any current issues. For example, pharmacies in the area were no longer allowed to order repeat prescriptions for people. And this was causing confusion for people, so the pharmacy team members were discussing the best way to handle the situation to minimise the disruption for people. The pharmacy team thought that the manager was approachable and receptive to any suggestions to improve the service offered to people. The team members said they were able to discuss any concerns with the manager. The pharmacist thought that people valued the services offered and he always tried to provide these. No targets were set for these.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is secure when the pharmacy is closed and adequately maintained. It has a sound-proof room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was basically clean, but the shelves and flooring needed cleaning in some areas. And there was some clutter on the benches and floor. The retrieval shelves were full and completed prescription bags were being stored on the floor. These were obstructing access to the shelves, disrupting the work flow and causing a trip hazard. The pharmacy was fitted out to an acceptable standard. The sink for preparation of medicines was clean. And there was hot and cold running water. The room temperature was comfortable, there was air conditioning. The pharmacy was well lit. All the team took part in general cleaning. And this was done when time allowed. The pharmacy had an adequately sized, signposted, sound proofed consultation room which the team used. There was a desk, chairs and computer. There were lockable cupboards in the consultation room.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. The pharmacy gets its medicines from reputable suppliers. And it stores and manages these safely. It responds appropriately to drug alerts and product recalls. And it makes sure that its medicines and devices are safe to use. The services are generally well managed. But sometimes people do not get all the information they need.

Inspector's evidence

There was direct access from the street through wide doors at the front of the pharmacy. And people in wheelchairs and those with mobility problems could access the pharmacy. The pharmacy advertised its services and opening hours in the retail area. Seating was provided for people waiting for prescriptions. A range of healthcare related leaflets were available for people to select and take away. People could request multi-compartmental compliance packs. And these were supplied to people to help them take their medicines at the right time. The team recorded details of any changes, such as dosage changes, on the patient sheets. And information which would help people visually identify the medicines. Patient information leaflets were supplied with the first dispensing only. This may mean that people do not always receive the most up-to-date information about their medicines. The pharmacy kept records of the delivery of controlled drugs from the pharmacy to people. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team checked the expiry dates of the stock every three months. And the team kept records of the activity. The team used stickers to highlight medicines that were expiring in the next six months. For example, Hylo-care had been marked as going out of date in November 2019. No out of date stock was seen on the sections looked at. The team recorded the date the pack was opened on liquid medicines. This allowed them to identify medicines that had a short-shelf life once they had been opened. And check that they were fit for purpose and safe to supply to people. The pharmacy used a range of stickers to indicate that a fridge line or CD needed to be added to the prescription before handing out to the people.

The pharmacist offered medicine use reviews (MURs) to people on high risk drugs such as warfarin. But did not have a process for routinely identifying and counselling these patients. So, the pharmacy could not demonstrate how often these checks took place. The team were aware of the pregnancy prevention programme (PPP) for people who were prescribed valproate. But they had not completed an audit to identify eligible patient. The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). No software, scanners or a SOP were available to assist the team to comply with the directive. The team had completed webinar training. Fridge temperatures were recorded using a digital thermometer. A sample of the records were looked at. And the temperatures were consistently within the correct range. But the temperature was not recorded on some occasions. The pharmacy obtained medicines from several reputable sources such as AAH, Norchem and DE. And invoices were retained. Drug alerts were received electronically from NHS mail printed off and actioned. And these were retained to provide an audit trail.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy's equipment is clean and safe, and the pharmacy uses it appropriately to protect people's confidentiality.

Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. There were a range of measuring cylinders used solely to measure methadone. These were marked. The pharmacy used a pump to pump methadone and this was cleaned after each use. Tweezers and gloves were available to assist in the dispensing of multi-compartmental compliance packs. The pharmacy had a first aid kit and spills kit should they be needed. Both fridges used to store medicines were of an appropriate size. Medicines were organised in an orderly manner. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't on view to the public. The computers were password protected. Cordless phones assisted in undertaking confidential conversations. Members of the pharmacy team had their own NHS smart cards. And these were being used appropriately.

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.