

# Registered pharmacy inspection report

**Pharmacy Name:** J.G. Squire Ltd., 54 Falsgrave Road, SCARBOROUGH,  
North Yorkshire, YO12 5AX

**Pharmacy reference:** 1038977

**Type of pharmacy:** Community

**Date of inspection:** 07/03/2024

## Pharmacy context

This pharmacy is amongst a parade of shops in the large coastal town of Scarborough. Its main activities include dispensing NHS prescriptions and selling over-the-counter medicines. And it provides several people with their medicines in multi-compartment compliance packs to help them take their medication correctly. The pharmacy provides other NHS services including the Pharmacy First service. And it delivers medicines to people in their home.

## 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	N/A	N/A	N/A
<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 identifies and manages the risks associated with its services well. It has written procedures that the team members follow to help ensure they provide the pharmacy's services safely. And it keeps the records it needs to by law. The pharmacy suitably protects people's private information, and it provides team members with guidance to help them respond correctly to safeguarding the welfare of vulnerable people. Team members respond appropriately when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

### Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. The Superintendent Pharmacist (SI) presented a new set of SOPs that had recently been reviewed and updated. Each SOP had a grid on the final page for pharmacy team members to sign, to show they understood and would follow the SOPs. Team members had read the existing SOPs but they had not signed the signature section. They demonstrated a clear understanding of their roles and worked within the scope of their role.

Team members were asked to find and correct errors spotted at the final check of a prescription. The pharmacy kept records of these errors known as near miss errors. The records were mostly completed by the pharmacist after discussing the error with the team member involved to identify what caused the error and their learnings. However, only a few records had been made in 2024. A sample looked at found some information about the error was recorded along with brief details of the actions taken to prevent a similar error. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. This included completing a report. All team members were informed of the dispensing incident so they could learn from it and were aware of the actions taken to prevent such errors from happening again. For example, team members were reminded to place the dispensing label on the medicines packaging under the medicine's details. So, the pharmacist could clearly see all the information when completing the accuracy check. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services.

The pharmacy had current indemnity insurance. A sample of legally required records including the Responsible Pharmacist (RP) record, private prescriptions records and controlled drug (CD) registers met legal requirements. Appropriate records were kept of CDs returned by people for safe destruction. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. The pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. And a random balance check undertaken during the inspection was correct. A set of Patient Group Directions (PGDs) supported the pharmacists' delivery of the NHS Pharmacy First service. And provided the legal framework for the pharmacist to supply medication such as antibiotics. However, the PGDs had not been signed by pharmacists to show they had read them, understood them and would follow them.

The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. It also displayed a privacy notice. Team members had completed training about the General Data Protection Regulations (GDPR). They separated confidential waste and shredded it onsite. The pharmacy had safeguarding procedures and guidance for the team to follow. And team members had completed training relevant to their roles. The delivery driver reported concerns to the team about

people they delivered to and they took appropriate action such as contacting the person’s GP.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they support each other in their day-to-day work. They are encouraged to make suggestions to ensure the efficient delivery of pharmacy services. Team members have some opportunities to receive feedback and complete training so they can suitably develop their knowledge and skills.

### Inspector's evidence

The SI and the other pharmacist owner covered most of the pharmacy's opening hours as RP. The pharmacy team consisted of a full-time dispenser, two part-time dispensers, a part-time trainee dispenser, a full-time pharmacy apprentice who had recently joined the team and a full-time medicines counter assistant (MCA). The pharmacy team also included a full-time delivery driver who had been in post several years. At the time of the inspection the SI, one of the part-time dispensers, the pharmacy apprentice and the MCA were on duty. The pharmacy apprentice had some protected time at work to complete their training. And was supported by the experienced team members who they could ask questions of.

The team had faced some staffing challenges after experienced team members left and whilst the process for recruiting for new team members took place. Team members worked well together to manage the workload and they ensured people presenting at the pharmacy were promptly helped. The MCA managed the large number of people that regularly presented at the pharmacy well and other team members provided support when required.

Team meetings happened as and when required but key pieces of information for all team members to be aware of was captured in a diary. Team members looked at each page in the diary since they were last on duty to ensure they'd read everything. Additional training for team members was limited to regulatory training and learning from errors. In preparation for the NHS Pharmacy First service the pharmacists had completed online training.

Team members received informal feedback from the SI and the other pharmacist owner. And they were encouraged to use their experience to suggest changes to processes. They could also speak privately with one of the pharmacists. One team member had discovered additional information that could be obtained from the pharmacy's patient medication record (PMR) system that would help the team with its workload. And had spent time coaching the other team members on how to access this information.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy premises are clean, secure and provide a suitable environment for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using its services.

### Inspector's evidence

The pharmacy premises were a good size and the team kept them tidy and hygienic. There was a clean, well-maintained sink in the area where medicines were prepared. Team members kept the work surfaces in the dispensary tidy and they kept floor spaces clear to reduce the risk of trip hazards. The pharmacy maintained its heating and lighting to acceptable levels. And there was sufficient storage space for stock, assembled medicines and medical devices.

The pharmacy had a defined professional area and items for sale in this area were healthcare related. There was a soundproof consultation room which the team used for private conversations with people and when providing services. The consultation room was located behind the pharmacy counter, so people had to access part of the dispensary when invited into the room. The team managed this by having a defined path to lead the person through, and to minimise the risk of any unauthorised access to confidential information.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides a range of services which are easily accessible and help people to meet their healthcare needs. Team members manage the pharmacy services safely and effectively to help make sure people receive medicines when they need them. They obtain medicines from reputable sources, and they adequately store and carry out checks on medicines to ensure they are in good condition and appropriate to supply.

### Inspector's evidence

People accessed the pharmacy via a step-free entrance. Team members asked appropriate questions when selling over-the-counter products and knew when to refer to the pharmacist. And they gave people information on how to access other healthcare services when required. The NHS Pharmacy First service was popular, and the team had seen several people present at the pharmacy since its launch. Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) including the requirement to supply original manufacturer's packs of valproate. Most people prescribed valproate did not meet the PPP criteria but when they did the pharmacist completed the appropriate checks with the person. And recorded the outcome on the PMR so all team members were aware.

The pharmacy provided medicines in multi-compartment compliance packs to help many people take their medicines correctly. Most people received their medication in the packs as weekly supplies and the prescriptions were sent as electronic repeat prescriptions. To ensure the service was efficiently managed team members recorded when each stage of the dispensing and checking of the packs was completed. So, they could identify if any packs had not been prepared. Each person had a record listing their current medication and dose times which team members referred to during the dispensing and checking of prescriptions. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The pharmacy received copies of hospital discharge summaries via the NHS communication system which the team checked for changes or new items. When this occurred the person's medication list and the PMR were updated. And new prescriptions were requested if required.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and prescriptions to help prevent them becoming mixed up. Prescriptions with queries were clearly separated in a dedicated basket so they were not inadvertently dispensed before a response was received. And to ensure the pharmacist had verified the information provided in the response as part of their clinical check of the prescription. The pharmacy had boxes on the dispensing labels to record who in the team had dispensed and checked the prescription. A sample of completed prescriptions found that the team completed both boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. The pharmacy kept a record of the delivery of medicines to people in case queries arose.

The pharmacy obtained medication from several reputable sources. Team members stored the medication tidily on shelves and in drawers, and they securely stored CDs. They checked the expiry dates on stock and marked medicines with a short expiry date to prompt them to check the medicine

was still in date. No out-of-date stock was found. The dates of opening were usually recorded for medicines with altered shelf-lives after opening so the team could assess if the medicines were still safe to use. However, an opened bottle of Galfer Syrup with one month's use once opened did not have a date of opening recorded. The team checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and returned CDs separate from in-date stock. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people's private information.

### Inspector's evidence

The pharmacy had reference resources and access to the internet to provide the team with up-to-date information. The pharmacy had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And it had an otoscope and blood pressure monitor that were recently purchased. There were two fridges in operation. One fridge held the medicine stock requiring storage at these temperatures and the other stored completed prescriptions waiting to be handed out.

The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. Team members used a telephone system with cordless option to ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other private information in the dispensary which had restricted public access.

### 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.