General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Grovelands Pharmacy, 2 Grovelands Road, READING, Berkshire, RG30 2NY

**Pharmacy reference:** 1028977

**Type of pharmacy:** Community

**Date of inspection:** 19/04/2023

## Pharmacy context

This is a community pharmacy in a residential area of Reading. It provides a range of services including dispensing prescriptions. And it has a selection of over-the-counter medicines and other pharmacy related products for sale. It dispenses medicines into multi-compartment compliance packs for people who have difficulty managing their medicines. And it offers a winter flu vaccination service and a blood pressure monitoring service. It also delivers medicines to people who have no other means of getting their medicines from the pharmacy.

## 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 has suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And its team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy adequately identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future. But the pharmacy does not do enough to ensure that its records accurately reflect its transactions. And it does not do enough to ensure that it keeps its records in the way the law requires.

### Inspector's evidence

The pharmacy had a system for recording its mistakes. But the team had not recorded them since the pharmacist manager left a few months earlier. The current responsible pharmacist (RP) was a locum who had worked regularly at the pharmacy for the last eight weeks. The RP described how he highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistakes from happening again. The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs). And in response to a mistake between ramipril capsules and tablets, team members made additional checks during dispensing and checking. And they had also separated the two products by having other medicines in between them. This approach had successfully reduced the occurrence of the same mistake. But while it was clear that the team discussed its mistakes. And it took action in response to them, by not keeping records it had not fully captured what had happened or what it had learned. And while the RP conducted a review at the time from what he remembered had happened before, there was no formal review process. The RP and inspector discussed this and agreed that by keeping records which they could refer to, team members would be better able to identify steps in their procedure which would prevent a repeat of similar mistakes in future. And this would help the team to monitor learning and improvement more effectively.

The pharmacy had put measures in place to keep people safe from the transfer of infections. It had a regular cleaning routine, and it cleaned the pharmacy's work surfaces and contact points regularly. It had hand sanitiser for team members and other people to use. And it had put screens up at its medicines counter. When they first joined the team, new staff attended a week-long induction programme. And during the week they learned about their job roles and the roles of others. They were also given an introduction into the running of a pharmacy and the responsibilities of the pharmacist. And other topics such as confidentiality. The pharmacy had a set of up-to-date standard operating procedures (SOPs) for its team members to follow. And to help them fulfil their roles and responsibilities. The medicines counter assistant (MCA) was a newer member of the team. She had not yet started a recognised MCA training programme. But she had been trained on the procedures to follow when selling pharmacy medicines and general items. And when handing out people's prescriptions. She consulted the pharmacist and her other colleagues regularly when she needed their advice and expertise. And she asked people appropriate questions about their symptoms and any other medicines they were taking. She did this to ensure that the medicines she sold to people were right for them. And when appropriate, to help the pharmacist decide on the best course of action for them. The RP had placed his RP notice on display where people could see it. The notice showed his name and registration number as required by law.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. The Pharmacy also had a complaints procedure to follow. And the team knew how to provide people with details of where they should register a complaint if they needed to. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. The team commented that, at times, people were unhappy that their prescription had not arrived or that their medicines were not ready or available. And some people took their frustration out on team members. But, to help the situation, the team chased prescriptions up when they could. And they also called the surgery to arrange for alternatives when they received a prescription for an item that they could not get. But workload pressures and staff shortages meant that they did not always have time to do this. The trainee MCA was observed handling people's queries well. And her colleagues stepped in unprompted to support her when needed. They asked people to come back later if problems with their prescriptions could not be sorted out at the time. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy generally kept its records in the way it was meant to, including its RP record, its private prescription records. And records of its emergency supplies. It had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. And this was complete and up to date. The pharmacy generally kept its controlled drugs (CD) register properly. And a record of its CD running balances. But team members recognised that its processes for audit required review. It was clear that the team understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They discarded confidential paper waste into separate waste containers as they worked. And they discarded the contents of the containers into confidential waste bags each day. All confidential waste was collected regularly for safe disposal by a licensed waste contractor. And the team kept people's personal information, including their prescription details, out of public view. Team members had completed appropriate safeguarding training. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. And it recalled how it had reported a concern about the welfare of a patient to their GP.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy adequately trains its team members for the tasks they carry out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another to help improve the quality of the pharmacy's services.

### Inspector's evidence

On the day of the inspection the RP worked with two dispensing assistants (DA)s, and the trainee MCA. A delivery driver was also on duty delivering prescriptions. The team kept the daily workload of prescriptions in hand. And it attended promptly to people at the counter. Team members appeared to work closely with one another. And they supported one another, assisting each other when required. The trainee MCA sought the help of more skilled and experienced team members when she needed it. And she dealt with queries promptly. But in recent months, the team had fallen behind with some of its other tasks. And it appeared that time pressures and workload had led to the team not following best practice in some areas such as general medicines management. But the team had worked hard to rectify this with the support of regional managers and the regular locum.

The RP felt he could make day-to-day professional decisions in the interest of patients. Team members described being able to discuss their concerns with the RP. But due to the demands of the day-to-day workload they did not currently have regular meetings or appraisals about their work performance. And so, the pharmacy team may not have enough opportunity to have its concerns raised with senior management or addressed by them.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy’s premises provide a suitable environment for people to receive its services. And they provide enough space for those services. They are tidy and organised. And they are sufficiently clean and secure.

### Inspector's evidence

The pharmacy was clean and adequately maintained. And it had a bright, modern appearance. The team had a regular cleaning routine. And it cleaned the pharmacy’s worksurfaces, floors and touch points regularly. The pharmacy had relatively spacious shop floor. And it had shelving and gondolas for displaying products for sale. The pharmacy had an opening with a short walkway from the shop floor to the dispensary. This created a small medicines counter on one side and a front- facing dispensing area on the other. And it also led to a larger dispensing area to the rear. The medicines counter had full height backwall behind it for displaying over-the-counter medicines. And screens along the countertop helped to prevent the spread of infections. The dispensing area on the other side, also had a full height backwall behind it. And here it had drawers and shelves for storing its more commonly prescribed medicines. In front of the dispensing counter, it had a higher height display unit which prevented people from looking into the dispensary. And seeing people’s prescriptions. The higher height unit continued round a corner where it had a small open hatch area. The open hatch area faced away from the medicines counter and shop floor. And so, it provided a more private area for the pharmacist to hand out prescriptions and counsel people if required. The pharmacy had a consultation room. And a small waiting area. These were located near to dispensary counter and hatch area. And so, together they created a professional consultation area away from the main retail space. The pharmacy’s consultation room was clean, tidy and organised. And as well as having an entrance from the shop floor, it also had an access door from the rear dispensary for the pharmacist.

The rear dispensing area had a sink with hot and cold running water. And it had a run of drawers and shelves for storing medicines and equipment.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. And in general it supplies its medicines with the information that people need to take their medicines properly. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. In general, the pharmacy ensures that all its medicines are stored correctly and safely.

### Inspector's evidence

The pharmacy had information on its windows promoting its services. And it had a doorway which provided step-free entry. Its customer area was free of unnecessary obstacles, making it suitable for people with mobility issues. The pharmacy could also order people's repeat prescriptions if required. And it had a delivery service. The service had expanded during the pandemic. And many people had not returned to previous arrangements where they picked up their medicines themselves or had someone collect them on their behalf. But the pharmacy prioritised the service for people who had no other way of getting their medicines. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. The pharmacy also supplied medicines against private prescriptions, some of which came from private online prescribing services.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. And for people living in care environments. These were dispensed at the company's centralised dispensing 'Hub.' The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. And it updated people's records. Compliance packs were labelled with a description of each medicine, including colour and shape, to help people to identify them. And the labelling directions gave the required advisory information to help people take their medicines properly. The pharmacy supplied patient information leaflets (PILs) with new medicines, but not always with regular repeat medicines. The inspector and the team agreed that it was important to ensure that people had all the information they needed about their medicines. The pharmacist gave people advice on a range of matters. And he would give appropriate advice to anyone taking higher-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP described how he would counsel at-risk people when supplying the medicine to ensure that they were on a pregnancy prevention programme. The pharmacy also knew to supply the appropriate patient cards and information leaflets each time.

The pharmacy offered a hypertension case finding service. And the pharmacist used the pharmacy's patient medication record (PMR) system to identify people who might benefit from the service. These were often people on regular repeat prescriptions. The RP also referred people back to their GP where further medical intervention was required. The RP had referred several people to their GPs following a high blood pressure reading. And several of those had returned to the pharmacy with a prescription for blood pressure lowering tablets. The pharmacy also offered a new medicines service (NMS). Its patient medication record (PMR) system recognised when someone had been prescribed a new medicine. Team members identified this from the PMR. And they notified the pharmacist. The pharmacist then

provided appropriate counselling and offered follow up appointments to answer any queries and offer advice. And to support the person to take their newly prescribed medicine. They did this after gaining the person's consent. And to show that the follow up appointments had been completed. The RP kept records to manage the process.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And in general, the team stored its medicines, appropriately. And stock on the shelves was mostly tidy and organised. But it had a pack of medicine with two distinct brands of the medicine inside it. And the strips did not all have a visible expiry date. And so, the additional strips could be missed if it were part of a medicines recall or a date checking exercise. The inspector discussed this with the team, and they agreed that team members should review their understanding of the correct procedures to follow when putting medicines back into stock after dispensing. The RP and DA agreed that all medicines should be stored in the manufacturer's original packaging where possible. It had recently conducted a thorough check of the expiry dates on all stock items. And it had reintroduced a system of regular date checks. And it kept records to show what had been checked and when.

The team identified and highlighted any short-dated items. And it removed them from stock. It only dispensed them with the patient’s agreement where they could use them before the expiry date. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. The pharmacy responded promptly to drug recalls and safety alerts. The team had not had any stock affected by recent recalls.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's confidential information safe.

### Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. Team members had access to a range of up-to-date reference sources. And they had access to personal protective equipment (PPE), in the form of sanitiser, face masks and gloves. The pharmacy had a sufficient number of computer terminals which it had placed at its workstations in the dispensary and in the consultation room. And computers were password protected. Team members had their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions out of people's view.

## 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. |