

Registered pharmacy inspection report

Pharmacy Name: West Cornforth Pharmacy, West Cornforth Medical Centre, Reading Street, West Cornforth, Ferryhill, Durham, DL17 9LH

Pharmacy reference: 9011623

Type of pharmacy: Community

Date of inspection: 28/10/2021

Pharmacy context

This is a community pharmacy in West Cornforth, Ferryhill. The pharmacy recently relocated to the Medical Centre. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and over the counter medicines. It supplies some medicines in multi-compartment compliance packs to people living in their own homes. And it provides a home delivery service. A flu vaccination service is provided. And the pharmacy is approved to provide covid-19 booster vaccinations commencing the first second in November.

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	2.4	Good practice	Pharmacy team members work within a culture of openness and learning. They work together to achieve common goals.
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 to keep members of the public and team members safe during the Covid-19 pandemic. Team members discuss dispensing mistakes and make some improvements to avoid the same errors happening again. The pharmacy keeps the records it needs to by law. People using the pharmacy can raise concerns and provide feedback. Team members securely dispose of personal information when it is no longer required. The pharmacy has relevant policies and procedures in place for most of its services. But the updated version is not accessible to all, so people may not be working consistently. The pharmacy has a safeguarding procedure and action is taken when a concern is raised.

Inspector's evidence

The pharmacy had risk assessed the impact of COVID-19 on the services and the people who used it. Team members wore face masks to help reduce the risks associated with the virus. The pharmacy had a hand sanitisation station at the entrance to the pharmacy and pharmacy posters advised of the need to still wear masks in the pharmacy.

The manager showed he inspector a file with the standard operating procedures SOPs they currently worked to. These covered most of the services the pharmacy provided. The team had all signed to indicate they had read and understood them. The superintendent (SI) had reviewed these in March 2021 with the intention of the team accessing them electronically. The manager on the day had not been able to access these. The SI was aware of the issue and was working with IT provider to resolve it. The RP picked up errors at the checking stage and entered these onto the electronic record. During the pandemic near misses had usually been recorded and the records demonstrated this. The manager brought up the near miss entries and reviews on the screen. The team entered their own near misses and details included how the error had happened and changes they had made to prevent a similar error happening again. For example, such separating the different strengths of ramipril. A member of the team provided some other examples of how they considered risk such as pointing out to each other the similarity of packaging when putting away the stock. The team had completed training on look-alike sound alike drugs and demonstrated how some of these had been separated. The team used an incident report form to record dispensing errors. The manager related an incident earlier in the week and showed the inspector the detailed report. The team had worked with the surgery to ensure that a similar incident wouldn't happen again.

The pharmacy prominently displayed a notice that told people who the RP on duty was. Members of the pharmacy team knew what they could and couldn't do, and what they were responsible for when the pharmacist was absent. The pharmacy had a complaints procedure. And this was detailed in the pharmacy leaflet displayed in the retail area. The team could not recall any formal complaints but provided examples of the way that they responded to people who expressed dissatisfaction with the service they received. A customer regularly collected medication for four or five people and usually had to wait. So, in consideration of this they had been advised the customer to telephone the pharmacy beforehand and the medications would be packed ready for collection.

The pharmacy had appropriate indemnity insurance in place and the certificate was displayed in the dispensary and valid until 30 June 2022.

The pharmacy kept an electronic record to show which pharmacist was the RP and when. The pharmacy had an electronic controlled drug (CD) register. The manager usually checked the register balance on each dispensing and did a full CD balance audit monthly. A balance check of one randomly picked CD in the cabinet did not initially tally with the CD register. The manager resolved the discrepancy straight away. The team recorded private prescriptions electronically and the prescriptions had been filed chronologically. The pharmacy had a system for the supplies of the unlicensed medicinal products it made which complied with MHRA regulations. The manager kept the certificates of conformity, patient details and invoices together in chronological order in the filing cabinet.

The pharmacy team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was segregated into a bin to avoid a mix up with general waste. And this was shredded on site. The manager and team had completed safeguarding training and demonstrated good understanding of what to look out for and what action to take. At the time of the inspection a team member had shared a concern about a patient who sounded confused on the telephone. The manager contacted the person so he could access their understanding of how to take their medication. The team related instances when they had reported concerns about people not taking all their medication regularly or who may have been confused. There had been an occasion when the manager had contacted the crisis team.

Principle 2 - Staffing ✓ Standards met

Summary findings

A small well trained enthusiastic team provides the pharmacy's services. They work effectively together and support the manager. They engage in safety reviews and share ideas which they use to inform the way in which the pharmacy provides its services. Ongoing training ensures the team are up-to-date with.

Inspector's evidence

The pharmacy team on the day consisted of the manager (the RP), three dispensing assistants and the part-time driver. The team worked well together and interacted well to ensure people got what they needed in an efficient way. Team members interacted with the inspector positively to provide evidence and to explain how they date checked and discussed errors. The team dealt with people on the telephone and in person in an efficient friendly manner. Most people who used the pharmacy were local. The pharmacy had direct access to the surgery by an internal side door. The team had a good relationship with the practice team so making changes and following up queries could be dealt with straight away. And people received a quick efficient service and were grateful for this.

The team usually managed with the current staffing levels. The manager had been trained to provide Covid 19 booster vaccines and second pharmacist cover would be provided. The company also had a technician to call on who had assisted in other branches delivering Covid 19 vaccinations. The team had bi-monthly team meetings with agenda items. The manager took notes, and all contributed. The team discussed ways to improve the service provided.

The team had access to Blue Stream Academy eLearning. The team completed training when time allowed. All had their own log in so could complete units at home. Examples of training completed included safeguarding, mental health awareness and infection control. Members of the team expressed their support for the manager, and they appreciated how he supported them and considered their views and opinions. A member of the team described an occasion when they had noted that the retrieval system of filing completed prescription bags alphabetically by surname on the shelf had not been working efficiently. So, they had suggested changing to a number system which worked well. The team found it easier to locate the right bag of medication when people came in to collect. The team knew what to do if they had a professional concern and described how they had acted when they had a concern previously.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides a suitable and secure environment for people to receive healthcare. And its premises are clean and well equipped.

Inspector's evidence

The pharmacy had recently relocated to its current position. The pharmacy had been designed and laid out to reduce risk. For example, the large double sided checking bench had compartments above where the team put baskets waiting to be checked. So, the checking bench was clear and only the medicine being checked occupied the bench. The team had generously sized designated working areas. The pharmacy had plenty of natural light and provided a bright welcoming environment. All areas looked clean and clutter free and the team worked hard to create a tidy and welcoming environment from which to provide its services. The floor area had been cleared of obstructions. Stock was stored tidily on the shelves. The pharmacy had air conditioning. The dispensary had a good-sized sink with hot and cold running water for medicines preparation and for staff use. The pharmacy had staff toilets with a sink with hot and cold running water. The pharmacy had a large sound-proofed consultation room with desk, computer, and seats where people could sit down with a team member. It was professional in appearance and was signposted by a sign on the door. The pharmacy had a large training/meeting room upstairs.

Principle 4 - Services ✓ Standards met

Summary findings

People with a range of health needs access the pharmacy's services easily. And the pharmacy manages and delivers these services effectively using technology and off-site dispensing. It obtains its medicines from reputable sources. And stores and manages its medicines appropriately.

Inspector's evidence

People had direct access into the health centre through double automatic doors to the front. So, people in wheelchairs and those with mobility issues could easily access the pharmacy. The pharmacy advertised its services and opening times in the window. The team had a healthy living display with a range of leaflets on display. So, people using the pharmacy had access to helpful information. The pharmacy had been approved to provide Covid-19 booster vaccinations. The superintendent (SI) had been co-ordinating with NHSE&I and the manager had attended training. The pharmacy provided a flu vaccination service and had provided around 190 to-date.

Team members signed the dispensing labels when dispensing and checking, so, they had a robust audit trail of the process in place. The team used baskets to hold prescriptions and medicines. This helped the team members stop people's prescriptions from getting mixed up. And to prioritise the workload. Team members used various stickers within the dispensing process as an alert before they handed out medicines to people. For example, they used "controlled drug" stickers to remind the team member handing out the medication that a CD needed to be given at the same time. The manager advised that they had very few owings, if and they had been unable to source a medicine then the surgery provided a prescription for an alternative. On the occasions when the pharmacy could not supply the full quantity prescribed the team used owing slips. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy delivered medicines to people in their homes. And used pro-delivery manager to track the driver's location and delivery route. So, people could be given a time slot for their delivery. The driver advised that the system made delivery easy. He confirmed that currently due to covid he only obtained an electronic signature from people in receipt of CDs.

The SI manager was aware of the pregnancy prevention programme (PPP) for people prescribed valproate, and of the risks. The inspector reminded the manager about the updated guidance from MHRA. He demonstrated an understanding of guidance and the pharmacy's obligations. Since the relocation, the team had been unable to locate the sodium valproate cards. Replacements had been ordered.

The pharmacy stored pharmacy medicines behind the pharmacy counter to prevent people self-selecting them. The pharmacy did not routinely stock codeine linctus but rather provided alternative treatments when appropriate. The team had one bottle of codeine linctus out of view in the dispensary for dispensing should a prescription be presented. The medicines on the pharmacy shelves in the retail area were tidy and well organised. The team had their own allocated areas to date check. They usually checked the expiry dates monthly and marked items with a three-monthly expiry so they could be easily identified and removed from the shelf before expiry. The team didn't keep a record of short-dated items or when date checking had been done. The pharmacy team recorded the date on liquid medicines

when they had been opened. So, checks could be done to see if they were fit to supply. A check of three areas in the pharmacy found no out-of-date stock. The pharmacy had procedures in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits. The pharmacy team checked and recorded the fridge temperature ranges daily. Both fridges' temperatures on the day were within the correct range. The team stored the medicines inside the fridges and CD cabinet in an organised tidy manner.

The pharmacy received MHRA alerts electronically. There was audit trail to provide assurance that all alerts had been received and actioned when appropriate.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is clean.

Inspector's evidence

Team members had access to up-to-date reference sources. And the team had internet access to look up information to help with queries. The team stored medicines waiting to be collected in a way that prevented people's confidential information being seen by members of the public. The pharmacy used a range of CE quality marked measuring cylinders. The team cleaned the equipment they used to measure, or count, medicines before they used it. The pharmacy had two pharmacy grade refrigerators to store pharmaceutical stock requiring refrigeration. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. Team members responsible for the dispensing process had their own NHS smartcard.

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.