

# Registered pharmacy inspection report

**Pharmacy Name:** Cornwell's Chemists, 51-53 Bodmin Avenue,  
Weeping Cross, STAFFORD, Staffordshire, ST17 0EF

**Pharmacy reference:** 1105665

**Type of pharmacy:** Community

**Date of inspection:** 09/12/2024

## Pharmacy context

This busy community pharmacy is located alongside shops and local services in the Weeping Cross area of Stafford. The pharmacy dispenses NHS prescriptions, and it provides NHS funded services such as the Pharmacy First service, blood pressure testing and seasonal vaccinations. The pharmacy team dispenses some medicines into multi-compartment compliance packs for people to help make sure they remember to take them. Private services are also available, and these include travel vaccinations and ear wax removal.

## Overall inspection outcome

✓ **Standards met**

**Required Action:** None

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## 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 manages the risks associated with its services to make sure people receive appropriate care. Members of the pharmacy team follow written procedures to make sure they work safely. They record their mistakes so that they can learn from them, and they make changes to reduce the risk of the same sort of mistakes from happening again. The pharmacy team keeps people's information safe and team members understand their role in supporting vulnerable people.

### Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. SOPs were reviewed and updated on an ongoing basis. The superintendent's team had developed the SOPs to reflect the pharmacy services provided. Some SOPs were held electronically, and some were on paper. Pharmacy team members accessed their personal electronic SOP record which confirmed that they had read them, and signature sheets were used to record training on the paper SOPs. Roles and responsibilities were highlighted within the SOPs.

The dispensing process had been designed using the in-built safety measures and workflow efficiency tool that the PMR system provided. Each member of the team had an individual log-in for the PMR system which provided an audit trail of who had been involved with the dispensing process. Every prescription was clinically checked by a pharmacist before it was released for dispensing. The management information was available on the new computer system which showed the percentage of products scanned and the number of incorrect barcodes scanned. These checks showed whether the pharmacy team members were complying with the process and their dispensing accuracy.

The team gave examples of how the new computer system had inbuilt patient safety features and, if it is used correctly, should reduce the risk of picking errors due to the barcode of each medicine being scanned to ensure it matched the medicine prescribed. The system also date checked medication during the process and printed the expiry date onto the dispensing label. Dispensing errors were recorded and reported to the superintendent's team. The pharmacy team explained that near misses and errors had reduced due to the new computer system and its patient safety features.

The pharmacy team members had a clear understanding of the complaints process. People could give feedback to the pharmacy team in several different ways; verbal, written and via email. The pharmacy team tried to resolve issues that were within their control and would involve the RP or pharmacy manager if they could not reach a solution and would contact head office for further support.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. Team members were trained to deliver some of the pharmacy's private services, such as ear wax removal, to allow the pharmacist to do other tasks. A dispensing assistant correctly answered hypothetical questions related to high-risk medicine sales and discussed how she managed requests for codeine containing medicines.

The pharmacy had up-to-date professional indemnity insurance. The Responsible Pharmacist (RP) notice was clearly displayed, and the RP log met requirements. Controlled drug (CD) registers were in order. Patient returned CDs were recorded in a register. Private prescription records were seen to comply with requirements. Specials records were maintained with an audit trail from source to supply.

Confidential waste was stored separately from general waste and sent offsite to be destroyed securely. The pharmacy team members had their own NHS Smartcards and they confirmed that passcodes were not shared. The pharmacy team had completed training on safeguarding as part of the NHS Pharmacy Quality Scheme (PQS) and the RP had completed level three safeguarding training. The pharmacy team understood what safeguarding meant and a list of safeguarding contacts was displayed in the dispensary. The dispensing assistants gave examples of types of concerns that they may come across and correctly described what action they would take.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough team members to manage the workload and the services that it provides. The team members plan absences in advance, so the pharmacy has enough cover to provide the services it offers. They work well together, and they know who to speak to if they need to raise concerns or make suggestions.

### Inspector's evidence

The pharmacy team comprised of two regular pharmacists, a pharmacy manager (pharmacy technician), two dispensing assistants, and a trainee dispensing assistants. In addition, two trainee pharmacy technicians based at a hospital pharmacy worked part time at the pharmacy as part of a cross-sector training programme.

Holidays were discussed with other team members and authorised by the pharmacy manager. The pharmacy manager checked the rotas in advance to see if any amendments were required. Pharmacy team members completed ongoing training and training needs were identified to align with new services, seasonal events, and the NHS Pharmacy Quality Scheme (PQS). An eLearning system was used for training.

The pharmacy team worked well together during the inspection and were observed helping each other and moving from their main duties to help with more urgent tasks when required. The pharmacy team had a huddle in the morning and tasks were allocated to members of the team dependent on the workload for the day, including the types of private services that were booked.

The pharmacy staff said that they could raise any concerns or suggestions with any of the pharmacists or the pharmacy manager and felt that they were responsive to feedback. Team members said that they would speak to head office, or GPhC if they ever felt unable to raise an issue internally. The RP was observed making himself available to discuss queries with people when requested, or with people on the telephone. Some targets for professional services were set and the team thought that these were sensible targets and attainable.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean and tidy, and it provides a suitable environment for the delivery of healthcare services. It has a consultation room, so that people can speak to the pharmacy team members in private when needed.

### Inspector's evidence

The pharmacy was smart in appearance and appeared to be well maintained. Any maintenance issues were reported to head office. The dispensary was an adequate size for the services provided; an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate areas of the worktops and on a large central workbench.

The pharmacy had air conditioning and the temperature in the dispensary felt comfortable. Lighting was adequate for the services provided. Prepared medicines were stored securely, and pharmacy medicines were stored behind the medicines counter. There was a private soundproof consultation room and was professional in appearance. The door to the consultation room remained closed when not in use to prevent unauthorised access.

The pharmacy was clean and tidy with no slip or trip hazards evident. It was cleaned by pharmacy staff. The sinks in the dispensary and staff areas had running water, hand towels and hand soap were available.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. It manages its services and supplies medicines safely. The pharmacy obtains its medicines from licensed suppliers, and stores them securely and at the correct temperature, so they are safe to use. People receive advice about their medicines when collecting their prescriptions. The team supplies medicines in multi-compartment compliance packs for those who may have difficulty managing their medicines.

### Inspector's evidence

The pharmacy had step free access from the pavement and a paid for home delivery service was available to people who wanted home deliveries. Health promotion leaflets were available, and posters were displayed around the premises. Pharmacy staff referred people to other local services using local knowledge and the internet to support signposting.

An automated collection point had been installed at the front of the pharmacy that allowed people to collect their prescriptions at a time that was convenient to them. People were sent a text message containing a collection code when the prescriptions was put into the machine. Some medicines had been identified as not being suitable for the collection point. For example, controlled drugs, cold-chain medicines, and prescriptions that required additional counselling.

The team were aware of the risks associated with the use of valproate containing medicines during pregnancy, and the need for additional counselling. Patient cards and counselling materials were available, supplied to people when appropriate and valproate containing medicines were supplied in their original packaging.

The pharmacy offered the NHS Pharmacy First service. The team had undergone training and they had quick reference guides available and the NHS PGDs (patient group directions) and supporting documentation had been printed for reference. The RP used the flow chart supplied by NHS England during his consultations to demonstrate the rationale for the advice that he gave. He explained that this helped manage people's expectations and that they could see the reason why he may not have recommended antibiotics.

Various private pharmacy services were available. Some were carried out by the pharmacist, and some were carried out by appropriately trained pharmacy team members. Consent forms were completed prior to administering vaccinations and records were maintained. The main private services were travel vaccinations and ear wax removal. Patient Group Directions were available for reference and named the RP as being authorised for the service.

The barcode on each of the medicines was scanned during the dispensing stage and the system only printed off a dispensing label if the medication scanned was correct. A clear warning message was displayed on the screen if it was incorrect. NHS prescriptions were downloaded electronically, and this information was used for the dispensing and labelling process which reduced the risk of a member of the pharmacy team entering incorrect information into the system. There were additional processes for

split packs, packs without barcodes and certain medicines that the team had identified as high-risk, such as controlled drugs.

Prescription items were dispensed into baskets to ensure prescriptions were not mixed up together. There was a quick response (QR) code on the dispensing label and the computer system recorded which member of the team had been involved in each stage, so there was a dispensing audit trail for prescriptions.

A random sample of dispensary stock was checked, and all the medicines were found to be in date. Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being stored in their original packaging. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in a designated area. Medicines were obtained from a range of licenced wholesalers. Drug recalls were received electronically.

The controlled drug cabinet was secure and a suitable size for the amount of stock that was held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridges were working within the required temperature range of 2°C and 8°Celsius.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide services safely. The pharmacy team stores and uses the equipment in a way that keeps people's information safe.

### Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF) and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough computer terminals for the workload currently undertaken. A range of clean, crown stamped measures and counting triangles were available.

Equipment for clinical consultations had been procured and was stored appropriately. Some of the equipment was single use, and ample consumables were available. Computer screens were not visible to members of the public. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

### 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.