

# Registered pharmacy inspection report

**Pharmacy Name:** Roys Pharmacy (Wroxham) Ltd., Forge House,  
Station Road, Hoveton, NORWICH, Norfolk, NR12 8DB

**Pharmacy reference:** 1035357

**Type of pharmacy:** Community

**Date of inspection:** 12/07/2024

## Pharmacy context

This community pharmacy is located inside a large department store in the town of Hoveton, near Norwich. It provides a variety of services including dispensing NHS prescriptions, the New Medicine Service (NMS), and the Pharmacy First service through Patient Group Directions (PGD's). It also provides medicines in multi-compartment compliance packs to people who have difficulty managing their medicines from the original packs.

## 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
<b>1. Governance</b>	Standards met	1.1	Good practice	The pharmacy keeps a risk register to help review and reduce the risks associated with its services.
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy manages the risks associated with its services well. And its team members record and regularly review any dispensing mistakes. The pharmacy largely keeps the records its needs to by law. And it has appropriate insurance arrangements in place. Team members know how to protect vulnerable people. And the pharmacy handles people's private information safely.

### Inspector's evidence

The correct responsible pharmacist (RP) notice was displayed in a prominent position in the pharmacy. The RP was also the superintendent pharmacist (SI). There was a range of standard operating procedures (SOPs) in the pharmacy, these were available electronically. Team members confirmed that they had read the SOPs but had not signed anywhere to confirm that they had been read. The SI said he would get team members to sign to confirm they had read the SOPs. The SOPs had been recently updated. The pharmacy had a risk register in place detailing the possible adverse events that could happen at the pharmacy. Each event was given a risk score and had details of what to do if the event occurred and how the risk of the event occurring could be reduced.

Near misses (dispensing mistakes which were spotted before a medicine left the pharmacy) were recorded on paper log sheets in the dispensary. The SI gave examples where similar sounding medicines had been separated on the shelves due to previous near misses. The SI said he discussed any near misses with the team member involved and the team also regularly reviewed near misses for any trends. Dispensing errors (mistakes which had reached a person) were recorded electronically in more detail than a near miss. The SI said there had not been a dispensing error in some time, but if an error did occur, an error report would be completed, and the team would have a meeting to discuss the error.

Complaints and feedback were usually submitted online. The SI that any complaints or feedback about the pharmacy could also be given in person or via a phone call and would be actioned in the same way. Complaints were usually resolved in store by the SI. Confidential material was disposed of in separate waste bins in the pharmacy. When full, the waste was taken away by a third party company for secure disposal. No confidential waste was found in the general waste bin. And no confidential information could be seen from outside the dispensary. The SI confirmed that he had completed level two safeguarding training with the Centre for Pharmacy Postgraduate Education (CPPE). Team members had also completed level one safeguarding training. The team knew what to do if a vulnerable person presented in the pharmacy. And they had access to details of local safeguarding contacts to report a concern if needed.

The pharmacy had current indemnity insurance. Balance checks were carried out regularly for controlled drugs (CDs), and records seen in the CD register were made in accordance with the law. A random check of a CD showed that the quantity in stock matched the running balance in the register. Records seen about private prescriptions dispensed were generally complete, although some were missing the name or address of the prescriber. The SI said this would be included for future records. Emergency supplies of medicines were complete with all supplies seen having an appropriate reason for the supply. Records about unlicensed specials were complete with all entries seen having the name of the person for whom the medicine was for and the date of dispensing. The RP record was largely

complete with only a couple of entries seen missing a finish time.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough team members to manage its workload. And team members do the right training for their roles. They do some ongoing training to keep their knowledge and skills up to date. And they have a regular formal review of their progress. Team members feel comfortable about raising any concerns they have.

### Inspector's evidence

The pharmacy team consisted of the SI who worked four days a week at the pharmacy with regular locum pharmacists working on the other days. Other team members included six dispensers and four counter assistants. The SI confirmed that the pharmacy had enough team members to manage the workload and the pharmacy was up to date with dispensing. All team members had completed appropriate training for their roles with an accredited training provider and certificates were on display in the pharmacy to show this. Team members were able to explain their roles and responsibilities within the pharmacy. And they also knew what activities they could and could not do in the absence of a pharmacist. The team did some ongoing training in the pharmacy on an ad-hoc basis, usually when a new medicine or service was being provided by the pharmacy. The SI said that he did a yearly formal appraisal with all team members to review their progress. Team members had no concerns about raising any issues and would usually go to the RP on duty or the SI with any concerns that they had. Team members were observed asking the appropriate questions when selling Pharmacy-only (P) medicines and making appropriate referrals to the pharmacist when necessary. The SI confirmed the team was not set any targets.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean and tidy and provides a safe and appropriate environment for people to access its services. People can have a conversation with a team member in a private area. And the pharmacy is kept secure from unauthorised access.

### Inspector's evidence

The front fascia of the pharmacy was in an adequate state of repair. The shop floor was clean and professionally presented and there were leaflets available about various health promotion topics for people to read and take away. There were also chairs available for people who wished to wait for a the pharmacy service. P medicines were stored securely behind the counter. The pharmacy had a consultation room for people who wished to have a conversation in private. It allowed for a conversation at a normal level of volume to be had without being heard from the outside. The room was a good size, and it was kept clean and was locked from the outside. The dispensary area was clean and tidy and had enough floor and desktop space for the team to work in. It had a sink for preparing liquid medicines which was kept clean. The temperature and lighting of the pharmacy were adequate. Team members had access to a staff toilet and breakroom in the staff area of the department store. The pharmacy was kept secure from unauthorised access.

## Principle 4 - Services ✓ Standards met

### Summary findings

On the whole, the pharmacy provides its services safely. The pharmacy gets its medicines from reputable suppliers and stores them appropriately. The pharmacy can cater to people with different needs. The team takes the right action in response to safety alerts to help ensure people get medicines and medical devices which are fit for purpose.

### Inspector's evidence

The department store had step-free access via an automatic door. The pharmacy was located at the far left of the store and was clearly sign posted. It was able to cater for people with different needs, for example by printing large-print labels for people with sight issues. There was enough space for people with wheelchairs and pushchairs to access the dispensary counter. The dispensary had separate areas for dispensing and checking medicines, and baskets were used to separate prescriptions and reduce the chance of prescriptions getting mixed up. Checked medicines seen contained the initials of the dispenser and checker and this provided an audit trail.

The pharmacy provided a delivery service for people who had difficulty collecting their medicines from the pharmacy. This was done by one of the pharmacy team members and the SI confirmed all team members had completed appropriate training to allow them to deliver medicines safely. The team member doing the deliveries used a paper sheet with people's details to keep a record of deliveries, which was returned to the store after the deliveries had been completed. A signature was obtained for all deliveries including ones with CDs. If there was a failed delivery, the medicines would be returned to the pharmacy and a note put through the door with information about arranging a redelivery.

The pharmacy used stickers to highlight prescriptions that contained a higher-risk medicine, a CD or an item requiring refrigeration. The SI confirmed that he regularly handed out higher-risk medicines and gave people the appropriate counselling for these medicines. Multi-compartment compliance packs were assembled in a separate area of the dispensary. Prepared packs seen contained all the required dosage and safety information as well as a description of the medicines inside. This included a description of the colour, shape and any markings on the medicines to help people identify their medicines. Team members confirmed that patient information leaflets (PILs) were always included with each supply of the packs. The SI said that team members would contact the surgery regarding any queries they had with prescriptions such as unexpected changes to people's treatment.

The pharmacy obtained its medicines from licensed wholesalers and invoices were seen confirming this. CDs requiring safe custody were stored securely. Medicines requiring refrigeration were stored appropriately. Fridge temperature records showed that temperatures were checked regularly, and records seen were within the appropriate ranges. The current maximum temperature of the fridge was found to be out of range; however, the thermometer was reset and then showed a temperature within the required range. Expiry date checks were completed regularly every two months on a rota basis. A random check of medicines on the shelves revealed no expired medicines. The SI received safety alerts and recalls electronically via email and checked these daily even when he was not working at the pharmacy. Any alerts received when the SI was not working at the pharmacy were sent directly to the RP on duty and shared with team members in a WhatsApp group. Arranging for alerts to be received via the pharmacy's email address to make communications more streamlined was discussed with the SI

who said he would arrange for this to be setup as a priority. Alerts received were actioned accordingly and details about this were subsequently archived in a folder.

Team members were aware of the risks of sodium valproate, and the SI knew what to do if a person in the at-risk category presented at the pharmacy. Team members were shown where to apply a dispensing label to a box of sodium valproate as to not cover any important safety information. They were aware about the recent change with regards to supplying sodium valproate in the original pack. For any people who required sodium valproate to be supplied outside of the original pack, the team was aware that a risk assessment needed to be completed and discussed with the person's surgery before starting. The pharmacy had access to the appropriate in-date PGDs for the Pharmacy First service and the SI had signed the electronic copies of the PGDs. The SI confirmed that he had completed the appropriate training for the Pharmacy First service.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the appropriate equipment to provide its services safely. And it protects people's privacy when using this equipment.

### Inspector's evidence

The pharmacy computers had access to the internet allowing team members to access any online resources they needed. Computers were password protected and faced away from public view to protect people's privacy. Team members were observed using their own NHS smartcards. The pharmacy had cordless phones so conversations could be had in private. The team confirmed that the electrical equipment had been safety tested the previous month. The pharmacy had a blood pressure monitor in the consultation room and the SI confirmed that it was about a year old. Eventual replacement or recalibration of the blood pressure monitor to ensure accurate readings was discussed with the SI. There were appropriately calibrated glass measures for measuring liquid medicines with some marked for use with certain substances only. And tablet triangles for counting tablets, with a separate one for counting cytotoxic medicines such as methotrexate. This equipment was clean and fit for use. The SI explained that the pharmacy had an otoscope for use with the Pharmacy First service, but it had recently been broken. The SI said that he had ordered a new one which was due to arrive in the next few days. But in the meantime, the SI said he would refer anyone requiring review with an otoscope to another nearby pharmacy offering the service.

### 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.