

Registered pharmacy inspection report

Pharmacy Name: Beccles HCC Ltd, St. Marys Road, BECCLES, Suffolk,
NR34 9NQ

Pharmacy reference: 1117110

Type of pharmacy: Community

Date of inspection: 03/11/2023

Pharmacy context

This community pharmacy is located next to a health centre in the town of Beccles. It provides a range of services including dispensing NHS prescriptions, the New Medicine Service (NMS), supervised consumption of medicines and onsite testing of blood pressure. It also provides medicines in multi-compartment compliance packs to people who have difficulty remembering 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

Overall, the pharmacy manages the risks associated with its services well. And people can provide feedback about its services. The pharmacy has appropriate insurance arrangements in place. And the team know how to protect vulnerable people. The team takes the right steps to protect people's confidentiality. The pharmacy does not always make accurate or complete records so these may be less reliable if they need to be referred to in future.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) that had been issued by the pharmacy's head office and these were available electronically. The responsible pharmacist (RP) who was also the superintendent pharmacist (SI) confirmed that a couple of team members who had started in the pharmacy last week had not yet read the SOPs, but all other team members had. However, team members had not signed to say they had read them. The SI said she would get team members to sign to say they had read the SOPs and get the new team members to read and sign also. The SOPs were due to be updated in Mid-2022, the SI said she would look into getting the SOPs reviewed and updated. However, team members working in the pharmacy knew their role and what they could and could not do in the absence of a pharmacist.

The pharmacy recorded near misses (dispensing mistakes spotted before a medicine had left the pharmacy). These were recorded on paper log sheets regularly and included some detail about the nature of the mistake. Dispensing errors (mistakes which reached a person) were recorded in more detail electronically. The SI said there had not been any dispensing errors for a very long time so did not have any error reports to show. But she stated that if an error occurred, a full investigation would be done, an error report written, and a meeting would take place with the team to discuss the error.

The pharmacy had a complaints procedure. People could submit a complaint or feedback about the pharmacy via email, in person or on the phone. And complaints would be investigated by the SI. The SI confirmed she had completed level 2 safeguarding training with the Centre for Pharmacy Postgraduate Education (CPPE) and other team members had completed level 1 safeguarding training. The team knew what to do if a vulnerable person presented in the pharmacy and had contact details of local safeguarding leads. Confidential waste was disposed of in a separate designated bin before being shredded on site. No confidential waste was found in the general waste bin.

The pharmacy had current indemnity insurance. Balance checks were carried out regularly for controlled drugs (CDs), and the CD register included all details required by law. A balance check of a CD showed that the amount in stock matched the recorded stock in the register. The pharmacy kept records about unlicensed medicines supplied to people. Some records seen were missing the details of the person whom the medicine was for. The team said that these details would be included on all records going forward. The private prescription register was not complete with about half of the entries not having the prescriber's name or address. Of the records seen that did have the prescriber's name and address, this did not always match the details on the prescription. The SI said that prescriber details would be more accurately checked when adding to the private prescription register, and going forward all entries would have prescriber details added. Records about emergency supplies were complete with entries seen listing the nature of the emergency. The RP record was generally complete with a couple of

entries missing a finish time. However, the RP notice on display at the start of the inspection did not show details about the correct RP. The SI was asked to correct this.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to manage its workload safely. And team members do the right training for their roles. Team members do some ongoing training to keep their knowledge and skills up to date. And they feel comfortable about raising any concerns.

Inspector's evidence

On the day of the inspection there was the SI, an accuracy checking technician (ACT), two dispensers and a counter assistant. Other team members included a part-time dispenser, a counter assistant and a pharmacist. The SI confirmed that the pharmacy had enough team members to manage the workload and that the team was up to date with dispensing. The team was observed working well together during the inspection. And team members were observed asking the appropriate questions when supplying Pharmacy-only (P) medicines. Two team members who had started at the pharmacy recently had not yet been enrolled on an accredited course yet but were due to in the next couple of weeks. All other team members had completed an accredited training course. The SI confirmed the team would receive some ongoing training in the pharmacy, for example when a new medicine or service was launched. The SI confirmed team members had regular reviews to monitor and discuss their progress.

Team members had no concerns about raising any issues and would usually go to the SI first who could escalate to head office if necessary. The SI confirmed the team was set some targets such as 80 NMS reviews and 40 blood pressure checks a month. The SI said that these targets could sometimes be difficult to achieve, but they would not let the targets affect the pharmacy's ability to provide a safe and effective service. And targets could be put on hold if necessary to ensure a safe and efficient service was being provided.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are safe and suitable for the provision of pharmacy 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 modern and professional looking. The shop floor area of the pharmacy was clean and tidy. And it had chairs for people who wished to wait for their prescriptions. P medicines were stored behind the counter. The dispensary area was clean and bright and had plenty of space for team members to work in. It also had a sink for preparing liquid medicines which was clean. The temperature and lighting in the pharmacy were adequate. And there was a staff toilet with access to hot and cold running water and handwash. The pharmacy also had a consultation room for people who wished to have a conversation in private. It was clean and tidy and allowed for a conversation at normal volume to be had without being heard from the outside. The pharmacy was kept secure from unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

On the whole, the pharmacy provides its services safely. And it stores its medicines safely. The pharmacy takes the right action in response to safety alerts ensuring people get medicines which are fit for purpose. And people with different needs can access its services.

Inspector's evidence

The pharmacy had step-free access via an automatic door. 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. The pharmacy provided the driver with a paper log sheet with people's delivery details. The driver would tick the sheet to indicate which people he had successfully delivered to. This sheet was then be returned to the pharmacy and stored. 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. If, after a couple of days, the pharmacy did not hear from a person to arrange a redelivery, they would contact the person directly.

The pharmacy used stickers to highlight prescriptions that contained a CD or an item requiring refrigeration. CD items were always rechecked by a pharmacist or ACT before being handed out to reduce the risk of any expired prescriptions being handed out. The SI confirmed that people taking high-risk medicines such as warfarin or lithium were counselled on their medicines when they were newly started, but not usually after this. So, people could be missing out on important information about their medicines.

Prepared multi-compartment compliance packs seen did not carry the required safety information about the medicines in the packs. The SI said she would make sure this was included on all packs going forward. However, the packs contained the required dosage information and a description of the medicines including the shape, colour and any marking to help people identify their medicines. The SI also confirmed that patient information leaflets (PILs) were supplied monthly with all packs. Team members also stated that they would contact the surgery regarding any queries they had with prescriptions such as unexpected changes to people's treatment.

The pharmacy obtained medicines from licensed wholesalers and invoices were seen confirming this. CDs requiring safe custody were stored securely. Medicines requiring refrigeration were stored appropriately. The pharmacy had three fridges for storing medicines. Two of the fridges were in the dispensary and records seen for these showed temperatures were kept in the required range. The pharmacy had a third fridge in the consultation room which stored vaccines. The thermometer used for this fridge showed a maximum temperature of 22.2°C, which was well above the maximum desirable temperature of 8°C. The minimum and current temperatures of the fridge however were in range as were the records kept for maximum and minimum temperature checks. The SI did not know how to

reset the thermometer and switching to an alternative thermometer was discussed with the SI. Expiry date checks were carried every two months on a rota basis. A random check of medicines on the shelves found no expired medicines. Safety alerts and recalls were received by email, which were actioned as appropriate but were not stored or archived anywhere. This could make it harder for the team to locate an alert or demonstrate what they did to action an alert. Archiving of actioned safety alerts was discussed with the SI.

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 a prescription at the pharmacy. Team members were shown where to apply a dispensing label to a box of sodium valproate so as not to cover any important safety information. The pharmacy had an anaphylaxis kit for anyone who had an allergic reaction to a vaccine. The kit was in date and readily available.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

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

Inspector's evidence

The pharmacy computers had access to the internet allowing team members to access any online resources they needed. The pharmacy had cordless phones so conversations could be had in private. Computers were password protected and faced away from public view to protect people's privacy. However, team members were observed not always using their own NHS smartcards, and some of the smartcards had the password written on them. This could make it easier for people to gain unauthorised access. The SI removed the passwords from the cards during the inspection. The SI confirmed that electrical equipment had been safety tested last year and was due to be tested again soon. She said she would arrange for this to be done. The pharmacy had a blood pressure machine in the consultation room which was relatively new and did not require recalibration or replacement. The pharmacy had the appropriate calibrated glass measures for measuring liquid medicines. It also had tablet triangles for counting medicines including a separate one for counting cytotoxic medicines such as methotrexate.

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.