

Registered pharmacy inspection report

Pharmacy Name: Beacon Pharmacy, Skegness Road, Ingoldmells, SKEGNESS, Lincolnshire, PE25 1JL

Pharmacy reference: 1116173

Type of pharmacy: Community

Date of inspection: 13/07/2022

Pharmacy context

The pharmacy is in the grounds of a medical centre in the coastal town of Ingoldmells, Lincolnshire. It is open extended hours, including late into the evening seven days a week. And it serves both local residents and tourists during the busy holiday season. The pharmacy's main services include dispensing NHS prescriptions and selling over-the counter medicines. It delivers a high proportion of dispensed medicines to people's homes. And it also supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines.

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	N/A	N/A	N/A
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 identify and manage risks associated with providing its services. And it uses feedback to help it to improve. It generally keeps the records it needs to by law. And it protects people's confidential information appropriately. Pharmacy team members act openly and honestly by discussing their mistakes and they act to reduce risk following these discussions. They understand how to safeguard potentially vulnerable people.

Inspector's evidence

The pharmacy had a range of SOPs to support the safe running of the pharmacy. Team members accessed the SOPs electronically. And the pharmacy kept each team members training record associated with the SOPs within their personnel file. The file also included, contracts, job descriptions and records of accredited training. Pharmacy team members were observed working in accordance with dispensing SOPs throughout the inspection. A trainee team member demonstrated their understanding of the tasks that could not be completed if the Responsible Pharmacist (RP) was absent from the premises. And another team member was observed providing factual information to a member of the public when discussing the NHS New Medicine Service.

The pharmacy was last inspected in November 2021. It had used feedback from this inspection to inform a number of improvements. This included increasing the frequency of near miss reporting by regularly encouraging pharmacy team members to report their mistakes. The manager had been well supported by a regular locum pharmacist, who had taken the opportunity to share learning about how to complete structured patient safety reviews. But the pharmacy had not completed a formal patient safety review for a few months. The manager acknowledged the need to get back on track with this to help share learning. In addition to reporting dispensing incidents electronically, the team had also introduced the use of reflective statements. This helped inform actions designed to help reduce the risk of a similar mistake occurring. For example, a mistake involving a high-risk medicine had prompted the addition of an extra check during the dispensing process. The pharmacy had a range of safety information and posters to support team members in dispensing with care. For example, information relating to 'look-alike and sound-alike' (LASA) medicines to alert team members about the importance of checking their selection when picking medicines from the dispensary shelves.

The pharmacy advertised its complaints procedure and its privacy notice to people. And team members understood how to manage feedback and escalate the feedback they received when required. A team member explained that recent feedback relating to closures had been escalated to the pharmacy's directors. Following this escalation, additional measures had been taken to secure an evening pharmacist. The pharmacy had information governance procedures to support its team members in managing people's confidential information securely. And team members on duty were observed managing people's information with care. The pharmacy stored most personal identifiable information in staff-only areas of the premises. Some information was stored in the consultation room, but this was not in the direct view of members of the public using the room. And the room could only be accessed from beyond the medicine counter. The pharmacy had a secure system for destroying confidential waste.

The pharmacy had up-to-date indemnity insurance arrangements in place. The RP notice displayed the correct details of the RP on duty. The RP record was generally maintained in accordance with requirements. But the sign-out time of the RP was omitted on several occasions in the three month sample examined. The pharmacy generally kept its private prescription register in accordance with legal requirements. The pharmacy kept records relating to the supply of unlicensed medicines. But some records did not contain an audit trail to include the details of the person the medicine had been supplied to. This meant the pharmacy may not always be able to show exactly what it had supplied in the event of a query. The pharmacy maintained its CD register with running balances. It generally completed balance checks monthly, but as the tourist season began checks had become less frequent. This meant it could be more difficult for the pharmacy to investigate a concern if one arose. Physical balances checked during the inspection complied with the balances recorded in the CD register. The pharmacy had a patient returned CD destruction register. And this was kept up to date.

The pharmacy had procedures relating to safeguarding vulnerable adults and children. And contact information for local safeguarding agencies was available. The RP on duty had completed level three safeguarding training. And most other team members had completed learning on the subject. A trainee team member was yet to complete learning. But this team member demonstrated a sound awareness of how to recognise and report concerns. A delivery driver provided an example of a concern that they had reported to the surgery team.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough, suitably skilled team members to manage its workload. And it has processes which appropriately support their learning needs. Pharmacy team members work well together and take care to support each other in their day-to-day work. And they understand how to provide feedback about the pharmacy and can raise a professional concern if needed.

Inspector's evidence

The pharmacy team on duty consisted of the RP (a regular locum), the pharmacy manager, who was a pharmacy technician and worked as an accuracy checker (ACT), two qualified dispensers, a trainee dispenser and two delivery drivers. The team reported it was short-staffed. This was due to a trainee dispenser being on planned leave, one trainee dispenser on unplanned leave and a pharmacy technician having very recently left the business. Another dispensary team member was on long-term planned leave. The manager had liaised with another pharmacy within the group. And the other pharmacy had agreed to send a team member over to support the team in managing its workload in the afternoon. The pharmacy did not have a permanent pharmacist. But it had regular locums working across the working week. And the pharmacy's directors also provided some cover. The pharmacy had needed to close on occasion due to lack of pharmacist availability. The manager explained the process the team followed to ensure the closures were reported to NHS England.

A delivery driver was conducting administration tasks and date checking tasks in the dispensary. They confirmed date checking was not part of their normal role and they had not completed any accredited training. This meant they were likely to be working outside their competence which could increase the risk of things going wrong. The rest of the team were all appropriately trained for their roles, or enrolled on accredited training courses. All team members engaged in some ongoing learning at work. For example, learning related to the NHS Pharmacy Quality Scheme. The pharmacy team was in the process of preparing for the annual staff appraisal. Team members understood how to raise concerns at work. And explained they could escalate concerns to one of the pharmacy's directors if needed.

The pharmacy team was encouraged to promote access to services, and to support the pharmacy in maintaining its dispensing volume. The RP discussed feeling able to apply their professional judgement when providing services. Team members expressed feeling supported in their roles. They were confident in asking questions and in seeking out information to support each other. Conversations relating to workload management and patient safety took place regularly. The team had documented some of these discussions for a period of time following the last inspection. But in recent months they had struggled to do this due to workload increasing.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are safe and secure. They provide a suitable space for the delivery of pharmacy services. But clutter within the consultation room may prevent some members of the public from accessing the room with ease.

Inspector's evidence

The public area of the pharmacy was small. It provided seating for people waiting for their prescriptions or for a service. And it stocked some health-related products. A gate at the medicine counter deterred unauthorised access through to the dispensary. The pharmacy's consultation room was beyond this gate. As such every person using the room was escorted. The room was a decent size but it was cluttered with large boxes containing stock medicines. This distracted from the overall professional appearance of the pharmacy. The team identified that it had cleared a suitable area in the room, away from public access, to store this stock safely following feedback at the last inspection. But team members reported that a senior manager had arranged for some stock and equipment relating to a COVID-19 vaccination clinic operated by another pharmacy within the group to be transferred for storage within the consultation room. This was taking up the space needed for the pharmacy to store its own stock sufficiently. And it meant that people using wheelchairs and pushchairs would find it difficult to access the room.

The dispensary was an adequate size for the services provided. There was an established workflow with shelving used to hold baskets off bench level. For example, to hold part-assembled prescriptions waiting for stock. A stock room at the back of the premises provided good space for holding assembled bags of medicines. To the back of the dispensary was another small room. The room provided space for managing tasks associated with the supply of multi-compartment compliance packs. A staff kitchen and toilet facilities were also accessed off the dispensary.

The premises were secure and maintained to an appropriate standard. They were clean with cleaning tasks split between team members and an employed cleaner. Lighting was bright throughout the premises. Heating and air conditioning was in working order. Antibacterial soap and paper towels were available at sinks throughout the pharmacy.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy makes its services accessible to people over extended hours. It obtains its medicines from reputable sources and generally stores them safely and securely. Pharmacy team members effectively manage the dispensing service. And they keep audit trails to help answer any queries that may arise. They provide some information when supplying medicines to help people use them correctly.

Inspector's evidence

The pharmacy was accessible through an automatic door, up a ramp from the car park. 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. These currently focussed on information relating to hypertension and maintaining a healthy body mass index (BMI). Team members understood how to signpost a person to another pharmacy or healthcare professional when the pharmacy was unable to provide a service or supply a medicine. The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them behind the medicine counter. And the RP was able to supervise activity in the public area from the dispensary.

The pharmacy team used bright stickers on bags of assembled items to prompt referral to the pharmacist. It used these to highlight higher risk medicines. Any checks associated with counselling for these higher risk medicines was verbal. This meant it could be more difficult for the pharmacy to monitor the effectiveness of these interventions. The pharmacy clearly highlighted valproate preparations on the dispensary shelves. And it had resources associated with the valproate pregnancy prevention programme (PPP) to hand. These included patient cards and guides. The RP discussed how he would manage a prescription for valproate for a person within the high-risk group. And details of his approach was in accordance with the requirements of the PPP.

The pharmacy kept each person's prescription separate throughout the dispensing process by using baskets. The team prioritised prescriptions for people waiting in the public area. And there was a clear system to manage owed medicines. This included holding part-assembled medicines and prescriptions in baskets on designated shelving. The shelving highlighted if the medicine required delivering, including the delivery route details to ensure it was loaded onto the correct van. The pharmacy maintained an audit trail of the deliveries it made to people's homes. This supported team members in answering any queries that arose.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The team used the pharmacy's patient medication record (PMR) system to manage tasks associated with the supply of medicines in multi-compartment compliance packs. Team members recorded changes to medicine regimes and queries within people's PMR. One team member was the lead for the service and another team member supported this role. The wider pharmacy team also supported the service. For example, by picking medicines ready for assembly into compliance packs. A sample of assembled packs included full dispensing audit trails, adverse warning labels and descriptions of the medicines inside to help people recognise them. The pharmacy provided patient information leaflets at the beginning of each four-week cycle of packs. The SOP relating to the compliance pack service had been reviewed and amended following the last inspection. It now allowed

for the pre-assembly of compliance packs in some circumstances ahead of the pharmacy receiving the prescription. The pharmacy team followed the SOP to ensure team members took accountability of tasks associated with additional checks of the compliance pack once the prescription was received. And there was a clear process in place to prevent compliance packs being supplied ahead of these checks taking place.

The pharmacy sourced medicines from licensed wholesalers. It stored medicines in their original packaging in an orderly manner throughout the dispensary. The pharmacy stored medicines subject to safe custody arrangements appropriately in a secure cabinet. Storage within the cabinet was organised. The pharmacy's fridges were clean and a suitable size for stock held. The pharmacy had recently introduced separate temperature records for each fridge. This allowed the team to apply additional monitoring checks if the temperature had fluctuated outside of the accepted temperature range of two and eight degrees Celsius. A fridge in the consultation room was part of the equipment left following the cessation of the COVID-19 vaccination service by another pharmacy within the group. It contained out-of-date vaccines that required safe disposal.

The pharmacy had a date checking matrix which it used to monitor the frequency of date checking tasks. These took place around every six months with short-dated medicines highlighted to prompt additional checks during the dispensing process. And team members were observed checking expiry dates when completing dispensing tasks. A random check of dispensary stock found no out-of-date medicines. But team members did not always annotate the date of opening on liquid medicines. This meant it was more difficult for them to identify that a medicine with a shortened shelf-life once opened remained safe and fit to supply. The pharmacy had medicine waste bins and CD denaturing kits available. The pharmacy received medicine alerts by email. And it retained both an electronic and paper audit trail related to checks made in response to these alerts.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. And its 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 and electronic reference resources available. These included the British National Formulary (BNF) and BNF for children. The pharmacy team used crown-stamped measuring cylinders for measuring liquid medicines. And it used separate equipment for measuring higher risk liquid medicines. Counting equipment was available for tablets and capsules. Equipment used to support the multi-compartment compliance pack service was single-use. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. For example, the pharmacy's blood pressure monitor was on the list of monitors validated for use by the British and Irish Hypertension Society.

The pharmacy's computer was password protected. And it was accessible to team members only using NHS smartcards. The pharmacy held bags of assembled medicines on shelves out-of-sight of the public area. This suitably protected people's information. Pharmacy team members used cordless telephone handsets. This allowed them to move out of earshot of the public area when a phone call required privacy.

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.