

Registered pharmacy inspection report

Pharmacy Name: New Marske Pharmacy, 1 Beacon Drive, New Marske, REDCAR, Cleveland, TS11 8ES

Pharmacy reference: 1102223

Type of pharmacy: Community

Date of inspection: 16/08/2023

Pharmacy context

This community pharmacy is in the North Yorkshire village of New Marske. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. It provides medicines to people residing in care homes. And it supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. The pharmacy delivers some medicines to people's homes. And it provides other NHS services which are helpful for people, such as advice and access to medicine through a local minor ailments scheme.

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 acts adequately to identify and manage risks associated with providing its services. It keeps people's confidential information secure, and it mostly keeps the records it needs to by law. Its team members know how to respond to feedback about the pharmacy or its services. They work well within their own roles, and they act openly and honestly by recording and discussing their mistakes. They understand how to recognise, and report safeguarding concerns to help keep vulnerable people safe.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to support its safe and effective running. These covered responsible pharmacist (RP) requirements, management of controlled drugs (CDs) and pharmacy services. The SOPs had clear review dates and were version controlled. Some team members who had worked at the pharmacy for a number of years had signed previous versions of the SOPs to confirm they had read and signed them. But they had not updated their learning when the most recent version of the SOPs was implemented. And some newer team members were still working through learning associated with the SOPs. Team members had a clear understanding of their roles and knew when to refer queries to the RP or pharmacy manager. A trainee team member discussed the tasks that could not be completed if the RP took absence from the pharmacy. The pharmacy manager who worked as an accuracy checking pharmacy technician (ACPT) showed how all prescriptions they checked received a clinical check by the pharmacist prior to medicines being released for delivery or handout to people.

The pharmacy had processes for recording mistakes identified during the dispensing process, known as near misses. Team members were provided with feedback about their mistakes, and they were encouraged to record them and reflect on them to help identify personal learning. The pharmacy manager discussed how the team shared learning and acted upon its mistakes. For example, by placing warning labels on shelf edges and separating medicines with similar names. But the team did not complete formal near miss reviews to help measure the effectiveness of the actions it took. Pharmacy team members were aware of the need to report a mistake that was identified following the supply of a medicine to a person, known as a dispensing error. The pharmacy kept evidence of these types of mistakes to share learning and help to reduce risk. It routinely recorded these types of events on the patient medication record (PMR) to prompt additional checks during the dispensing process.

The pharmacy displayed details of its current indemnity insurance. The RP notice on display contained the correct details of the RP on duty. And the RP record was generally completed in full; occasional records did not have the sign-out times of the RP. A sample of other pharmacy records examined complied with legal and regulatory requirements. The pharmacy maintained running balances in its CD register and completed full balance checks of physical stock against the register regularly. A random physical balance check of a CD conducted during the inspection complied with the running balance in the register. The team recorded patient-returned CDs in a separate register at the point of receipt. The pharmacy had procedures relating to information governance. It kept personal identifiable information in the staff-only area of the premises and confidential waste was separated and securely disposed of. It clearly displayed a privacy notice for people to see.

The pharmacy had a complaints procedure, although this was not clearly advertised to people. Pharmacy team members understood how to manage feedback and how to escalate a concern when required. They talked about the feedback they received as a team and responded to this effectively. For example, the team now contacted people when medicines owed to them were ready to collect. This had reduced feedback about wasted visits to the pharmacy caused by delays in obtaining some medicines which were outside of the pharmacy's control. Team members had a good understanding of how to recognise and report concerns relating to safeguarding vulnerable people. The RP had completed level two safeguarding learning, and other team members had completed some safeguarding learning through their accredited training courses. The delivery driver explained that as part of their role they were encouraged to engage with people, and they provided examples of reporting concerns promptly to the RP for further investigation. The pharmacy displayed a chaperone notice close to the entrance of its consultation room. The team had completed specific learning about code words promoted by safety initiatives designed to offer a safe space for people experiencing domestic violence. And a trainee team member knew what action to take if a person attended the pharmacy requesting to use its safe space.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy employs an enthusiastic team of people who work together well to deliver its services. Pharmacy team members engage in regular conversations to help manage workload and minimise risk. And they understand how to raise concerns at work.

Inspector's evidence

The RP was the full-time regular pharmacist. They were supported by the pharmacy manager, a trainee dispenser, two apprentices and the delivery driver during the inspection. The pharmacy also employed three qualified dispensers. There was some flexibility within the team to cover for annual leave and unplanned leave. The pharmacy was part of a wider ownership group and as such the pharmacy manager explained there was some capacity to request support from another pharmacy within the group if needed. All trainee team members were enrolled on GPhC accredited learning relevant to their roles. They reported receiving learning time at work, this included protected time for the apprentices. The pharmacy had operated a structured appraisal process prior to the COVID-19 pandemic. The pharmacy manager explained they were preparing to reintroduce this to support team members learning and development needs. The pharmacy team was up to date with workload and team members were observed working together well and showed genuine interest when engaging with people.

The pharmacy had some targets associated with its services. The RP and manager spoke positively when discussing these and explained focus was on ensuring the timely management of services. Pharmacy team members understood how to raise and escalate concerns at work. They felt supported in their role and were confident in providing feedback and making suggestions. All team members engaged in regular discussions about workload, service delivery and patient safety. But the team did not take the opportunity to record the outcomes of these discussions.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is secure and maintained to an appropriate standard. It offers a suitable environment for delivering its services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure and adequately maintained. Team members knew how to report maintenance concerns and confirmed there were no current maintenance issues. The pharmacy was clean and tidy throughout. Floor spaces were free from trip and fall hazards. Lighting was bright and air conditioning in part of the premises helped to provide an ambient environment for the storage of medicines and the delivery of pharmacy services. Fans and heaters were also used in a secondary dispensary at the back of the premises. Room temperature in an area of this dispensary was monitored due to the pharmacy holding a wholesaler dealers authorisation (WDA) licence. Pharmacy team members had access to sinks equipped with appropriate hand washing materials.

The public area was open plan with seating provided for people. A consultation room was accessible to the side of the public area. The room was professional in appearance, and it provided a suitable space for holding private consultations. A chain was available to separate the public area and staff-only area of the pharmacy. But this was not in regular use. The staff-only area included two dispensaries with designated spaces for managing acute and repeat workflow. Clear workbench space was available for assembling and checking tasks. Off the dispensary team members had access to staff facilities. There was also a designated warehouse used to hold medicine waste and some dispensary sundries.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are readily accessible to people. It obtains its medicines from licensed sources. And it mostly stores its stock medicines safely and securely. Overall, the pharmacy team members work effectively to manage the pharmacy's services. They take regular opportunities to engage people in conversations about their health and the medicines they are taking. But they do not always provide information leaflets when supplying medicines to support people in taking their medicines safely.

Inspector's evidence

People accessed the pharmacy through a door from street level. The pharmacy advertised its opening times and details of its services for people to see. Team members had appropriate knowledge of other local healthcare services and knew how to signpost people to these services in the event the pharmacy was unable to provide a service or supply a medicine. The team had access to current protocols and patient group directions (PGDs) to support the supply of medicines to people via the local minor ailments service and the urinary tract infection (UTI) test and treat service. The minor ailments service was popular and supported people in accessing medicines to treat minor conditions without the need to see a doctor. The RP also reported positive outcomes from the NHS Hypertension Case-Finding Service which had identified people with previously undiagnosed hypertension. This had seen people begin treatment and the RP had supported them in commencing their new medicine through the NHS New Medicine Service.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. The RP had appropriate supervision over the medicine counter and public area. Team members were aware of how to manage requests for over-the-counter medicines subject to abuse, misuse and overuse. They were observed referring queries to the RP appropriately. The pharmacy identified some higher-risk medicines requiring ongoing monitoring. And the pharmacist provided verbal counselling when handing out these medicines. But interventions carried out in this way were not generally recorded on people's medication records to support continual care. The pharmacy team had engaged in ongoing audits. A recent audit included checks associated with the valproate Pregnancy Prevention Programme (PPP). A discussion with the RP and pharmacy manager highlighted the specific counselling requirements of the PPP when supplying valproate to people within the at-risk group. The pharmacy supplied some valproate preparations in multi-compartment compliance packs to people residing in a care home. It had considered some of the risks of doing this, including holding conversations with carers administering these medicines. But it did not have a documented risk assessment to support it in supplying medicines in this way.

The pharmacy used effective systems for managing its dispensing services. It kept an audit trail of the deliveries and people were required to sign individual pages within a delivery book when receiving a CD. A range of audit trails supported the team members in answering queries they may receive about the pharmacy's dispensing services. This included team members taking ownership of their work by signing their initials within the 'dispensed by' and 'checked by' boxes on medicine labels. The pharmacy used a schedule to assist with ensuring compliance packs were assembled and ready for collection and delivery in a timely manner. And individual records helped to support the dispensing process. A sample of assembled compliance packs found backing sheets did not include adverse warnings associated with

the medicines inside the compliance packs. And the pharmacy did not always supply a patient information leaflet (PIL) when supplying medicines in this way. It supplied PILs for new medicines and when people commenced on the service. A discussion took place about the requirement to supply PILs routinely when supplying a medicine. And the matter of the required adverse warning labels was brought to the attention of the team during the inspection, immediate action was taken following the inspection to rectify this issue.

The pharmacy supplied medicines to people residing in care homes in a number of ways, dependent upon the requirements of the individual care home. This included dispensing original packs and supplying medicines in multi-compartment compliance packs. It had a schedule for dispensing these medicines. And it had a separate daily workflow dedicated to dispensing acute prescriptions. This included flagging urgently needed medicine for immediate delivery. It provided medication administration records (MARs) when supplying medicines in this way to assist care home staff in administering the medicines and in re-ordering prescriptions. The pharmacy supplied some medicines in a multi-compartment compliance pack system for people residing in care homes. Its processes included checks to ensure medicine regimens remained up to date. And the manager or a qualified dispenser visited the homes each month to support care home teams in managing their medicines safely. There was a process for alerting the RP to any concerns found during these visits. The pharmacy supplied PILs when supplying medicines in original packaging and for new medicines routinely. But it did not always supply PILs to the care homes when supplying medicines in the compliance packs each cycle.

The pharmacy obtained its medicines from licensed wholesalers and stored them tidily. A few medicines were found in stock which were not kept in their original packaging. This was discussed with the team and the medicines were disposed of. Stock CDs were kept securely, but date-expired CDs and CDs people had returned were not appropriately stored. This was immediately acted upon and assurances provided that they would be stored in accordance with requirements until safely denatured. And following the inspection, the pharmacy confirmed that this was the case. The pharmacy had two fridges, and records showed that the temperatures had stayed within the appropriate range. The pharmacy had appropriate medical waste receptacles to support the safe disposal of medicine waste. But there was a large amount of medicine waste waiting for collection. The team explained it had struggled with the amount it had received since the pandemic. The waste was held in a separate room and did not compromise the working environment. But the need to organise an additional collection was discussed. The pharmacy received medicine alerts electronically and it kept an audit trail of the action it took in response to the alerts affected community pharmacy.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy the appropriately maintained equipment it needs for providing its services. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members generally accessed the current version of common reference resources electronically. Hard copies of some reference resources were also available. They could also access the internet to help them look up information. The pharmacy's computers were password protected computers and most team members had their own NHS smartcard which they used when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicines on designated shelving within the dispensary out of direct view of the public area.

Pharmacy team members used appropriate counting and measuring equipment when dispensing medicines. This included separate equipment for counting and measuring higher-risk medicines which mitigated any risk of cross contamination when dispensing these medicines. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. For example, the pharmacy's blood pressure monitors were on the list of monitors validated for use by the British and Irish Hypertension Society. The pharmacy's electrical equipment was subject to regular checks to ensure it remained in safe working condition.

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.