

Registered pharmacy inspection report

Pharmacy Name: Well, The Village Surgery, Dudley Lane,
CRAMLINGTON, Northumberland, NE23 6US

Pharmacy reference: 1093029

Type of pharmacy: Community

Date of inspection: 29/07/2019

Pharmacy context

The pharmacy is in a health centre in Cramlington town centre. Pharmacy team members mainly dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). And, they supply medicines to people in multi-compartmental compliance packs. They provide a substance misuse service, including supervised consumption. The pharmacy delivers medicines to people's 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 procedures in place to manage the risks to its services. And, pharmacy team members are clear about how to carry out their roles safely. They discuss and record mistakes they make. And they make changes to prevent the same or similar mistakes happening again. Pharmacy team members understand their responsibility to protect people's private information. And, they know what to do if they have a concern about the welfare of a child or vulnerable adult. The pharmacy mostly keeps the records required by law.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place to manage the risks to its services. And, they were available for pharmacy team members electronically. The superintendent pharmacist's (SI) office reviewed the procedure every two years on a monthly rolling cycle. And, it sent new and updated procedure to pharmacy team members via the eExpert training system approximately each month. Pharmacy team members read the procedures. And, they completed a test after each one. If they passed the test, they then signed off the procedure as having read and understood it. The pharmacy defined the roles of the pharmacy team members in each SOP. And, pharmacy team members defined their tasks further by using a rota, which was displayed on the staff noticeboard. The pharmacy had a dispenser who was accredited to perform the final accuracy checks of prescriptions. The dispenser explained she was able to check prescriptions that had been clinically checked by a pharmacist. And, the pharmacist signed prescriptions to confirm a clinical check had been completed. She maintained a portfolio of her checking activity and a log of the mistakes she made while checking. She submitted her portfolio and error log to her accreditation organisation every two years to obtain revalidation of her checking competence.

The pharmacist or accuracy checker highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes on a paper log and on an electronic system, called DATIX. The pharmacy team discussed the errors made. But, they did not discuss or record much detail about why a mistake had happened. If they did, they usually said rushing or misreading the prescription had caused the mistakes. And, their most common change after a mistake was to double check next time or to separate affected products on the shelf to prevent further picking errors. The pharmacy manager analysed the data collected about mistakes every month. And, she recorded her analysis in a monthly patient safety report. In the examples of the analysis seen, the manager identified patterns of mistakes based on quantitative information, such as the quantity of errors made. And, she analysed the data for the number of different types of error, such as wrong strength or wrong quantity mistakes. But, she did not analyse the information to establish any patterns of causes. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents using DATIX. The sample of records seen were comprehensive about what had happened. But, pharmacy team members did not record much detail about why a mistake had happened and what had been changed to reduce the risk of recurrence, despite them discussing causes. And, making changes, such as separating look alike and sound alike medicines involved in mistakes on the shelves. They also attached alert stickers to the shelves and drawers in front of medicines that had been involved in mistakes. These were used to highlight the risks of error to people while dispensing to help prevent the same mistake happening again.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. A dispenser said that after some recent feedback, pharmacy team members had changed the layout of the chairs and retail stands in the pharmacy's retail area. She said previously, the stands had blocked people's view of the pharmacy counter and made it difficult to move around. So, they moved the stands and placed the chairs in the middle of the floor. And, this had made moving around the space easier and people could see pharmacy team members more clearly.

The pharmacy had up to date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity weekly, including methadone. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. The pharmacy team monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register. But, in the samples seen, pharmacy team members did not record either the date on the private prescription, the date of supply, or both. They recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. Pharmacy team members had been trained to protect people's privacy and confidentiality. They completed training via the eExpert online training system each year. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR). When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and adults. They explained how they would refer to the pharmacist and discuss the issues with the person's GP if necessary. The pharmacist said they would assess the concern. And would seek advice from head office colleagues if necessary. Pharmacy team members said they would use the internet to find out contact information for local safeguarding teams. Pharmacy team members had trained via the documented procedures and by verbal instruction and training from the pharmacist. And, they had attended a recent local training event. The pharmacist completed training via the Centre for Pharmacy Postgraduate Education (CPPE) every two years.

Principle 2 - Staffing ✓ Standards met

Summary findings

Pharmacy team members have the right skills and qualifications for their roles and the services they provide. They complete training regularly. And, they discuss any learning needs with their manager. Pharmacy team members plan and talk together openly to effectively manage the workload and improve ways of working. And they have group discussions about why mistakes happen, to help inform the changes they make to help prevent mistakes happening again.

Inspector's evidence

The pharmacy had installed a new electronic patient medication records (PMR) system three days prior to the inspection. During the inspection, pharmacy team members were experiencing difficulties with the system and with printers. And, this was putting them under pressure whilst dealing with people and prescriptions. But, pharmacy team members were seen communicating clearly and effectively with each other. They had clear leadership from the pharmacy manager. And, these ways of working were helping them to manage the situation well and to minimise the impact on people using the pharmacy. The pharmacy manager explained that a rota was used to make sure people tasks were clearly defined each day. And, pharmacy team members frequently discussed what needed to be done. She also explained that the rota had been implemented to make sure that pharmacy team members moved around all areas of the pharmacy operation. And, this helped them to remain multi-skilled and flexible when pharmacy team members were absent.

At the time of the inspection, the pharmacy team members present were a locum pharmacist, four dispensers and a pharmacy student. Pharmacy team members completed training via the eExpert online training system and by regular discussions with the pharmacist and pharmacy team members. They received training modules to complete about various subjects each month. And, these included new procedures and their associated assessments. Pharmacy team members said they did not often have time to complete training at work. So, most of their learning was done at home in their own time. The pharmacy had an appraisal process. Pharmacy team members received an appraisal with the manager every year. Before each appraisal, pharmacy team members completed a self-assessment about their own performance over the last year. They discussed their responses with the manager during their appraisal meeting. Then, they agreed and set objectives to address any learning needs. A dispenser gave one example of an objective she had set to improve her knowledge and confidence with preparation of multi-compartmental compliance packs. She said she had been trained and supported by more experienced colleagues. And, the pharmacy manager had planned to provide cover for her dispensing, so she could spend time learning. The dispenser explained she was now one of two key contacts for the whole team if they had queries about compliance packs.

A dispenser said she would raise professional concerns with the pharmacy manager, pharmacist, regional development manager or superintendent pharmacist's (SI) team. She said she felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. And pharmacy team members knew how to access the process. Pharmacy team members explained a change they had made after they had identified areas for improvement. They explained that when their new manager had started, they had identified that not all team members knew how to do every job in the pharmacy. So, they had created a list of the key pharmacy processes. And, they had carried out a baseline assessment of each

of their skills. They had then used this to train each other in areas where they were less confident until all pharmacy team members could carry out all the necessary processes. Pharmacy team members said this had made a huge improvement to how flexible they could be. And, they said it meant they were easily able to cover each other's absences and keep the pharmacy running smoothly regardless of who was there. The company asked the team to achieve targets in various areas. For example, the number of prescriptions dispensed, the volume of over-the-counter sales and the number of medicines use review and new medicines service consultations completed. The manager explained that she felt supported by the regional development manager to achieve the targets. And, she was confident that she could ask the regional development manager for help if necessary. She said that pharmacy team members from other local branches were available to help train staff and support team improvement if required.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the health services provided. And, it has a suitable room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The pharmacy also had air conditioning. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy is accessible to people. And, it provides its services safely and effectively. It stores, sources and manages medicines safely. And, it completes robust checks when it introduces new systems. So, it can be confident its procedures are safe. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines. And to identify what they look like. Pharmacy team members take steps to identify people taking high-risk medicines. And, they provide these people with advice to help them take these medicines safely.

Inspector's evidence

The pharmacy had level access from the car park and from the surgery reception area. Pharmacy team members said they would ask people with differing needs about the best way to help them if possible. They said they would use written communication with people who had hearing impairment. And, they would make sure people could see their lips to lip-read. But, they were unsure about how they would help someone with a visual impairment.

Since the pharmacy had installed a new computer system three days prior to the inspection, pharmacy team members attached labels to bags of dispensed medicines that contained a unique barcode. When they were ready to store a completed prescription bag, they scanned the barcode using a hand-held device. The information on the device was linked to the electronic patient medication records system. Pharmacy team members chose a location to store the bag. And, they scanned the barcode attached to the location and placed the bag on the shelf. When people came to collect their medicines, pharmacy team members entered their details into the hand-held device. The device then told them where the bags were stored. Pharmacy team members marked the bag as collected and a record was made of the time and date of collection. They said they were still getting used to using the system. And, there were still bags on the shelves without a barcode attached. But, they had already noticed the system helping to prevent bags kept in different locations being missed and the people leaving without all their prescription.

The pharmacy had started to send some prescriptions to the company's off-site dispensing hub, where medicines were picked and assembled by a dispensing robot. The pharmacist explained that prescriptions were assessed to establish whether they were suitable to be sent to the hub. She said that it took three days for prescriptions to be processed and medicines to be returned from the hub. So, since the pharmacy had only started using the hub two days prior, it had not received any medicines back for the prescriptions submitted. And, the pharmacy continued to dispense prescriptions for urgent acute items, such as antibiotics, medicines stored in the fridge or prescriptions for unusual quantities of medicines. The pharmacist said prescriptions sent to the hub were most commonly for people's regular repeat medication. And, the pharmacy asked these people for their consent to send their prescriptions to the hub to be dispensed. The pharmacist also explained that part of the prescription could be sent to the hub for assembly. And, the other parts, unsuitable for the hub, could be dispensed in the pharmacy. When a prescription was received, pharmacy team members annotated on the electronic prescription token which items were being sent to the hub and which items were for the team to dispense. Then, they generated the dispensing labels. The labels for items to be dispensed in the pharmacy were printed. And, the information for labels for medicines assembled at the hub were sent to the hub

pharmacy electronically. Once the information for labelling had been inputted, the prescriptions were held in a queue for the pharmacist to perform a clinical and accuracy check. The pharmacist logged on to the system to perform the necessary checks. Once the pharmacist was satisfied, they released the prescription which was then sent to the hub for assembly. Only the pharmacist, using their personal smart card and password, were able to perform the clinical and accuracy check and release prescriptions to the hub. Once released, pharmacy team members dispensed and packaged any medicines that were unsuitable for the hub. And, they filed the prescriptions ready for the hub medicines to be received. Three days later, the pharmacy received the items dispensed at the hub. It received the medicines in sealed packages. Pharmacy team members married up the bags with the relevant prescriptions and any medicines that had already been prepared. And, the bags were scanned on to shelves ready for collection. The pharmacist explained that the hub system was still being implemented at the pharmacy. And, the pharmacy were required to carry out an audit of 300 prescriptions returned from the hub. She explained that all 300 bags from prescriptions sent would be opened when they were returned to the pharmacy. And, she would perform a final accuracy check of all items. She said that any errors or issues found would be recorded and reported to the hub and the superintendent pharmacist's (SI) office.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy supplied medicines in multi-compartmental compliance packs when requested. The pharmacy attached backing sheets to the pack, so people had written instructions of how to take the medicines. And it included the descriptions of what the medicines looked like, so they could be identified in the pack. Pharmacy team members provided people with patient information leaflets about their medicines each month. And, they documented any changes to medicines provided in packs on the patient's medication event diary. But, they did not record details of which prescriber had requested the changes.

Pharmacy team members checked medicine expiry dates every 12 weeks. And, they recorded their checks electronically. They highlighted any short-dated items with a sticker on the pack up to six months in advance of its expiry. And they recorded expiring items on a monthly stock expiry record, for removal during the month before their expiry. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. The pharmacist provided counselling and information to people presenting prescriptions for valproate who might become pregnant. She checked with whether they were enrolled on a pregnancy prevention programme. And contacted their GP to find out if necessary. The pharmacy also had a stock of information material to give to people prescribed valproate.

The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet(s) tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. Pharmacy team members kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members had received training about the Falsified Medicines Directive. And, they were checking packs of medicines to make sure tamper evident seals were intact. The manager explained that the necessary scanners were in place to scan medicines packaging. But, the software was not ready. She said she expected the SOPs to be updated when the software issues were

resolved. And, pharmacy team members were ready to implement the system. But, they said they had not been given any information about when that would be.

The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries. Delivery record sheets were folded to help protect people's confidential information when they were asked to sign. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy to arrange a re-delivery. The team highlighted bags containing CDs with a sticker on the bag and on the driver's delivery sheet.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate set of measures to dispense methadone. The pharmacy positioned computer terminals away from public view. The terminals were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. And, it collected confidential waste dedicated bins. The bins contained bags which were sealed when they were full. And they were collected by a contractor and sent for secure destruction. The dispensary fridge was in good working order. And the team used it to store medicines only. Access to all equipment was restricted and all items were stored securely.

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.