General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Thurston Pharmacy, Unit 2, Thurston Granary, Station Hill, Thurston, Bury St. Edmunds, Suffolk, IP31 3QU

Pharmacy reference: 9011070

Type of pharmacy: Community

Date of inspection: 28/09/2022

Pharmacy context

The pharmacy is situated alongside other retail businesses in the village of Thurston 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.

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	3.2	Good practice	The pharmacy's private consultation rooms are clearly advertised. And they are designed with care taken to ensure they are accessible to all.
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 generally identifies and manages the risks associated with its services appropriately. And it keeps people's private information secure. Pharmacy team members understand how to respond to feedback about the pharmacy's services. And they know how to recognise and act on safeguarding concerns. They engage in some learning following the mistakes they make during the dispensing process. But they do not always record these mistakes to help inform regular safety reviews. This means there may be some missed opportunities to share learning and to inform actions designed to improve patient safety.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) designed to support its safe and effective running. But core SOPs relating to the responsible pharmacist (RP) role, controlled drugs (CDs) and pharmacy services were overdue for review. This increased the risk of information within the SOPs being out of date. Most pharmacy team members had signed the SOPs. One trainee team member who hadn't signed the SOPs demonstrated a sound knowledge of their own role. And they clearly explained what tasks couldn't take place if the RP was absent from the premises. The RP on duty, a locum pharmacist, had access to the SOPs but had not been asked to read them.

The pharmacy had tools to support its team members in recording near misses and dispensing incidents. But near miss reporting was inconsistent, and there was some reliance on verbal feedback following mistakes made during the dispensing process. Pharmacy team members identified some of the actions they had taken to help reduce risk following feedback from near misses. For example, they took extra care when dispensing medicines which looked alike or had similar names. And warning signs around the dispensary clearly identified these medicines to support team members in taking extra care when dispensing them. There was evidence of learning from dispensing incidents. For example, by highlighting previous incidents on people's medication records to support additional checks during the dispensing process. And the RP explained how she would manage, investigate, and report a dispensing incident.

The pharmacy had a complaints procedure, but this was not clearly advertised to members of the public. Team members understood how to manage feedback and escalate the feedback they received to either the regular pharmacist, pharmacy manager or superintendent pharmacist. The pharmacy had recently experienced a rise in feedback relating to stock issues in the supply chain. And team members were observed managing this type of feedback by offering to contact other local pharmacies to enquire if they had stock available to fill the prescription. 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 a consultation room whilst it was being processed. But this was not in the direct view of members of the public using the room. And the door to the room remained closed with access closely monitored. 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 a accordance with requirements. But the record made for 1 September 2022 was not clear, and there was an omission in the record on 2 September 2022. The pharmacy kept its private prescription register in accordance with legal requirements. It kept records relating to the supply of unlicensed medicines in accordance with the requirements of the Medicines and Healthcare products Regulatory Agency. The pharmacy maintained its CD register with running balances. It generally completed balance checks monthly or every other month. Physical balances checked during the inspection complied with the balances recorded in the CD register. Entries within the register largely complied with legal requirements. But the pharmacy did not always record the address of the wholesaler in the register when entering the receipt of a CD. The pharmacy had a patient returned CD destruction record. But one CD marked as a patient return within the cabinet had not been recorded within the record. The RP acted immediately to record the return in the record.

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 two safeguarding. And other team members had also completed learning on the subject. The pharmacy displayed details of support services for people suffering from domestic abuse. And a team member identified how they would act to safeguard a member of the public who attended the pharmacy and asked for ‘ANI’, an initiative to help provide a safe space for people experiencing domestic abuse.

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. They understand how to provide feedback about the pharmacy and can raise a professional concern if needed.

Inspector's evidence

The RP was supported by two trainee dispensers and a qualified dispenser during the inspection. The pharmacy also employed a regular pharmacist and a delivery driver. The pharmacy manager was a member of the senior management team and visited the pharmacy regularly. And the superintendent pharmacist also worked at the pharmacy occasionally. The pharmacy had a business continuity plan. And its team members identified how they would scale back vaccination clinics and rebook people if the team was short-staffed. They explained how this allowed remaining staff to concentrate on delivering essential NHS services. The team reported that on occasion during the pandemic, two pharmacists had worked to support the delivery of pharmacy services when staffing levels had been low. Workload in the dispensary was up to date and team members were observed working together well.

The two trainee dispensers were apprentices. They received protected training time to support their learning and had regular check-ins with their course tutor. The dispenser described feeling supported in completing accredited learning associated with their role. They had gone on to complete a range of learning associated with healthy living, and more recently vaccination training. A training certificate displayed in the consultation room provided people accessing the vaccination service with assurance that the team member had completed specific training to provide the service. The pharmacy had a whistle blowing policy in place and team members on duty discussed feeling able to feedback any concerns at work. The RP was not set any specific targets relating to the pharmacy's services. And they confirmed they felt able to feedback concerns to the pharmacy manager or superintendent pharmacist.

Pharmacy team members communicated well with each other. They used a secure messaging application to keep in touch between shifts. Day-to-day informal conversations about workload and services took place. The team reported that the pharmacy manager often held a 'team huddle' when they attended. The huddle helped to share information and outline key actions. These action points were recorded as lists to help prompt team members in completing them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and maintained to an appropriate standard. It offers a modern and professional environment for delivering its services. The pharmacy's private consultation spaces are well-equipped. And its team members promote access to Its range of private consultation spaces taking into account specific needs of the people using them.

Inspector's evidence

The premises were modern and secure. Creative wall displays throughout the pharmacy offered a welcoming and professional environment for providing healthcare services. Lighting was bright and ventilation was adequate, with the front door left open to increase the amount of fresh air coming into the premises during busy periods. The pharmacy was generally clean and organised. There was a small amount of limescale build-up around the dispensary sink, and some cardboard waste near to the staff kitchen area awaiting disposal. Pharmacy team members had access to staff facilities, including sinks equipped with antibacterial hand wash, paper towels and hand sanitiser.

The public area of the pharmacy was fitted with wide-spaced aisles leading to the medicine counter. The pharmacy had two large consultation rooms, accessible to the side of the public area. The rooms were well advertised with clear signs displayed. Both rooms were well equipped to provide consultation services. One of the rooms was in use throughout the inspection to support the vaccination services. And the other remained accessible to people requiring a quiet word with a team member. The pharmacy had considered the environment required to help children feel at ease during a consultation. And it had bright wall art and wipe-clean toys available in one of the consultation rooms. A wipe-clean children's book in the room also provided information about vaccinations. The dispensary was an appropriate size to support safe management of the pharmacy's dispensing workload. Work benches in the dispensary remained free from clutter and team members used the space well.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people. It obtains its medicines from licensed sources. And it generally stores these medicines safely and securely. Its team members use audit trails effectively to help manage and answer queries relating to its dispensing services. But pharmacy team members occasionally stray from the requirements of the procedures and protocols in place to support the safe and consistent delivery of clinical pharmacy services. This has the potential to increase the chance of something going wrong when delivering these types of services.

Inspector's evidence

People accessed the pharmacy through a simple door at street level, parking was available close by. The pharmacy advertised its services clearly, including the walk-in COVID-19 and flu vaccination service. A sign on the pharmacy door informed people of its opening times. Colourful displays promoted access to a range of local health and social care services. Pharmacy team members understood how to signpost people to another pharmacy or healthcare provider should they not be able to provide a service.

The pharmacy had up-to-date and legally valid frameworks available to support its team members delivering the COVID-19 and flu vaccination service. These services had received positive feedback from people accessing them. The pharmacy's main vaccinator was a dispenser. Team members reported that up until the previous week, the vaccination services had always been delivered under the supervision of a regular pharmacist. And risk assessments and training records confirmed they had been delivered in keeping with the national protocols. But the RP on duty was a locum pharmacist. They had not been made aware that they were taking overall responsibility for the vaccination services when working. And they had not completed specific learning relating to the national protocols in use. The RP was completing the clinical screening of people attending for the service and the preparation of vaccinations was completed under RP supervision as required. But the vaccinator liaised with an offsite pharmacist if additional support was required during the session. This was not in keeping with the specific requirements of the national protocol model which provided further information about the characteristics of staff completing each stage of the vaccination service. For example, the onsite clinical supervisor was expected to be competent in the handling of the vaccine product and use of the correct technique for drawing up the correct dose. A conversation highlighted the need for the pharmacy to review its procedures and risk assessments, ensuring it always delivered its vaccination services in keeping with the specific requirements of the national protocols.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. Pharmacy team members recognised the risks associated with the abuse, misuse, and overuse of some higher-risk over-the-counter medicines. And they provided an example of where they had sought information from a person's own GP to support pharmacists in considering whether a supply of a P medicine was appropriate. Pharmacy team members identified some higher-risk medicines during the dispensing process. For example, they used stickers to highlight medicines requiring storage in a refrigerator. And team members explained that the regular pharmacist provided some verbal counselling when handing out higher-risk medicines requiring ongoing monitoring checks. But there was no evidence that the pharmacy recorded these types of interventions. The pharmacy had a range of patient safety tools to support the safe supply of valproate to people in the high-risk group.

And pharmacy team members had completed some learning associated with the valproate pregnancy prevention programme (PPP) prompted by a clinical audit. The RP discussed the specific requirements of the valproate PPP with confidence.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels when dispensing medicines. And they used baskets throughout the dispensing process to help keep medicines with the correct prescription. The pharmacy used a workload planner and individual records to support the supply of medicines in compliance packs to people. The record sheets contained information about a person's medicine regimen. But changes to medicine regimens were not always recorded clearly with details explaining why the change had been applied. The pharmacy had no assembled compliance packs available for inspection. But a team member confidently demonstrated and explained how the service was managed. The team member described completing dispensing audit trails and providing descriptions of the medicines on labels attached to the compliance packs. But they explained that the pharmacy did not routinely supply patient information leaflets (PILs) alongside compliance packs. This meant that people may not have all the information required to support them in taking their medicine safely.

The pharmacy sourced medicines from licensed wholesalers. It generally stored these medicines in an orderly manner, on shelves throughout the dispensary. But it did not always store medicines within their original packaging. For example, some amber bottles and white boxes containing stock medicines did not include the full details of the batch number and expiry date of the medicine inside. The pharmacy stored CDs appropriately within secure cabinets. Both the pharmacy's stock fridge and its vaccine fridge were clean and a suitable size for the amount of medicines held inside. The pharmacy maintained fridge temperature records to support it in ensuring its cold-chain medicines were stored within the correct temperature range of two and eight degrees Celsius.

The pharmacy team reported completing regular date checking tasks. There was no record to support the completion of these tasks. But a check of the dispensary shelves found no out-of-date medicines, and short-dated medicines were clearly identifiable. The pharmacy had appropriate medicinal waste bins and CD denaturing kits available. The team received medicine alerts by email. And could demonstrate how it checked and responded to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to the equipment they require to provide the pharmacy's services safely. And they manage and use this equipment appropriately.

Inspector's evidence

Pharmacy team members had access to the internet and a range of paper and electronic reference resources. They accessed password protected computers and some team members had NHS smartcards to access people's medication records. Two team members reported being in the process of applying for their NHS smartcards. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicines on designated shelving within the dispensary. This meant details on bag labels and prescription forms could not be read from the public area.

Pharmacy team members generally used appropriate counting and measuring equipment when dispensing medicines. But two plastic measures were available alongside British standard measures for the purpose of measuring liquid medicines. Pharmacy team members were not sure why these were in place and explained they did not use them and would dispose of them. 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 in the consultation room was readily available to support team members in delivering the pharmacy's service. This included a trolley with access to consumables used when providing vaccination services, including anaphylactic supplies.

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.