General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Western Elms Pharmacy, 351-353 Oxford Road, READING, Berkshire, RG30 1AY

Pharmacy reference: 1028990

Type of pharmacy: Community

Date of inspection: 20/07/2023

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

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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	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 it completes the records it needs to by law. The pharmacy 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.

Inspector's evidence

The responsible pharmacist (RP) was the regular RP and the pharmacy manager. And she had worked at the pharmacy for approximately 18 months. The RP described how she 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 recorded its mistakes. And the RP reviewed the records every month. The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs). And in response to a mistake between gabapentin and pregabalin, team members made additional checks during dispensing and checking. And they had also separated the two products to different areas of the dispensary. This approach had successfully reduced the occurrence of the same mistake. But the team recognised that preventing such mistakes required on going monitoring and intervention. And while it was clear that the team discussed what had gone wrong. And it took action in response to its mistakes, it did not record what its team members had learned or how they would improve. The RP and inspector discussed this and agreed that it was important to identify steps in procedures which would prevent mistakes in future. And this would also help the RP to monitor learning and improvement more effectively.

The pharmacy had introduced a new team in the last 12 to 18 months, after previous team members had left. The dispensing assistants (DAs) on duty had completed their training at another pharmacy. But when they first joined, all team members completed an induction programme. And as part of the induction, they learned about their job roles and the roles of others. The pharmacy had a set of up-to-date standard operating procedures (SOPs) for its team members to follow. And they had read them. And they appeared to understand and follow them. The DAs consulted the RP when they needed her advice and expertise. And they asked her appropriate questions before handing people's prescription medicines to them. They did this to ensure that people got the right advice about their medicines. The team had received a new SOP about the flu vaccination service in advance of the upcoming flu season. And team members were in the process of reading it. The RP had placed her RP notice on display where people could see it. The notice showed her 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, when the new team first took over the running of the pharmacy, people were sometimes unhappy that their prescription had not arrived or that their medicines were not ready on time. And some people took their frustration out on team members. But, to help the situation, the team asked people to allow more time between requesting their prescriptions

and collecting them. This allowed staff to chase 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. The pharmacy had also had concerns raised about the new door which some people found heavy. The door could not be opened automatically with a push button as it was before. And this had posed access difficulties for some people. The team had reported the issue to head office. But the matter had still to be resolved. 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 controlled drug (CD) registers. And it kept a record of its CD running balances. 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. Its RP record was generally in order although it had some gaps where locums had forgotten to log out at the end of their shift. Its private prescription records were also in order, other than some entries which had the prescriber's details missing. The pharmacy's emergency supply records were generally in order. But they did not all give a clear reason for the decision to supply. 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, so that they can improve the quality of the pharmacy's service.

Inspector's evidence

On the day of the inspection the RP worked with two dispensing assistants (DA)s. 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 and on the phone. Team members appeared to work closely with one another. And they supported one another, assisting each other when required. The new team had worked hard to ensure that it delivered a good service for people after the previous team had left. And it had worked together to put changes in place which meant that it could meet the standards expected of community pharmacies. The DA described how she and her colleagues had introduced a medicines ‘amnesty’ where they had identified short-dated stock which the pharmacy was unlikely to use before it expired. They then returned the stock to the company warehouse where it could be ordered by other branches which would use it. This had freed up space on the pharmacy’s shelves. And it had reduced waste.

The RP felt she could make day-to-day professional decisions in the interest of patients. Team members described being able to discuss their concerns with the RP. And they discussed issues as they worked. Team members had annual reviews about their work performance. The team reported that the head office team had expanded recently. And it now had opportunities to raise issues with different people in senior management according to issues with governance, operations, services, or administration as well as the Superintendent and area manager. These changes had led to the team feeling better supported.

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 a compact retail space with shelving for displaying products for sale. The pharmacy had an opening with a short walkway from the shop floor to the dispensary. And it had a small medicines counter on one side and a consultation room on the other. The walkway led to a larger dispensing area to the rear. The medicines counter had a half height backwall behind it for displaying over-the-counter medicines. And screens along the countertop helped to prevent the spread of infections. The pharmacy also had a small waiting area for people.

The pharmacy had a consultation room which was located near the dispensary and counter. The pharmacy's consultation room was clean, tidy and organised. And it had an entrance from the shop floor. The dispensary had a 'U' shaped dispensing bench with shelves and drawers above and below for storing medicines and equipment. This area was out of people's view. And so, team members could work here relatively undisturbed. The dispensary had a separate run of work surface which provided an accuracy checking area for pharmacists. Pharmacists could see people waiting at the counter from here. And they alerted staff when someone needed their attention. The pharmacy had a sink with hot and cold running water. And it had a staff area and further storage to the rear.

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 it ensures that 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. But the pharmacy prioritised the service for people who had no other way of getting their medicines. And it could also order people's repeat prescriptions if required. The team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. It 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. 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 she 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 she would counsel at-risk people when supplying the medicine to ensure that they were on a pregnancy prevention programme. The pharmacy also knew to provide the appropriate patient cards and information leaflets with each supply.

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 been prescribed blood pressure lowering tablets as a result. 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 tidy and organised. The pharmacy checked the expiry dates of its stock, regularly. 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. And it labelled them so that people knew to use the oldest pack first. 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. And these were clean. 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 two computer terminals which it had placed at a workstation in the dispensary and in the consultation room. 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.