General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Newdays Pharmacy Limited, 1 London Road, Twyford, READING, Berkshire, RG10 9EH

Pharmacy reference: 1028983

Type of pharmacy: Community

Date of inspection: 31/10/2022

Pharmacy context

This pharmacy is one of four local pharmacies under the same independent ownership. It is on the main crossroads in the centre of Twyford, near Reading in Berkshire. It dispenses people's prescriptions, sells over-the-counter medicines and offers healthcare advice. It runs a COVID vaccination clinic upstairs, and it also provides flu vaccinations in the autumn and winter months. Other services include deliveries for those who can't visit the pharmacy in person. And it dispenses some medicines in multi-compartment compliance packs to help people manage their medicines more easily.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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	3.1	Good practice	The pharmacy is well fitted out and provides a professional environment for providing its services, particularly the upstairs area currently being used as a COVID vaccination clinic.
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's team members are clear about their roles and responsibilities. And they work to professional standards, identifying and managing risks effectively. The pharmacy has effective plans in place for use in an emergency and has updated those plans appropriately for the pandemic. The team manages and protects confidential information well and tells people how their private information will be used. Team members understand their role in helping to protect the welfare of vulnerable people. The pharmacy keeps adequate records of the mistakes that happen during the dispensing process. The pharmacist manager reviews them with members of the team so that they can learn from them and avoid problems being repeated. But they don't adequately record how they have reflected upon their mistakes and learned from them. The pharmacy has detailed written procedures for its team to follow. But those procedures haven't been reviewed or updated recently enough.

Inspector's evidence

The pharmacy had a file containing written standard operating procedures (SOPs) which members of its team had signed to show that they had read and understood the SOPs, and that they would follow them. The SOPs had been in place for several years and the superintendent pharmacist (SI) acknowledged that they needed to be updated.

A workplace risk assessment had been carried out and all members of the team were wearing face masks to help minimise the risks of spreading airborne viruses. There was a detailed business continuity plan in place to ensure people could still access the pharmacy's services if it had to close for any reason. The plan had been updated at the beginning of the pandemic. The SI explained that he could move people from one pharmacy to another if necessary, so that services could be maintained.

There was a file for staff to record their near misses and errors showing the nature of the incident, who had made it and a space for additional comments to be added. But it was not clear from the form what had been learned from the errors so amending the form accordingly was discussed. The manager discussed errors or near misses with the team member involved at the time, to help make sure they learned from their mistakes. But these discussions weren't documented so the SI had been considering using the reverse of the form for recording regular reviews. The SI had since updated the report form to incorporate space for recording any learnings and on the reverse, space for reflection.

There was a roles and responsibilities section within the SOP folder, listing team members' key tasks. Everyone understood their own responsibilities and knew when to ask for help. The correct notice was on display to show people the name and registration number of the responsible pharmacist (RP) who was on duty. There was also a daily RP record kept on the pharmacy computer system. There were occasional entries where the RP hadn't recorded the time when their responsibilities ended for the day. Staff could describe what they could and couldn't do in the absence of the RP.

Prescription labels were initialled to show who had assembled and checked the prescriptions. There was a complaints procedure in place with a notice on display for people to see. People could provide feedback on the pharmacy's services via a link on its website. Team members confirmed that the superintendent would discuss people's feedback with them to see how they could improve their service. There were certificates of insurance on display in the staff area to show that the pharmacy had

valid professional indemnity and employer's liability insurance in place.

Private prescription records were maintained using the pharmacy's patient medication record (PMR) system. Those records examined were generally complete although some didn't have all the required prescriber details present. Once this had been pointed out, the RP agreed to ensure that the correct prescriber details would be recorded in future. Some emergency supplies were made and recorded appropriately on the PMR system, with a valid reason for the supply. The controlled drugs (CD) register was easily accessible, and those records examined were in generally order. Alterations were highlighted with an asterisk and a brief explanation outlining the nature of the amendment. Although the amendments were dated, there was nothing to indicate who had made the amendment. The entries in the CD register were balanced against the items held in stock at irregular intervals. The RP stated that they tended to check the stock level whenever they booked any items in or out. Upon reflection, she agreed that it would be better to check the balance regularly in accordance with the frequency specified in the SOP. There was a record of CDs returned by people who no longer needed them. The entries were all complete and there were no patient-returned CDs awaiting destruction. The pharmacy didn't currently have any kits for denaturing and disposing of the unwanted CDs, but the registered technician explained that she ordered them as and when they were needed. There was a file containing details of unlicensed medicines, or 'Specials', used by the pharmacy. Those records examined were in order and the certificates of compliance contained the necessary details.

There was an information governance (IG) file containing the pharmacy's IG policy and a privacy notice was on display for people to see. Team members were able to describe how they would protect people's confidential information. There was a container for confidential waste which was shredded at the end of each day.

There was a safeguarding folder containing local safeguarding policies and contact details of the local safeguarding agencies. All registrants had completed the required safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough staff to manage its workload safely. Pharmacy team members are well-trained and have a clear understanding of their roles and responsibilities. They work well together and can make suggestions to improve safety and workflows where appropriate

Inspector's evidence

At the time of the inspection there was one qualified ACT, two medicines counter assistants (MCAs) and the responsible pharmacist on duty. This appeared to be sufficient for the workload and they were working well together. The SI explained that staff from other branches could help if needed to cover staff shortages. They could also call upon him to help if required. There was also a locum pharmacist on duty in the COVID-19 vaccination clinic upstairs.

There was a training folder containing details of the accredited courses that team members were currently undertaking. There were also some certificates showing the courses that had been completed. Staff were seen to be asking appropriate questions when selling medicines and were aware of which medicines may be liable to abuse. They knew when to refer to the pharmacist and which products they couldn’t sell. There was a whistleblowing policy in place and staff knew who they could speak to if they had any concerns. There were no targets from the superintendent and registrants were free to make their own professional decisions in the best interest of people using the pharmacy’s services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a secure and professional environment for people to receive its services. The premises include private rooms which the team use for some of its services and for private conversations. The pharmacy makes effective use of all the space available so that it can provide its extra services.

Inspector's evidence

The premises appeared bright, clean and airy. They were of a modern, professional design with a clear layout so that people could easily find what they wanted. There were signs on the door asking people to wear a face covering, and signs on the floor indicating a one-way flow. There was a short medicines counter and prescription reception in front of the dispensary, both with Perspex screens.

There was enough space to work safely and effectively with a logical workflow along the workbench. Work areas and public areas were well organised, clean and tidy. The dispensary sink was clean and free of limescale. Hot and cold water, soap and drying facilities were present. All worksurfaces were clean.

There was one consulting room just inside the front door, with access from the retail salesfloor. The door was open while the room wasn't in use. It was used for providing services such as the seasonal flu vaccination service. There was a sink with hot and cold running water in the room, along with a desk and seating for two people. There was an open sharps container on the desk, an anaphylaxis kit containing adrenaline ampoules, and a password-protected computer. No confidential information was visible. The RP agreed to keep the door closed when the room wasn't in use.

There were stairs at the rear of the shop floor leading upstairs to a COVID-19 vaccination clinic. There were plenty of seats on the landing where people waited for their appointment. The upstairs consulting room was spacious and had the necessary equipment to provide the vaccination service. The vaccines were stored in a tall glass-fronted medical fridge in the adjacent stock room. The stockroom was also used for assembling multi-compartment compliance aids. There was a large island workbench in the centre of the room and a separate bench along one of the walls. There was also a small staffroom where team members could take a break. The flooring was all clean and the décor was professional and modern. Room temperatures were maintained to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy delivers its services in a safe and effective manner, and people with a range of needs can easily access them. The pharmacy sources, stores and manages its medicines safely, and so makes sure that all the medicines it supplies are fit for purpose. It responds well to drug alerts or product recalls to make sure that people only get medicines or devices which are safe for them to take. It identifies people supplied with high-risk medicines so that they can be given extra information they may need to take their medicines safely. But it's team members don't record the checks they make, which may make it harder to show what had been done if a problem were to arise in the future.

Inspector's evidence

There was a single semi-automatic door into the pharmacy from the main road outside, making it easily accessible for people using wheelchairs or mobility scooters. There were bold notices in the windows advertising the services available.

There were controls in place to minimise errors such as separating those items which looked alike or whose names sounded alike (LASAs). For example, amitriptyline tablets were kept well away from amlodipine tablets. Anticoagulants had been separated from other medicines. Baskets were used to keep all the items for a prescription together while they were being assembled and then awaiting a final check. The baskets were stored tidily to help prevent any mix ups. There was a documented owings process in use when the pharmacy couldn't supply all the medicine(s) on a prescription.

There was a separate tray for those prescriptions awaiting delivery. The delivery driver used a paper drop sheet to record each delivery. The driver marked the sheet to indicate whether a delivery had been made or not. Failed deliveries were redelivered the following day after leaving a note.

Compliance aid assembly was carried out in a dedicated area upstairs away from distractions. Compliance aids were supplied to people on either a once weekly basis or every four-weeks depending upon their needs. Any changes to people's medicines were recorded on the PMR system so that there was an audit trail. They were assembled on a four-week cycle and there was a checklist matrix to show when each stage of each person's compliance aid had been completed. Patient information leaflets (PILs) weren't always supplied unless there was a new item. Upon reflection the RP agreed that PILs should be supplied at least with the first delivery of each cycle. There were descriptions of the medicines included within the compliance aids and an indication of which medicines were supplied separately.

The technician described how she checked that women taking valproates who could become pregnant were aware of the risks and had suitable long-term contraception in place. The RP acknowledged that they didn't currently keep a record of those interventions on the pharmacy's PMR system but would do so in future. They asked whether people taking warfarin had their INR checked but didn't record it. There were fewer people taking warfarin now because many had moved on to safer more modern medicines. Despite this they agreed that they would record the checks they made.

The pharmacy offered the NHS seasonal flu vaccination service using a valid patient group direction (PGD) as the legal mechanism for doing so. There were valid Patient Group Directions PGDs in place for both NHS and private vaccinations. There were adrenaline ampoules in the consultation room for use in an emergency. Several people arrived to have a flu vaccination during the course of the inspection.

The pharmacy provided a substance misuse service to a small number of people. Those records examined appeared to be in order. The RP confirmed that if people failed to turn up for their medicine on three consecutive days, then the prescriber would be contacted in accordance with the service specification.

The COVID-19 vaccination service used PGDs as the legal basis for administering the vaccines. Those PGDs examined were all in order. The pharmacist explained which vaccine he was mainly using and highlighted the need for extra care over which vaccine to use when people arrived for a first vaccination under the 'evergreen offer'. The vaccines were stored appropriately.

The pharmacy obtained its medicines from appropriately licensed wholesalers and stored them in the manufacturer's original containers. The technician confirmed that she carried out regular date checks and put a sticker on any items that would be going out of date within the next three months. There were no written records of these date checks. Fridge temperatures were monitored daily and recorded on the PMR system.

Prescriptions awaiting collection were stored out of sight of people waiting at the medicines counter. Any prescriptions for schedule 2 CDs were highlighted with 'CD' written on the token so that staff would know to look in the CD cabinet. Prescriptions for items that needed to be stored in the fridge were highlighted in a similar way. The date on all CDs was also highlighted so that staff knew not to hand them out after 28 days. The prescription retrieval shelves were cleared every three months and a record kept of those items in case people came back to collect them.

There were suitable containers for storing unwanted medicines, including a purple-lidded bin for hazardous medicines. Controlled drugs were brought to the attention of the pharmacist and appropriately recorded before being denatured and safely disposed of. People bringing sharps back were signposted to the local council. There was a file containing copies of alerts received from the Medicines and Healthcare products Regulatory Authority (MHRA). Those alerts were annotated to show what action had been taken in response, when and who by.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has adequate facilities for the services it provides, and it makes sure that they are properly maintained. It also ensures that people’s private information is kept safe and secure. But its team members aren’t always taking enough care over the security of their individual NHS smartcards.

Inspector's evidence

There was a set of standard conical measures available to use with liquid medicines. Some had been marked so that they would only be used for measuring methadone solution. There was also suitable equipment for counting tablets and capsules. The two fridges were clean and in good working order.

All computer screens were positioned so that they were not visible to the public and were password protected. NHS smartcards were in use, but two of them had their passwords written on them and were being used by other members of the team. This was rectified when brought to the attention of both the RP and the SI. The SI subsequently confirmed that this practice had been stopped and that arrangements had been made to obtain cards for those who currently didn't have their own. The pharmacy had access to a range of online resources and had the British National Formulary (BNF) for reference.

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.