

Registered pharmacy inspection report

Pharmacy Name: Sunningdale Pharmacy, 43 Chobham Road, Ascot, Berkshire, SL5 0DS

Pharmacy reference: 9011895

Type of pharmacy: Community

Date of inspection: 17/01/2023

Pharmacy context

This pharmacy is located alongside other shops and local businesses in the village of Sunningdale. It sells over-the-counter medicines, and it dispenses NHS and private prescriptions. The pharmacy team provides healthcare advice, and the pharmacy offers other NHS services including flu vaccinations, the Hypertension Case Finding Service and the Community Pharmacy Consultation Service (CPCS). It also supplies some medicines in multi-compartment compliance packs to people living in their own homes, and it offers a home 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 | 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 generally manages the risks associated with its services. It keeps the records it needs to by law, and it has appropriate insurance for the services it provides. The pharmacy has written procedures, so the team works safely. But the pharmacy cannot show that all team members receive training on the SOPs, so they might not always know what to do or how to complete tasks. Team members discuss any errors so they can learn from them. They keep people's information safe, and they have a basic understanding of their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had some systems and processes to help identify, manage and reduce its risks. It had standard operating procedures (SOPs) explaining how to complete operational tasks. The team members could view the SOPs on the company's shared drive. SOPs had been reviewed within the last two years. Some of the pharmacy's team members had signed training logs to show they had read and understood the SOPs. But the trainee dispenser hadn't done this, and she wasn't familiar with the SOPs. The pharmacy team worked under the supervision of the responsible pharmacist (RP). A notice was displayed in the pharmacy naming the RP on duty. Team members wore uniforms so members of the public could easily identify them. They understood their job roles and limitations. A business continuity plan was available on the shared drive and the team knew who to contact if a problem arose.

Pharmacy team members recorded any mistakes involving the supply of prescription medicines including near misses and dispensing errors. The RP usually discussed any learning points with the team. He explained how they had sometimes separated stock on the shelves to prevent picking errors if medicines had similar names or packaging. Dispensing errors were reported to the pharmacy director.

The pharmacy had a complaints procedure. But there was no information available for members of the public explaining how to make a complaint or provide feedback, so people may be less confident raising a formal concern. The RP said he dealt with and resolved most issues as they arose. He was aware of the pharmacy receiving a more serious complaint about the delivery of medicines. The pharmacy director had taken responsibility for managing the matter, and he had discussed the issues arising from the complaint with the team to make sure the same thing didn't happen again.

The pharmacy displayed a copy of the company's professional indemnity insurance certificate. It used a recognised patient medication record (PMR) system to record prescription supplies. RP logs and controlled drug (CD) registers were in order. CD balance checks were completed regularly. A random CD balance checked was found to be accurate. Patient returned CDs were recorded in a separate register and segregated in the CD cabinet. Records of private prescriptions were maintained on the PMR. The entries usually included the required information, but the prescriber's details were sometimes incomplete or inaccurate, which could make it harder to explain what has happened in the event of a query. The pharmacy kept records of the receipt and supplies of unlicensed medicines ('specials').

All team members understood the principles of data protection and information governance. Confidential material was stored and disposed of securely. No confidential information was visible from

the customer areas. Team members usually used their own NHS smart cards, but the trainee dispenser did not have her own card which limited the activities she could undertake. The pharmacy did not display a privacy notice explaining how it handled people's data, so people did not have easy access to this information.

The RP had completed level 2 safeguarding training and could access local contacts if they needed to report a concern, The dispenser had completed some safeguarding training in a previous role. It was unclear if other members of the team had access to safeguarding training or guidance, and the team were unsure if there was a specific safeguarding policy or procedure.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to effectively manage the workload, and the team works well together. The team members receive the appropriate training for their roles. But the pharmacy does not have a structured approach to training, so the team members may delay developing the skills and knowledge needed for their roles and miss additional opportunities to learn.

Inspector's evidence

The pharmacy team consisted of the RP, two full-time dispensers, and a part-time delivery driver. The RP was a long-term locum who usually worked four days a week at the pharmacy. Locums or a company relief pharmacist covered his days off. One of the dispensers was qualified and her certificate was displayed in the consultation room. The other dispenser was relatively new to the business. She confirmed she was enrolled on an accredited course, but she hadn't made any progress in completing this and most of her training had been based on hands on experience. The pharmacy did not have formal staff policies including staff training records, dedicated training time or performance reviews. Holidays were planned so only one team member was off at a time. Staff from another nearby pharmacy which was owned by the same company could usually provide cover if needed.

The team members worked well together. They were comfortable discussing issues with each other and were responsive to people's needs. Team members could raise issues with the pharmacist or pharmacy director, who was contactable by telephone. He also visited the pharmacy twice a month to monitor activity, offer support and provide the team with any updates. The pharmacy had a whistleblowing policy. The pharmacy team were incentivised to provide some services, but the pharmacist felt this did not compromise his professional judgement as he would only provide a service within the scope of its specification.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare services. It has consultation facilities so people can speak to a member of the team or receive services in private.

Inspector's evidence

The pharmacy occupied a small retail unit. It had relocated from another premises nearby in August 2022. There was a small retail area and larger dispensary to the rear. Access to the dispensary was restricted by the counter. The dispensary had dedicated areas for labelling, dispensing and checking prescriptions. There was enough bench and storage space for the nature of the services provided. Fittings were modern and suitably maintained. The pharmacy was bright, clean and professional in appearance. Portable heaters were used to heat the premises. And there was a small staff kitchen area and toilet adjacent to the dispensary. The pharmacy had a consultation room which was accessible from the retail area. It was used for services such as flu vaccinations and the hypertension finding services. It was fitted with bench space and two chairs. It was fairly small but adequate in size. It was a little cluttered during the inspection as it was being used to store boxes of sundries.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy manages its services and supplies medicines safely. The team provides people with information and advice to ensure they know how use their medicines correctly. The pharmacy obtains its medicines from reputable suppliers. It stores them securely and makes checks to ensure that they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy was open 9am to 6pm Monday to Friday, and 9am to 5pm Saturday. There was a small step at the entrance and a manual door, but the staff could offer people assistance if needed. Opening times were displayed. The pharmacy offered a home delivery service three days a week, and the RP showed how the team kept a record of deliveries so they could be tracked if there was a query.

Dispensing baskets were used to keep individual prescriptions separate to prevent these being mixed up during the assembly process. Dispensed medicines awaiting collection were bagged and kept in the dispensary. People were usually asked to confirm their name and address or date of birth before prescription medicines were handed out, to make sure the correct prescription had been selected. The pharmacy had a retrieval system and counselling notes were flagged at the point of handout. The pharmacy dispensed a higher-than-average number of private prescriptions. Private prescriptions were sometimes received by fax or email, and copies were printed and kept. But original prescriptions were not always received promptly, and the pharmacy could not clearly show it had a reliable system in place to audit these prescriptions.

The team members were aware of the types of prescription only medicines which would be considered high-risk. The team knew about the risks associated with the use of valproate and isotretinoin during pregnancy. All stock packs of valproate contained suitable warning cards, and the pharmacy team knew that educational materials should be provided if needed to people in the at-risk group.

The pharmacy was not taking on any new compliance pack patients, but the RP was aware that people should be assessed to determine what adjustments would be most suitable to their needs, and that packs were not the only option. Audit trails were in place to help make sure the compliance pack service operated smoothly. People's individual preferences and any changes were documented. Packs were prepared in advance, so they were ready in good time. Packs were clearly labelled and included a description of the medicines it contained so that people could identify them. The manufacturer's packaging leaflets weren't always supplied. The RP explained that people often requested not to receive the leaflets, but this was not evident on their records. And it could mean that some people might not have all the information they need to take their medicines correctly. The pharmacy supported a small number of people receiving treatment for substance misuse. The pharmacist managed this service and reported any concerns about people receiving treatment to the drug and alcohol service.

The pharmacist provided the hypertension case finding service, and the pharmacy offered ambulatory monitoring in addition to the standard blood pressure checks. The team had promoted the services to people within the scope of the service and a few GP referrals had been made as a result. The pharmacy

also participated in a locally commissioned service permitting treatment of UTIs with antibiotics to people living in a specified locality. The service was provided under a patient group direction as were flu vaccinations.

Pharmacy medicines were stored behind the counter so sales could be supervised. The pharmacy team provided frequent healthcare advice and information. The team members were aware of which over the counter medicines were prone to abuse and alerted the pharmacist if people were buying these medicines repeatedly. The pharmacy did not normally sell codeine linctus or Phenergan Elixir because of the potential for misuse.

Stock medicines were obtained from licensed wholesalers and suppliers. Medicines were stored in an organised manner in the dispensary. Expiry date checks were completed periodically but they were not documented. A random check of the shelves found no expired items. A fridge was used to store cold chain medicines. Fridge maximum and minimum temperatures were checked daily and recorded. Recent records showed the temperature was within the required range. CDs were stored in the cabinet. Obsolete CDS were segregated. Other waste medicines were disposed of in dedicated bins, and these were collected periodically by a waste contractor. Drug alerts were received by e-mail and checked by the pharmacist or dispenser. Alerts were usually printed and saved in a folder once they had been reviewed.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the right equipment and facilities to provide its services safely. Equipment is appropriately maintained and used in a way which protects people's privacy.

Inspector's evidence

The pharmacy team had access to the internet and appropriate reference sources. The dispensary sink was clean. The pharmacy had a range of clean glass liquid measures for preparing medicines, with separate ones for measuring methadone to avoid contamination. The pharmacy had equipment for counting loose tablets and capsules as well as disposable containers for dispensing medicines. The pharmacy's blood pressure meter was new. And it had sundries necessary for the provision of vaccination services, including adrenaline injections. Hand sanitiser was available.

The CD cabinet was suitably secured. The pharmacy had two computer terminals in the dispensary, which was sufficient for the volume and nature of the services. Computer screens were not visible to members of the public. Access to computer systems was password protected. Team members could take telephone calls away from the counter so they could not be overheard. All electrical equipment was in working order.

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. |