

Registered pharmacy inspection report

Pharmacy Name: Crook Pharmacy, 50 Hope Street, CROOK, County Durham, DL15 9HU

Pharmacy reference: 1111112

Type of pharmacy: Community

Date of inspection: 21/02/2020

Pharmacy context

This pharmacy is situated on the edge of the town centre. 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 flu vaccinations and supervised methadone consumption. And supplies medicines to some people in multi-compartment compliance packs to support them to take their medicines. It supplies medicines to some care homes in the area.

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 understand their roles and tasks. And they work in a safe way to provide services to people using the pharmacy. 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 understand how to protect the safety of vulnerable people. The team members responsibly discuss mistakes they make during dispensing. But the detail they record is limited. So, they may be missing out on some learning opportunities to prevent similar mistakes from occurring. The pharmacy mostly keeps 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 had read. The new owner had worked at the pharmacy previously and the new company was following the previous set of SOPs. The new superintendent (SI) had reviewed them at the beginning of January 2020 and they were still applicable and relevant. The majority had been revised in April 2019. The SI advised he was going to review them all further and produce a new set in a different format over the next few months. The SOPs provided the team with information to perform tasks supporting delivery of services. The pharmacy had separated these in to sections such as responsible pharmacist, controlled drugs (CDs) and services. The SOPs had signature sheets and the team had read and signed the sections relevant to their role. The team could advise of their roles and what tasks they could do. They advised what they could do in the absence of the responsible pharmacist. The SI advised all the team would reread the SOPs as a refresher.

The pharmacy workflow provided different sections for dispensing activities with dedicated benches for assembly and checking. The team used the side benches for the homes and compliance pack preparation. The pharmacy team members used baskets throughout the process to keep prescriptions and medicines together. They used larger baskets for the compliance packs and homes. And different colours of baskets, with red for people waiting and silver for delivery to distinguish people's prescriptions by degree of urgency and this helped plan workload. They had a system in place for the prescription for the repeat dispensing service and generally prepared these at the weekend, ready for people to collect the following week.

The pharmacy recorded near miss errors found and corrected during the dispensing process. The pharmacist had recently introduced the team members to record their own when possible. Examples recorded included tramadol with wrong quantity, but the quantity not specified. This had a comment 'double pack but split'. And paracetamol 250mg with 200mls and 100mls given with a comment to check the prescription. Other comments included 'don't dispense off labels' but lacked detail of the actual error. The SI was trying to encourage recording and completion of possible reasons with more detailed comments. The team discussed near miss errors. The pharmacy had marked the shelf edges for the fast-moving lines and had clearly indicated the strengths to help with picking. They had a notice in the dispensary with the Look-Alike Sound-Alike (LASA) drugs to alert the team to take care with these. And had a few shelf alerts for these drugs. The pharmacist undertook reviews monthly, but the content was limited. The pharmacist had completed the yearly review for the Quality payment. This had included actions taken and a reflection of the types of near-miss errors. The benefits of more detailed

recording and reviews would ensure the team could read these and they would not miss opportunities for learning.

The pharmacy had a practice leaflet on the counter although the name of the pharmacy was still the old name. The pharmacist advised he was waiting for the approval from the council in order for him to change the name on the fascia. And then he would promote the change of name to inform people. There was information available to people on how to provide comments and about the complaints process. This included referral to the Patient Advice and Liaison Service (PALS). The pharmacy had a procedure to record and report dispensing errors. The pharmacist owners dealt with any concerns raised. The pharmacy had current indemnity insurance with an expiry date of first January 2021.

The pharmacy displayed the correct responsible pharmacist (RP) notice. And the pharmacist completed the responsible pharmacist records as required. The pharmacy suitably maintained controlled drugs (CD) registers. The registers showed headings completed and running balances kept. The registers indicated the pharmacy undertook weekly stock balance checks. 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. But the team had not completed the date of return for some entries. 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. It maintained a book for the recording of private prescriptions. Some of the dates of the prescriptions were unclear and the records for the emergency supplies.

The pharmacy displayed information on the confidential data kept, with a privacy notice displayed. The team had read General Data Protection Regulation (GDPR) information. And the pharmacy had an Information Governance policy which included consent, data transfer and use of smart cards. The IT system was password protected. The computer stored patient medication records (PMRs) electronically. And the team stored completed prescriptions and other patient sensitive information safely. The pharmacy team stored confidential waste in separate containers for offsite shredding. The pharmacy had a child protection and vulnerable adult protection policy. The pharmacy had contact numbers for local safeguarding available for the team. But the team members did not know where to locate these. The team advised they would discuss any concerns with a pharmacist first. The pharmacists and one of the dispensers had undertaken level 2 CPPE training. Some staff had completed level 1 training. And they had completed Dementia Friends training.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough qualified staff to provide safe and effective services. The pharmacy team members are suitably trained or working under supervision during training. They understand their roles and responsibilities in providing services. Pharmacy team members complete ongoing training on an ad-hoc basis. But the pharmacy doesn't provide structured ongoing training. So, team members may miss opportunities to complete learning relevant to their role. 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 three dispensers working in the pharmacy at the time of the inspection. In addition, there was another dispenser and a student who worked in the pharmacy. The dispensers worked a range of hours, with one working about 50 hours a week and others working 40 hours, 24.5 hours and five hours a week. The student worked around ten hours a week. The pharmacist owner and superintendent (SI) worked around 40 hours although sometimes more. The other pharmacist owner worked around 40 hours. The pharmacy had regular locum cover for the evenings and Saturdays, with the owners generally working on Sundays. The student was hoping to study pharmacy and had only worked at the pharmacy for around two months and was being put on to a dispensing course. The dispenser who worked five hours a week was leaving. The pharmacist advised he had a family member who was going to join the pharmacy and would do the dispensing course.

The pharmacy had recently developed training folders for the team members. But to date the pharmacy had not added any training articles to the folders. The team members described how they read through articles and the pharmacist kept them up-to-date with current topics. The pharmacists supported the team in their learning and the team discussed items during dispensing to learn and improve their knowledge. They advised that when the pharmacy was quiet, they could take some training time. The SI advised this was something he was going to focus on improving. But had been concentrating on other aspects on the business since he took over. All of the team were undergoing training for the smoking cessation service as the funding had recently been granted by public health for the service in pharmacy. The pharmacist advised it would be useful for people to be able to obtain this service in the evening. The pharmacist advised there was some training for naloxone being provided through a PGD and he would undertake this training.

The team members had informal conversations but not formal performance reviews. They advised that they obtained feedback and could discuss development needs. One dispenser advised she had discussed undertaking the technicians' course in the future. The team carried out tasks and managed their workload in a competent manner discussing any issues which arose and dealing with any telephone queries. They worked well together as a small team. The team said they could raise concerns about any issues within the pharmacy by speaking to the pharmacists.

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 an acceptable standard with reasonable space for dispensing, storing stock and medicines and devices waiting for collection. The pharmacist advised that during the weeks they prepared the homes the space was limited. They tried to keep areas as tidy and organised as possible. 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 cleaned at night when it was quieter. The pharmacy team generally 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 suitable, signposted, sound proofed consultation room which the team used. 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 pharmacy had a barrier at the entrance to the dispensary which the team put down as required. The counter was clearly observed from the dispensary and the staff were aware of customers in the premises.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are accessible to people. And it displays some information about health-related topics. The pharmacy provides its services using a range of safe working practices. It takes the right action if it receives any alerts that a medicine is no longer safe to use. The pharmacy team members take steps to identify people taking some high-risk medicines. And they provide these people with extra advice. The pharmacy team members dispense medicines into multi-compartment compliance packs to help people remember to take them correctly.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was a small step at the entrance. And the team members assisted people if they required help. A person in a mobility scooter knocked on the window and the team assisted her as required. There was a bell on the outside, but this did not work. There was some customer seating. There was a working hearing induction loop in place. The pharmacy provided the hours of opening in the practice leaflet. The pharmacist advised he had been clearing the posters and notices. He had removed the hours of opening from the window. But he would address this with the new fascia. There were some leaflets available for people for the collection and delivery service. There were a few more leaflets in the consultation room on a range of healthcare topics. The pharmacy had a defined professional area. And items for sale were mostly healthcare related. The team kept the pharmacy medicines behind the counter and assisted people who wished to purchase these items.

The pharmacy provided Medicines Use Reviews (MURs) and the New Medicine service (NMS). It had targeted the high-risk groups, so it was harder to find suitable people for reviews. It undertook around 35 NMS a month. The pharmacist advised people liked these. And it gave him the opportunity to build up relationships with people using the pharmacy. He generally provided advice on side effects and reinforced how to take or use medication. The pharmacist provided flu vaccinations as and when people came to the pharmacy. And generally managed to undertake these throughout the working day. The pharmacy provided the minor ailments service with paracetamol and ibuprofen for children being the most popular items. The pharmacists provided Emergency Hormonal Contraception (EHC) through a Patient Group Direction (PGD). And the pharmacy offered the free condom service, C-Card and the team undertook brief alcohol interventions. The pharmacy provided the Community Pharmacist Consultation Service (CPCS). People accessed the CPCS service through NHS 111 referrals. The CPCS linked people to a community pharmacy as their first port of call. This could be for either the urgent provision of medicines or the treatment or advice for a minor illness. The pharmacy had had a few referrals and provided medicine through the minor ailments service to some people. It had also provided advice and undertaken a few emergency supplies to people.

The pharmacy supplied medicines to around 100 people in multi-compartment compliance packs to help them take their medicines. And it supplied to six care homes with a range of beds with a total of around 240 beds. The team followed systems for assembling and preparing the homes, with the medication on racks. They left out any items with queries to ensure they dealt with these before the home required the supplies. This took up some bench space, particularly when it was the larger home and the team tried to keep this area organised. Some people in the community received their compliance packs weekly and others monthly, depending on how the pharmacy received the

prescriptions. The doctors generally had assessed people as to their suitability for compliance packs. The pharmacy supplied patient information leaflets (PILs) to people in the community once each month and they supplied to the homes with each cycle. The pharmacy offered a substance misuse service with about 12 people using this service. Most of them attended the pharmacy daily, between 7am and 9am in the morning to collect their supply. The pharmacy made up the supplies the night before ready for the next day.

There was an 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 team members used CD and fridge stickers on bags and prescriptions to alert the person handing the medication over that there was an item required they needed to add. There were some alerts stickers applied to prescriptions to raise awareness at the point of supply. Or the team marked the issues on the prescription which ensured patients received additional counselling. Or they added a note to the bag.

When the pharmacy could not provide the product or quantity prescribed in full patients received an owing slip. And the pharmacy kept one with the original prescription to refer to when dispensing and checking the remaining quantity. On occasions, the pharmacy contacted one of the other local pharmacies to see if they had the item. The pharmacy also contacted prescribers if items were unobtainable for an alternative. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme. They had undertaken an audit. They had two people in the at-risk group. And they explained the information they provided to these people. They had a pack with the additional guides and cards which they provided to people. The pharmacy provided a repeat dispensing service. And had around 500 people who used this service. They had a system in place to prepare the items ready for people to collect. The pharmacist advised that at the point of hand out they also asked if people still required all the items. The pharmacist undertook an MUR or intervention if anything had changed. 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 pharmacist was looking at getting a hand-held pod device for the delivery service.

The pharmacy stored medicines in an organised way, generally within the original manufacturers packaging and at an appropriate temperature. And it kept a few bulkier items directly on the floor. The pharmacy had a refrigerator from a recognised supplier. This was 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 refrigerator remained within the required temperature range. The pharmacy team checked expiry dates on products and had a rota 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 with the date of opening which allowed them to check to ensure the liquid was still suitable for use.

The pharmacy obtained medicines from reputable sources. The pharmacy had a process to receive drug safety alerts and recalls. They received these directly from the Medicines and Healthcare products Regulatory Agency (MHRA) and through PharmOutcomes. The team actioned these and kept records of the action taken. The team used appropriate medicinal waste bins for patient returned medication. These were uplifted regularly. And the pharmacy sometimes paid for additional pick-ups due to the limited storage space in the pharmacy. The pharmacy had appropriate denaturing kits for the destruction of CDs. The pharmacy had registered with SecurMed ready for implementation of the Falsified Medicines Directive (FMD). It had scanning devices. The pharmacist advised the system was

being updated. He was not sure when the pharmacy would fully implement the requirements for FMD.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the pharmacy services it provides. There are provisions in place to maintain people's privacy.

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. The team had marked the measures for methadone with stickers. It also had a range of equipment for counting loose tablets and capsules. The team members had access to disposable gloves, tweezers and they had alcohol hand washing gel at various workstations.

The pharmacy stored medication waiting collection on shelves where people waiting in the pharmacy could not see any confidential details. The area for this was well organised but there were a few bulkier items on the floor. The team filed prescriptions in boxes in a retrieval system out of view, keeping details private. 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. And took these in the consultation room if they felt they required additional privacy.

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.