

Registered pharmacy inspection report

Pharmacy Name: Cookham Pharmacy, Lower Road, Cookham Rise,
MAIDENHEAD, Berkshire, SL6 9HF

Pharmacy reference: 1028924

Type of pharmacy: Community

Date of inspection: 21/09/2022

Pharmacy context

This community pharmacy is located close to a GP surgery in Cookham village. It mainly supplies NHS prescriptions, and it sells some over the counter medicines and healthcare products. The pharmacy offers home deliveries, and it supplies some medicines in compliance packs for people who have difficulty managing their medicines at home. It also provides some other NHS services such the New Medicine Service (NMS), the Community Pharmacy Consultation Service (CPCS), the Community Pharmacy Blood Pressure Check Service, as flu and covid 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 generally identifies and manages the risks associated with its services. It has policies and procedures in place to help make sure that its team members work safely, and it keeps the records it needs to by law. Pharmacy team members keep people's private information safe, and they understand their role in protecting and supporting vulnerable people.

Inspector's evidence

The pharmacy was part of a family run independent chain of around 30 pharmacies. It had up to date standard operating procedures (SOPs) which were regularly reviewed and updated by the company's management team. The team could access electronic versions of the SOPs on the company drive. Paper copies were available in the pharmacy although these were not the most up to date versions. Team members confirmed they had read the SOPs, but training records demonstrating this were not accessible. Team members clearly explained and demonstrated how they completed tasks in line with the SOPs. The management team at head office regularly circulated additional information to make sure the team members were kept well informed and knew what to do. For example, the seasonal flu vaccination service was due to start, and the team had received specific work instructions from head office to make sure this service operated safely alongside the covid vaccinations service.

The pharmacy team members explained their individual roles and responsibilities. Team members working on the counter wore uniforms so they could be easily identified. A responsible pharmacist (RP) notice identified the pharmacist in charge. The incorrect notice was initially displayed, however the RP rectified this. An RP log was maintained using the facility in the patient medication record system (PMR). The log contained the required details although the time the RP ceased their duties was sometimes missing, which could cause confusion.

The pharmacy had systems to manage risks in the dispensing process. Dispensed and checked boxes were completed on dispensing labels identifying the team members involved in the supply of prescription medicines. The team routinely recorded near miss incidents. Team members were encouraged to identify and rectify their own errors, so they learnt from them. The pharmacy manager reviewed near miss logs periodically for trends, but this was not always documented. The team discussed any common errors and learning points and made changes if needed, for example separating stock to prevent picking errors. Some team members had completed training on common look-alike-sound-alike medicines. Near miss log were also sent to the management team each month for monitoring. The pharmacist showed an example of an incident report which had been completed following a dispensing error. Incident forms were sent to head office for review in case any further action was needed and so learning could be shared with other pharmacies in the group where relevant. Complaints were handled by the RP in conjunction with the pharmacy manager and head office. A notice was displayed in the retail area explaining how people could raise a concern or provide feedback.

The pharmacy had professional indemnity insurance with a recognised provider. Records were generally in order although some registers could not be located. Controlled drug (CD) registers were in order. The team had completed a balance check the previous month and a random balance check was

accurate. A form was used to record and report any CD discrepancies. The pharmacist explained how patient returned CDs were recorded in a separate register. Records of private prescriptions were recorded on the PMR. The team members explained how they used certificates of conformity to record supplies of unlicensed medicines.

All team members had completed yearly training on information governance. Patient data and confidential waste were handled securely. A customer leaflet available in the retail area explained how the pharmacy's privacy policy and how data was handled. Team members working in the dispensary used their own NHS smart cards.

Pharmacists had completed appropriate safeguarding training and knew how to escalate a concern. The pharmacy had a safeguarding SOP. The pharmacist described a safeguarding concern about a vulnerable person who was having difficulty managing their medicines, and how he had liaised with their GP to make sure they received additional support at home. One of the medicines counter assistants (MCAs) said she would tell the pharmacist if she had any concerns about potentially vulnerable people.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to deliver its services safely. The team members work well together, and they have access to appropriate training. But the pharmacy does not have a structured approach to training which means its team members might delay developing the skills needed for their roles or have gaps in their knowledge.

Inspector's evidence

On the day of the inspection, the RP was supported by a second pharmacist, a trainee pharmacist, and two MCAs. The pharmacy manager and regular dispenser were both absent and the second pharmacist was providing interim cover. The RP was a company relief pharmacist and the second pharmacist worked as a regular locum, so they were both familiar with the pharmacy's systems and processes. The pharmacy team worked well together and effectively managed the busy workload. The team members said they could contact head office and request additional staff cover if needed and felt well supported in their roles.

The trainee pharmacist was supported by the pharmacy manager as their tutor. The company was experienced in providing training and support for trainee pharmacists.

The pharmacy did not have training records for support staff, so it was not clear what training each team members had completed. One of the MCAs explained she was enrolled on a course. The other MCA had not completed any formal training; she had worked at the pharmacy for around five months and was due to leave the following week. The pharmacy employed two Saturday assistants who were responsible for replenishing retail stock, cleaning and filing prescriptions. The team members confirmed that the dispenser and the regular delivery driver had completed some training, but there was no evidence available to support this. The pharmacist explained that head office provided some additional training material to support the team's ongoing development however there were no records of this.

The pharmacists felt the company were focused on patient care and they felt able to use their professional judgement to make decisions. The team communicated openly, and team members felt able to raise issues with the pharmacy manager and could contact head office independently if they preferred. The pharmacy had a whistleblowing policy in place.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides a safe, secure and professional environment for people to receive healthcare services. The pharmacy has a spacious consultation room where people can receive services, such as vaccinations, and have private conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy was in a residential area of the village close to the GP surgery. It had a retail area, counter and dispensary to the rear. A spacious and well-equipped consultation room was accessible from the retail area.

The pharmacy was generally clean, tidy and suitably presented. Lighting was sufficient and the room temperature was controlled. The fixtures and fittings were maintained to an acceptable standard, and the pharmacy was secured overnight.

The dispensary had sufficient bench and storage space with a separate area dedicated to compliance packs. Most areas were well organised, but some areas were cluttered and untidy including the rear stock room. The staff kitchen area was less well maintained.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services that people can easily access. Its working practices promote safe and effective delivery of its services. The pharmacy gets its medicines from reputable suppliers, and it stores them appropriately. The pharmacy team members complete some checks and manage medicines to make sure they are fit for purpose and suitable to supply. But the team does not always manage waste and unwanted medicines safely.

Inspector's evidence

The pharmacy had a single door and a slight slope at the entrance, so access was reasonably unrestricted. The retail area was clear, and the consultation room was large so there was adequate space to accommodate a wheelchair or buggy. The pharmacy promoted some of its services using signs and leaflets in the retail area, and the company website provided information about the pharmacy. The team members were able to signpost people to other services locally that the pharmacy did not offer, for example free emergency hormonal contraceptive services.

Workplan charts identified weekly tasks so the team members could prioritise the workload. The dispensing workflow was organised. The team used baskets during the dispensing process to prioritise the workload and minimise the risk of prescriptions getting mixed up. A pharmacist checked all prescriptions before they were bagged or handed out. Assembled prescriptions were stored in an organised manner and there was a retrieval system. Notes could be added to prescriptions to highlight important information or if counselling was needed. The pharmacists were aware of the risks of taking valproate and the pregnancy prevention programme. Interventions were usually recorded on the PMR. Prescriptions were scanned at the point of hand out as a collection or delivery so there was an audit trail. Home deliveries were offered three days a week. The pharmacist explained the delivery driver kept a paper audit trail of deliveries.

The pharmacy supplied around 50 people with compliance packs. Most compliance packs were assembled at the company's hub pharmacy. The pharmacy had clear procedures relating to this activity, and checklists were used to make sure procedures were followed. Packs were clearly labelled, and the pharmacy usually supplied packaging leaflets on a monthly basis. Most people were referred by the doctor, but the pharmacy sometimes reassessed people to determine if compliance packs were the most suitable option. The team kept records for each compliance pack patient so they could monitor for medication changes and make sure the hub pharmacy was kept informed.

The covid vaccination service was provided on an appointment basis. The pharmacy offered around three vaccination sessions each week and these were planned in advance to make sure the pharmacy had enough staff cover. A second pharmacist managed the dispensing operation whilst the covid vaccination service was being offered. Pharmacists administered all vaccinations under patient group directions.

The pharmacist could intervene and supervise sales of over-the-counter medicines. Pharmacy medicines were stored behind the counter, so people had to ask to purchase these. The MCA was

aware of the risks associated with codeine containing painkillers and referred requests to the pharmacist. The pharmacist said they didn't usually sell codeine linctus or Phenergan Elixir as they knew they could be misused.

The pharmacy had a large stock holding. It sourced stock medicines centrally from the company warehouse or other from wholesalers. were date checked at regular intervals. Dispensary stock was reasonably well organised but excess medicines in the stock room were less well organised, which meant the pharmacy might find it harder to account for and monitor these medicines.

No date-expired medicines were found on the shelves. The pharmacist trainee was unsure of the process for managing returned medicines but showed how obsolete medicines were placed in pharmaceutical waste bins, so they were kept separate from stock. The bins were overflowing, and one bin contained some gabapentin capsules, which should be denatured prior to disposal. The pharmacist removed the capsules and agreed to remind the team about handling waste and returned medicines. The CD cabinet was small but big enough for the amount of stock. Obsolete CDs were segregated in the cabinet.

Medicines requiring cold storage were kept in three fridges. The team monitored the maximum and minimum fridge temperatures daily, and records showed these were in the required range. The pharmacy received MHRA safety alerts and medicine recalls by email and recent alerts had been received.

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 including the latest versions of the British National Formularies (BNF). There was a dispensary sink and the pharmacy had clean glass liquid measures for preparing medicines, and equipment for counting loose tablets and capsules as well as disposable containers for dispensing medicines. The pharmacy had equipment for providing vaccination services such as anaphylaxis kits, needles and syringes and sharps bins. A blood pressure meter was available for the hypertension service and the pharmacist explained how this was used.

The pharmacy had two computer terminals in the dispensary so sufficient for the volume and nature of the services. The team could also access the system from terminals on the counter and in the consultation room. Computer screens could not be viewed by members of the public. Access to computer systems was password protected. All electrical equipment appeared to be 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.