

Registered pharmacy inspection report

Pharmacy Name: Pyramid Pharmacy, Beaconsfield Medical Centre,
Walkwood Rise, Beaconsfield, HP9 1TX

Pharmacy reference: 9011902

Type of pharmacy: Community

Date of inspection: 15/02/2024

Pharmacy context

This is a community pharmacy next to a medical centre in Beaconsfield, Buckinghamshire. The pharmacy dispenses NHS and private prescriptions. It's team members provide advice and sell over-the-counter medicines. The pharmacy offers local deliveries, seasonal flu vaccinations, the Pharmacy First Scheme, New Medicines Service (NMS), and travel vaccinations.

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 identifies and manages the risks associated with its services in a satisfactory way. Members of the pharmacy team deal with their mistakes responsibly. But it was not possible to verify the necessary recorded details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. Team members understand their role in protecting the welfare of vulnerable people. And the pharmacy largely keeps the records it needs to by law. But the pharmacy team could do more to ensure people's confidential information is appropriately protected.

Inspector's evidence

The pharmacy team had access to a range of documented standard operating procedures (SOPs). They provided guidance for the team to carry out tasks correctly and had been signed by the staff. Team members understood their roles and responsibilities. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display.

The pharmacy had some systems in place to identify and manage risks associated with its services. Incidents were managed by the responsible pharmacist (RP), and their process was suitable. Staff described recording their near miss mistakes, details were discussed, and relevant action taken in response. Look-alike and sound-alike (LASA) medicines had been identified and separated. Examples of this were provided. However, records to verify this could not be located during the inspection.

Team members were trained to protect people's confidential information. Sensitive details could not be seen from the retail space. Confidential material was stored and disposed of appropriately. The pharmacy's computer systems were password protected. However, team members were still using each other's NHS smart cards to access electronic prescriptions. Two people's NHS smart cards had been left within computer terminals and were being used during the inspection. Neither one of these people were on the premises at the time and their passwords were known. This limits the pharmacy's ability to control access to people's private information and was the same as the last inspection.

The pharmacy's team members had been trained to safeguard vulnerable people. They could recognise signs of concern and knew who to refer to in the event of a concern. The RP had undertaken level two safeguarding training through the Centre for Pharmacy Postgraduate Education (CPPE). Details about local safeguarding agencies were on display and easily accessible.

The pharmacy's records were mostly compliant with statutory and best practice requirements. This included records about emergency supplies and controlled drugs (CDs). On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. However, some details within the headers for the CD registers were incomplete. The pharmacy had suitable professional indemnity insurance arrangements in place. Records verifying that the temperature of the fridge had remained within the required range were seen. The RP record often had details missing of when the pharmacist's responsibility had ceased. Within the electronic register for supplies made against private prescriptions, incomplete or missing prescriber details were noted. This was discussed at the time.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has an adequate number of staff to sufficiently manage its workload. The pharmacy provides its services using a team with different levels of experience. But the pharmacy delivers ongoing training in an unstructured way. This could affect how well the team carry out tasks and adapt to change with new situations.

Inspector's evidence

Staff present during the inspection included a locum RP, two dispensing assistants, one of whom was undertaking accredited training for this role and an apprentice who was working on the medicines counter. The pharmacy dispensed a large volume of prescriptions, the team was up to date with the workload and had an adequate number of staff to manage this. They were observed to work well together. Counter staff knew what they could or could not do in the absence of the RP. Relevant questions were asked before selling medicines and the team referred appropriately. Team members had access to some resources for ongoing training, but this was delivered in an unstructured way. Staff in training were provided time at work if needed to complete course material. Their performance was informally monitored, and they had informal meetings to discuss relevant points as and when required. Some formal targets were described, in relation to services provided and the number of items dispensed. Questions were asked when figures were lower than usual. However, there was no undue pressure to complete services and no repercussions if targets were not met.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises generally provide a professional environment to deliver its services from. The pharmacy also has a separate space where confidential conversations or services can take place.

Inspector's evidence

The pharmacy's premises consisted of a medium sized retail space and open plan dispensary with a staff area, WC facilities and a consultation room to one side. The pharmacy was bright, with modern fixtures and fittings and overall, the premises were professional in appearance, but some areas required cleaning. This included the floor, particularly in the retail area and staff WC. There were also a few assembled bags of prescriptions stored on the floor. These risked medicines being damaged. Staff were advised to place them inside appropriate boxes to minimise this. The dispensary had adequate space to carry out dispensing tasks safely. Dispensing benches were kept clear of clutter. The pharmacy had a sign-posted consultation room available for private conversations and services. This was of an adequate size for its purpose.

Principle 4 - Services ✓ Standards met

Summary findings

People can easily access the pharmacy's services. The pharmacy obtains its medicines from reputable sources and manages its medicines adequately. But its team members do not always identify people who receive higher-risk medicines and make the relevant checks. This limits the pharmacy's ability to show that people are provided with appropriate advice when supplying these medicines.

Inspector's evidence

People could enter the pharmacy through an automatic front door and there were several car parking spaces outside. The retail area had wide aisles and clear space which further assisted people with wheelchairs or restricted mobility to access the pharmacy's services. Staff could make reasonable adjustments for people with different requirements. This included using written communication for people who were partially deaf, speaking louder if no-one else was present and clearer for people who were visually impaired. The pharmacy also had a few posters on display to provide information about various health matters. This also included a poster advertising various diagnostic testing services which were said to be available. The latter was placed in the pharmacy premises directly in front of the entrance. On enquiring, staff said that this was offered by the clinic next door. However, this was misleading advertising as it was unclear that it was not offered by the pharmacy. Staff were advised to move this to the clinic side which was present on the right-hand side of the pharmacy.

The pharmacy provided various services, most of which were provided by the regular pharmacist who was not present at the time of the inspection. This included the recently commissioned Advanced NHS service – Pharmacy First scheme. The service specification and patient group directions (PGDs) to authorise this were readily accessible and had been signed by the regular pharmacist. Staff had also been trained and flow charts as well as checklists were on display in the dispensary to help aid the team with their knowledge on the processes involved. However, staff said that a few people had received medication under this scheme but there was no suitable equipment present to help ensure that the service was provided safely and effectively (see Principle 5).

The pharmacy provided a blood pressure (BP) service which appropriately trained support staff provided. Staff explained that people with undetected high blood pressure had been seen who were referred to the GP surgery and resulted in them receiving prescribed medication. The pharmacy also provided a local delivery service and the team kept suitable records to verify this. Failed deliveries were brought back to the pharmacy and people were contacted to inform them about the attempt made. Medicines were not left unattended.

Staff were aware of the risks associated with valproates; they had identified people at risk and ensured the warning label was visible when this medicine was dispensed. However, people prescribed other higher-risk medicines were not routinely identified, asked relevant questions or details about their treatment recorded.

The workflow involved prescriptions being prepared by staff before being accuracy-checked by the RP. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. The baskets were colour-coded to highlight priority and different types of prescriptions. After the staff had generated the dispensing labels, there was a

facility on them which helped identify who had been involved in the dispensing process. Team members routinely used these as an audit trail.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Medicines were generally stored in an organised way. The team date-checked medicines for expiry regularly and described keeping records of when this had happened. However, the records could not be located during the inspection. Short-dated medicines were identified and there were no date-expired medicines seen. CDs were stored under safe custody. Dispensed CDs and medicines requiring refrigeration were stored within clear bags. This helped to easily identify the contents upon hand-out. Staff explained that medicines returned for disposal, were accepted, and stored within designated containers usually but there were no containers present during the inspection. This did not include sharps or needles which were re-directed accordingly. Drug alerts were received by email and actioned appropriately. Records were kept verifying this.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the facilities it needs to provide its services safely. Its equipment is generally clean, but some equipment needed to provide the pharmacy's services are missing. This could affect how safely and appropriately these services are provided.

Inspector's evidence

The pharmacy's equipment and facilities were suitable for their intended purpose. This included access to suitable reference sources, clean, standardised conical measures for liquid medicines, legally compliant CD cabinets and an appropriately operating pharmacy fridge. Triangle tablet counters were also available including a separate one marked for cytotoxic use only. This helped avoid any cross-contamination. The pharmacy had hot and cold running water available, but the dispensary sink for reconstituting medicines could have been cleaner. Computer terminals were positioned in a location that prevented unauthorised access. The pharmacy had cordless telephones so that private conversations could take place if required and confidential waste was suitably disposed of. However, there was no relevant equipment for the Pharmacy First scheme seen such as an otoscope and thermometer, for example and only one EpiPen (adrenaline) was present. The latter is required in the event of a severe reaction to a vaccine. Keeping two was advised in case one was used during the provision of services and another was inadvertently required before the next stock order could replace it.

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.