

Registered pharmacy inspection report

Pharmacy Name: Well, 70 Bishopton Lane, STOCKTON-ON-TEES,
Cleveland, TS18 2AJ

Pharmacy reference: 1108254

Type of pharmacy: Community

Date of inspection: 06/12/2019

Pharmacy context

This pharmacy is situated on the outskirts of the town centre near to a medicinal practice. It is open 100 hours a week. And it is open seven days a week. The pharmacy dispenses NHS and private prescriptions. And offers advice on the management of minor illnesses and long-term conditions. It offers a range of services including supervised methadone consumption and flu vaccinations. And supplies medicines in multi-compartment compliance packs. These help people remember to take their medicines.

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 written procedures that the team follows. The team members have a clear understanding of their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. The team members responsibly discuss mistakes they make during dispensing. The pharmacy provides people using the pharmacy with the opportunity to feedback on its services. The pharmacy team members look after people's private information. And they know how to protect the safety of vulnerable people. The pharmacy generally maintains all the records as required, by law in compliance with standards and procedures.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) which the pharmacy team members have read. These provided the team with information to perform tasks supporting delivery of services. They covered areas such as dispensing of prescriptions and controlled drug (CD) management. These were subject to regular review. The team completed tests on their understanding after reading SOPs. And signed them as read. The team could advise of their roles and what tasks they could do. There were also several other corporate checks undertaken weekly to manage the running of the pharmacy.

The public area of the pharmacy was compact, but it had a large dispensary with ample bench and storage space. There were three computer terminals in use for dispensing. And the pharmacist had a dedicated checking area. There was plenty room for the compliance pack preparation. And storage of the packs. The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used different colours of baskets, with red for people waiting, white for the electronic collections and grey for deliveries. They also used blue trays for the compliance packs. This distinguished people's prescriptions by degree of urgency and this helped plan workload.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The pharmacist flagged any near misses to the team. And the team members recorded these on a specific template. And then transferred them on to the computer system, Datix. They ticked the paper record when they had put it on to Datix. Examples included 'four daily' when it should have been 'one to four a day' and the form salbutamol Easi-breathe with the pressurised inhaler given. The pharmacy kept the completed near miss logs and near miss analysis in the patient safety folder. The team had huddles and discussed and shared learning from near misses. The monthly patient safety report included learning such as to try to avoid interruptions and finish tasks before serving people or answering the phone. The review had noted that the number of form errors had gone down. The pharmacy team members had separated the look-alike sound-alike drugs. They had put warning labels on the shelves to highlight these drugs. And noted on the patient medication records (PMR). They discussed articles from the company for learning, with a recent error at his branch which involved lithium. They had discussed the various strengths, and all read the article. They signed after reading.

The pharmacy displayed information to people on how to provide comments and about the complaints process. The team advised on the procedure to record on the company Datix system to report dispensing errors. The team kept evidence in the folder, and they followed the company procedure. The

pharmacist carried out root cause analysis following any incidents and used a fishbone diagram tool to investigate and learn from any error. The pharmacist ensured that she informed the people involved in any error. And the team discussed for learning. The pharmacy had current indemnity insurance in place.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacists completed the responsible pharmacist records as required. A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy checked CD stock against the balance in the register after each dispensing. This helped to spot errors such as missed entries. The pharmacist undertook weekly stock audits. Physical stock of an item selected at random agreed with the recorded balance. The pharmacy kept a record of CDs which people had returned for disposal and it had a process in place to ensure the team destroyed these promptly. And did not allow a build-up in the CD cabinet. The pharmacy kept special records for unlicensed products with the certificates of conformity completed. The pharmacy kept records for private prescriptions in a book. But the book was a spiral bound notebook with numbered pages. And did not comply with the legal requirements. The pharmacy manager confirmed after the inspection that she had obtained a new bound book. The pharmacy had undertaken few private prescriptions with only 14 pages since 2017. And one or two entries on each page.

The pharmacy displayed a notice on the company's privacy policy with information on the confidential data kept and how it complied with legislation. The team had read General Data Protection Regulation (GDPR) information. And had some training on this. The IT system was password protected. And the team stored completed prescriptions safely. And kept patient sensitive information securely. The pharmacy team stored confidential waste in separate containers for offsite shredding.

The pharmacy had a policy for safeguarding vulnerable adults and children. The pharmacists had undertaken level 2 CPPE training. And the team had completed Dementia friends training. The team had also undertaken the training required by the company on safeguarding and undertook refresher training as required. The pharmacy had contact numbers for local safeguarding available for the team.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe and effective services. The pharmacy team members are competent and have the skills and qualifications they need for their role. The pharmacy encourages and supports the pharmacy team to learn and develop. And it provides access to ongoing training. The pharmacy team members support each other in their day-to-day work. And they feel comfortable raising any concerns they have.

Inspector's evidence

There was one pharmacist and seven dispensers who worked in the pharmacy. In addition, there were several pharmacists covering the additional hours. The pharmacy had just appointed a new full-time second pharmacist who would be working 40 hours a week. Relief pharmacists for the company or locums covered the remainder of the hours. There was a regular locum who worked on Saturday evenings and Sundays. The pharmacists worked eight-hour shifts on the day they worked. The dispensers worked a variety of hours from 40 to 12 hours. The pharmacy usually had three dispensers present at busier times. And one in the earlier part of the morning and later in the evening. One of the dispensers was on maternity leave and the pharmacy had received temporary cover with another dispenser. The pharmacist planned the rota for the team about six weeks ahead which ensured there was suitable cover.

Certificates and qualifications were available for the team in a folder. The team members undertook training on the company system, E-expert. They all had their own log-in code. They explained some training was mandatory such as operational tasks, SOPs and any revised SOPs. The manager advised that she received reminders about training and displayed a notice for the team of any training they required to do. The team were all up-to-date with training. They undertook training during the quieter parts of the day. The team received performance reviews once a year which gave the chance to receive feedback and discuss development needs.

The team members carried out tasks and managed their workload in a competent manner discussing any issues which arose and dealing with any telephone queries. They kept notes in a book so they could pass messages to each other between shifts. The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacist.

There was a whistleblowing policy and telephone numbers were available so the team members could easily and confidentially raise any concerns outside the pharmacy if needed. The pharmacy team had targets for services such as MURs. These were achievable and done when they met the patient's needs.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is safe and clean, and suitable for the pharmacy services it provides. People can have private conversations with a pharmacist or team member in the consultation room.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. And fitted out to a suitable standard with suitable space for dispensing, storing stock and medicines and devices waiting for collection. The sink in the dispensary for preparation of medicines was clean. Separate hand washing facilities were in place for the team. The benches, shelves and flooring were all clean and the team members advised they generally cleaned in the evenings when it was quieter. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. The room temperature was comfortable, and the pharmacy was well lit.

The pharmacy had a good sized, signposted, sound proofed consultation room. There was a notice about the chaperone policy asking patients if they would like a family member or chaperone present. The pharmacy team kept the consultation room locked when not in use. The team could clearly see people coming into the pharmacy. The public area of the pharmacy consisted of a small waiting area. There was a gate over the counter which prevented people entering the dispensary.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides its services using a range of safe working practices. The pharmacy team takes steps to identify people taking some high-risk medicines. And they provide people with additional advice. They dispense medicines into compliance packs to help people remember to take them correctly. The pharmacy gets its medicines from reputable suppliers. It adheres to storage requirements during the dispensing process. It takes the right action if it receives any alerts that a medicine is no longer safe to use. And takes the correct action to return it to the supplier.

Inspector's evidence

The pharmacy had some steps at its entrance, and it had a bell which people could ring for attention if required. The public area was very small and consisted of the waiting area only, with some chairs available for people to use. The pharmacy displayed its services in a ladder in the window and within the pharmacy. The pharmacy displayed the hours of opening on the door. The pharmacy had a range of leaflets and posters with healthcare information. It displayed the company's customer care notice which included the privacy notice about how it handled private information, customer satisfaction information and the chaperone policy. It also provided information on the dispensing process at its central hub for people, the central fulfilment. The pharmacy kept a small range of medicines and items for sale behind the counter. This included the pharmacy medicines. The team assisted people if they required to purchase anything. The team members advised that they sometimes ordered items for people and kept these in the back of the pharmacy which had plenty of room.

The pharmacy undertook Medicine Use Reviews (MURs). The team highlighted people who were eligible for the service using the criteria highlighted. The pharmacist advised that people found them beneficial. Recently she had undertaken a review in which the man had stopped taking his heart medication for no reason. So, she had advised him and referred him back to his doctor to be reassessed. The pharmacy provided the New Medicines service (NMS) and followed up people by phone. They advised it was useful being open in the evening as they often managed to get people in for the follow-up conversation. The pharmacist had provided around 100 flu vaccinations with a mixture of vouchers received and private vaccinations. The team undertook blood pressure checks which was popular. They gave the person a copy of the result, kept one and if required provided the person's doctor with a copy. People often returned for additional readings if the reading was higher than they expected. The pharmacy received a few requests for Emergency Hormonal Contraception (EHC) but generally prescriptions came from the surgery.

The pharmacy provided the Community Pharmacy Consultation Service (CPCS). The CPCS service connected patients who have a minor illness or need an urgent supply of a medicine with a community pharmacy as their first port of call. The referrals came from NHS 111. The pharmacist had set an alert on the computer to check the system to be aware of any referrals. The pharmacist advised some people rang to say they were coming. And she tried to contact people. She advised that she provided people with advice which often resulted in a purchase. And some people were confused as they thought the service would be free. And they would not have to pay for items such as dressings.

The pharmacy supplied medicines to people in their homes in multi-compartment compliance packs .

Either the pharmacists or the doctors assessed people for suitability for a compliance pack depending where the person first asked. The pharmacist also made requests to the surgery if she felt someone would benefit from having a compliance pack. The pharmacy also provided medicines to one small home with about 13 beds. It provided the medicines on racks to the home. The pharmacy prepared the packs, four weeks at a time. And most people collected, or the pharmacy delivered, the four weeks of packs together, in line with the prescription. The team planned the work and did fewer community compliance packs on the week they prepared for the home. The home ordered the prescriptions and the pharmacy worked a bit ahead which ensured the medicines were ready in time. The team members generally prepared the packs over the weekend when it was quieter. They used trackers for ordering, when they received prescriptions, when they had labelled and had a column for any queries. They marked when they had resolved queries. And they recorded on the tracker who had assembled, clinically checked, accuracy checked and if the compliance pack had been delivered or collected. They kept a medication record cycle for each person. And they kept a communication sheet with each person's record and initialled if there had been any changes made. They provided patient information leaflets (PILs) with each four-week cycle.

The pharmacy offered a substance misuse service for methadone and buprenorphine. The pharmacist generally made up the items at the weekend, ready for the week. It was quieter at the weekends which allowed time for this task. Most people were supervised at the time of collection.

There was a clear audit trail of the dispensing process. The team completed the 'dispensed by' and 'checked by' boxes which showed who had performed these roles. And a sample of completed prescriptions looked at found compliance with this process. The team used appropriate containers to supply medicines. And used clear bags for dispensed CDs and fridge lines so they could check the contents again, at the point of hand-out. The pharmacy used the company's central fulfilment service for some prescriptions. As a monitoring service for accuracy each day, the pharmacy checked one full completed pack from the hub, one prescription which both the hub and the pharmacy had been involved in. And one completely dispensed in the pharmacy. It recorded any issues and fed back any concerns. They advised that on one occasion they had felt the bag from the hub had not been sealed well but confirmed all items were correct. They received a code to log the issue on the system for feedback.

There were some alerts stickers used to apply to prescriptions to raise awareness at the point of supply. These included 'pharmacist advice' which ensured patients received additional counselling. The team members used CD and fridge stickers on bags and prescriptions to prompt the person handing the medication over that some medication required to be added to complete the supply. The CD stickers recorded the last date for supply, to make sure it was within the 28-day legal limit. This prevented supplies when the prescription was no longer valid. When the pharmacy could not provide the product or quantity prescribed in full, patients received an owing slip. And the pharmacy kept a copy with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy contacted prescribers if items were unobtainable to ask for an alternative. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme (PPP). The team had highlighted the shelves where the pharmacy kept the stock with reminders about the PPP. And they explained the information they provided to the 'patients in the at-risk' group. The pharmacy kept a delivery sheet as an audit trail for the delivery of medicines from the pharmacy to patients. This included a signature of receipt of the delivery. The driver used a separate delivery sheet for controlled drugs. The driver generally undertook deliveries between 11am and 2pm. The team contacted people who had not collected their medication after four weeks to establish if they still required it. The team returned items to the NHS spine if people did not require them anymore.

The pharmacy obtained medicines from reputable sources. The team members advised they had an update in November about the Falsified Medicines Directive (FMD). They had undertaken training on the company's system E-expert. And they were scanning packs out as a move towards FMD. But they were not scanning packs in. They did not have a date for implementation fixed yet. But were aware of various tests being undertaken on the system. The pharmacy stored medicines in an organised way, within the original manufacturers packaging and at an appropriate temperature. The pharmacy had two refrigerators from a recognised supplier. These were appropriate for the volume of medicines requiring storage at such temperatures. The team members recorded temperature readings daily and they checked these to ensure the refrigerators remained within the required temperature range. The pharmacy team checked expiry dates on products and had a date checking schedule in place to ensure all sections were regularly checked. The team members marked short-dated items and they took these off the shelf prior to the expiry date. The team members marked liquid medication. They used stickers with 'date opened' which allowed them to check to ensure the liquid was still suitable for use.

The team used appropriate medicinal waste bins for patient returned medication. The contents of the bins were securely disposed of via the waste management contractor. The pharmacy had appropriate denaturing kits for the destruction of CDs. The pharmacy had a process to receive drug safety alerts and recalls. The team actioned these and updated the company system as the company required. They discussed any alerts they received as a team. And they recorded these on their monthly patient safety review for information.

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 to protect people's confidentially.

Inspector's evidence

The pharmacy team members had access to a range of up-to-date reference sources, including the British National Formulary (BNF). They used the internet as an additional resource for information such as the Electronic Medicines Compendium (EMC) for patient information leaflets (PILs). The pharmacy had measuring equipment available of a suitable standard including clean, crown-stamped measures. It had a separate range of measures for measuring methadone. It also had a range of equipment for counting loose tablets and capsules. The equipment such as the blood pressure machine appeared in good working order. The pharmacy replaced the blood pressure monitor when required.

The pharmacy stored medication waiting collection on shelves. And kept prescriptions attached to the bags. The team scanned out all collected medication bags. No confidential details could be observed by people for the waiting area. The computer in the consultation room was screen locked when not in use. The computer screens in the dispensary were out of view of the public. The team used the NHS smart card system to access to people's records. The team used cordless phones for private conversations.

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.