

# Registered pharmacy inspection report

**Pharmacy Name:** Station Pharmacy, Unit 1, Cattlepens, Station Road  
Elmswell, BURY ST. EDMUNDS, Suffolk, IP30 9HD

**Pharmacy reference:** 1105107

**Type of pharmacy:** Community

**Date of inspection:** 28/09/2022

## Pharmacy context

The pharmacy is in the rural village of Elmswell in Suffolk. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and administering COVID-19 vaccinations. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine delivery service to people's homes.

## 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	1.4	Good practice	The pharmacy actively encourages feedback from people using its services. And it responds well to the feedback it receives by using it to help improve access to healthcare services for people in the local community.
<b>2. Staff</b>	Standards met	2.5	Good practice	The pharmacy encourages its team members to regularly feedback their ideas. And it is good at using this feedback to help inform the way it provides its services.
<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 appropriately. It keeps people's private information secure and it keeps the records it must by law. The pharmacy encourages feedback from members of the public. And it responds well to feedback by acting on people's comments to improve access to healthcare services. Pharmacy team members understand how to recognise and respond to safeguarding concerns. And they engage in shared learning to help reduce risk following mistakes made during the dispensing process.

### Inspector's evidence

The pharmacy had a comprehensive range of standard operating procedures (SOPs) to support its safe and effective running, these were due for review. They covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. The majority of team members had signed SOPs to confirm their understanding of them. Several newer team members had begun working their way through the SOPs, concentrating on those relevant to their job roles. Pharmacy team members discussed their roles and responsibilities with confidence. A team member explained clearly what tasks could not take place if the RP took absence from the premises. The pharmacy had processes for identifying and managing risks associated with the services it provided. This included completing risk assessments and ensuring team members had completed relevant learning to deliver a service. For example, an accessible file in one of the consultation rooms provided SOPs, risk assessments and training records associated with the COVID-19 vaccination programme. The pharmacy had an annual planner designed to support its team members in completing daily and weekly tasks associated with maintaining a safe environment for the delivery of its services. But use of the planner to support completion of these tasks had reduced recently.

Pharmacy team members recognised the importance of recording mistakes made during the dispensing process. And they followed procedures relating to near miss and incident reporting. The pharmacy encouraged its team members to reflect on why a mistake had occurred when completing the near miss record. But they used the action section of the near miss record to record immediate steps taken to correct the mistake, rather than the action taken to reduce future risk. This meant that it could be more difficult for the team to measure how effective its actions were in reducing risk. Pharmacy team members demonstrated recent actions taken to reduce risk when dispensing. For example, separating similar-looking medicines on the dispensary shelves. The RP on duty was a locum pharmacist, and they confidently discussed the steps they would take to manage and report a dispensing incident to the superintendent pharmacist (SI).

The pharmacy had a complaints procedure. And it shared details of how people could provide feedback or raise a concern about the pharmacy. The pharmacy had sought feedback through its social media page by asking members of the community what it could do to support them. In response to this it had liaised with the local audiology department and was now a hearing aid battery collection point. This reduced the need for people to travel further afield to collect replacement batteries. Feedback had also been used to arrange for a visiting chiropodist to provide regular clinics from one of the pharmacy's consultation rooms. The pharmacy held personal identifiable information within staff only areas of the premises. It had procedures to support its team members in handling personal data with care.

Pharmacy team members disposed of confidential waste securely. The pharmacy had procedures relating to safeguarding vulnerable adults and children. A trainee team member explained what action they would take to support and safeguard a person in the event they attended the pharmacy and asked for 'ANI', an initiative to help provide a safe space for people experiencing domestic abuse. Pharmacy professionals had completed level two safeguarding learning. And other team members had completed some learning on the subject to support them in their role.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice was changed shortly after the inspection began to reflect the correct details of the RP on duty. The pharmacy kept its specials records, RP record and private prescription register in accordance with legal and regulatory requirements. The pharmacy maintained running balances in its CD register. And there was evidence of some regular physical balance checks of stock taking place against the register. A random physical balance check conducted during the inspection complied with the running balance in the register. Entries in the register generally conformed to legal requirements with some minor omissions found. For example, the pharmacy did not always complete page header. And it did not always record the address of the wholesaler when entering receipt of a CD. The pharmacy had a patient returned CD destruction register, and this was maintained to date.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has a dedicated team of people who work together well. Pharmacy team members demonstrate enthusiasm for their roles. And they are confident in sharing their thoughts and ideas at work. The pharmacy uses their feedback to help inform how it provides its services. Team members are supported in learning and developing skills relevant to their roles. And they engage in conversations to help minimise risk.

### Inspector's evidence

The RP (a company director) was busy running the vaccination services during the inspection with administration support from a trainee medicine counter assistant. A second pharmacist, a locum, was providing the pharmacy's other services. And they were supported by the pharmacy manager (a pharmacy technician). The SI was the full-time regular pharmacist, they were on leave on the day of the inspection. The pharmacy also employed another trainee medicine counter assistant, two dispensers and a delivery driver. A nurse also worked at the pharmacy on occasion to support the team in providing the vaccination services. Team members worked flexibly to support each other in covering both planned and unplanned leave. The pharmacy team considered the impact of workload associated with each service well. For example, it arranged its vaccination services over three working days and its health check services over the remaining two full working days. This helped ensure enough team members were available to complete dispensary workload and run the additional services offered by the pharmacy.

Pharmacy team members received a percentage of their hours as protected time at work to support their learning needs. Trainee team members were appropriately enrolled on GPhC accredited training courses relevant to their role. Pharmacy team members had regular check-ins with the manager and were able to feedback on a one-to-one basis with the SI. Regular team meetings took place and the pharmacy manager emailed the notes of these team meetings to all team members to support shared learning. The meetings focussed on a range of topics including housekeeping, patient safety, and workload management. The pharmacy did not set any specific targets for its team members to meet. It had a whistleblowing policy and its team members were confident in providing feedback and sharing ideas. For example, the pharmacy had set up a dedicated vaccine-reception station following feedback from a team member about crowding at the medicine counter. The reception station worked effectively to support the flow of people through the vaccination services.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy premises are secure and maintained to an appropriate standard. They provide a suitable space for the delivery of healthcare services. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

### Inspector's evidence

The pharmacy was secure and maintained to an appropriate standard. Floor spaces were free of clutter and working areas were clean and generally organised. There were some areas, near ceiling level, that required attention due to cobwebs forming. Lighting throughout the premises was bright and ventilation was appropriate. Pharmacy team members had access to hand washing facilities, in both the dispensary and consultation rooms. Sinks were equipped with antibacterial hand wash and hand sanitiser was available.

Workflow in the dispensary was efficient with separate working areas to complete labelling, assembly and accuracy checking tasks. And there was space for managing tasks associated with the assembly of medicines in multi-compartment compliance packs. The pharmacy had two small, private consultation rooms accessible from the public area. One room was generally used to provide vaccination services. There was some bright interactive wall-art on the back of the door to this room. This supported vaccinators in engaging with children who visited the pharmacy to receive their vaccination. The second room was used for other consultations and NHS health checks.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's services are fully accessible to people. Pharmacy team members regularly engage people in conversations about their health and their medicines. And they take opportunities through the health check service to support people in identifying positive changes they could make to improve their health and wellbeing. The pharmacy obtains its medicines from reputable sources. And It mostly stores its stock medicines safely and securely.

### Inspector's evidence

The pharmacy was accessible through a simple door, from its onsite carpark. It advertised details of its opening hours and services clearly for people to see. And it engaged people in conversations about their health and wellbeing through its prominent health promotion displays. The team had held a community event in a local hall to offer free blood pressure checks over the summer. And this had been an effective way to talk to people about their health and wellbeing. Pharmacy team members understood the need to signpost people to other pharmacies or healthcare providers should they be unable to provide a service or supply a medicine.

All team members were observed engaging well with members of the public, and taking time to talk to them about their healthcare needs. The pharmacy's COVID-19 vaccination service, flu vaccination service and health check service were popular. Vaccination clinics were organised well with some gaps to help facilitate walk-in appointments. The pharmacy had up-to-date patient group directions and national protocols to support the service. And team members understood which framework they were working under for each clinic. The pharmacy manager had engaged in sharing structured feedback and learning points to the local NHS team about the health check service. This included sharing the individual steps associated with the pathway to support the development and roll out of the service. The service included blood pressure checks, glucose checks, cholesterol checks, and tools to support healthy living and to reduce the risk of chronic disease. A guide to support delivery of the service included interactive activities that encouraged people to think about the impact of their current lifestyle on their health and wellbeing.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them behind the medicine counter. And pharmacists could supervise activity in the public area from the dispensary. The pharmacy had some resources readily available to support the supply of higher risk medicines to people. These included some information associated with the valproate Pregnancy Prevention Programme (PPP). Pharmacy team members could not recall seeing a prescription for a person within the at-risk group. The RP discussed how he would manage a prescription for valproate for a person within this at-risk group. And details of the approach described was in accordance with the requirements of the PPP. Pharmacists generally provided verbal counselling when handing out higher-risk medicines. But details of these types of interventions were not recorded.

The pharmacy kept each person's prescription separate throughout the dispensing process by using baskets. And there was a clear system to manage owed medicines. This included holding part-assembled medicines and prescriptions in baskets on a designated work bench. The pharmacy maintained an audit trail of prescriptions it ordered on people's behalf, and of the medicine deliveries it

made to people's homes. This supported team members in answering any queries that arose. Pharmacy team members generally signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. But they did not routinely sign the 'dispensed by' box when supplying medicines in multi-compartment compliance packs. And the pharmacy did not routinely provide patient information leaflets (PILs) when supplying medicines in compliance packs. A discussion highlighted the requirement to provide a PIL when supplying a medicine. The pharmacy scheduled workload associated with the service well. And it used individual records to record details of people's medication regimens. It updated these records using tracked changes when there was a change to a person's medication. A sample of assembled packs contained descriptions of the medicines inside to help people identify them.

The pharmacy sourced medicines from licensed wholesalers. It generally stored medicines in their original packaging in an orderly manner throughout the dispensary. But it stored a small number of medicines in amber bottles. And it did not record the full details of the medicine, along with the batch number and expiry date on these bottles. This meant it could be difficult for the pharmacy to establish if these medicines remained safe to supply to people. The pharmacy stored its current stock of medicines subject to safe custody arrangements appropriately in a secure cabinet. Storage within the cabinet was organised. But the inspection found out-of-date medicines subject to safe custody arrangements stored inadequately. The pharmacists on duty acted immediately to secure these medicines. But this meant storage space for these stock medicines was limited due to the high number of out-of-date medicines awaiting destruction. There was a need for the pharmacy to arrange an authorised witness visit to support the safe destruction of these medicines. And to order appropriate CD denaturing kits to ensure safe disposal of the medicines could take place. The pharmacy's fridges were clean and a suitable size for the medicines they held. There were some minor gaps in fridge temperature records. But temperatures either side of these gaps remained within the accepted temperature range of two and eight degrees Celsius.

The pharmacy kept evidence of the date checking tasks its team members completed. A random check of dispensary stock found no out-of-date medicines. Liquid medicines were clearly marked with details of their opening dates. The pharmacy had medicine waste bins and a single, small CD denaturing kit available. It received medicine alerts by email through the Central Alerting System and kept an electronic audit trail of these alerts.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It monitors this equipment to ensure it remains safe to use. And pharmacy team members act with care by using the equipment in a way which protects people's confidentiality.

### Inspector's evidence

The pharmacy had up-to-date written reference resources available including the British National Formulary (BNF). Pharmacy team members accessed password-protected computers. And they used NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicines on designated shelving out of direct view of the public area. Personal identifiable information at the vaccination reception desk was appropriately monitored to avoid the risk of unauthorised access.

Pharmacy team members used appropriate counting and measuring equipment when dispensing medicines. The pharmacy had separate equipment available for counting and measuring higher risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. Equipment for the NHS health check service was provided through an NHS procurement team. The pharmacy completed the necessary monitoring and calibration checks of this equipment in line with the service specification. All equipment was readily available for team members to use. For example, anaphylactic supplies were kept to hand in the consultation room during vaccination clinics. Electrical equipment was in working order and cables and plugs were visibly free from wear and tear.

### 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.