General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tilehurst Pharmacy, 7 School Road, Tilehurst, READING, Berkshire, RG31 5AR

Pharmacy reference: 1028995

Type of pharmacy: Community

Date of inspection: 02/11/2022

Pharmacy context

This is a community pharmacy belonging to an independently run group of 25 pharmacies. The pharmacy is on a parade of local shops and businesses in a suburb of Reading in Berkshire. 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 provides a selection of other services, including a winter flu vaccination service. The company operates a central dispensing 'hub' to which the pharmacy sends many of its prescriptions for dispensing.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not do enough to identify and manage the risks associated with its dispensing service.
		1.2	Standard not met	The pharmacy does not adequately review and monitor the risks associated with its services.
		1.6	Standard not met	The pharmacy does not keep all of its essential records in the way it needs to.
2. Staff	Standards not all met	2.2	Standard not met	The company does not train its staff to the standard required.
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 not all met**

Summary findings

The pharmacy doesn't effectively manage all the risks associated with its services. In general the pharmacy's team members rectify their mistakes appropriately. But the pharmacy does not follow up on the team's mistakes to ensure that it learns from them and improves the safety and quality of its processes. The pharmacy has suitable procedures to help the team with their tasks. But the company hasn't reviewed them for several years so they may no longer meet the needs of the team. Team members can't easily access those procedures which makes it hard for them to know that they are doing the right things. The pharmacy does not do enough to ensure that it keeps its records the way it must. The pharmacy has insurance to cover its services. And it keeps people's private information safe. Its team members know how to protect the safety of vulnerable people.

Inspector's evidence

The pharmacy had a system for recording its mistakes. The responsible pharmacist (RP) was a locum who had not worked at the pharmacy before. But team members described how the pharmacists usually highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistake from happening again. But while the team recorded its mistakes, it did not record any other details. And it did not review them regularly. Records did not show who had made the mistake, how it had happened, what the team member had learned or what they would do differently next time. The RP and other team members agreed that if they had more details of what they had learned from their mistakes they could review them and monitor improvement more effectively. And it would provide the team with a better opportunity to prevent mistakes and continue to improve.

The pharmacy had put measures in place to keep people safe from the transfer of infections. The team had a regular cleaning routine, and it cleaned the pharmacy's work surfaces and floors regularly. The pharmacy had hand sanitiser for team members and other people to use. And it had put screens up at its medicines counter. The pharmacy had reduced the range of its usual services during the pandemic. It had done this because of staff shortages from time to time and to concentrate on delivering a safe dispensing service. The pharmacy had a set of standard operating procedures (SOPs) to follow, but the SOPs needed to be reviewed. Several SOPs including the dispensing SOP had last been reviewed in 2016, six years earlier. And so, a review was overdue. The SOPs were stored electronically. And staff could not find them easily. But the inspector was informed that team members all read SOPs when they joined the team. And newer team members were in the process of reading the SOPs relevant to their roles. But staff appeared to understand their job roles. The medicines counter assistant (MCA) consulted the pharmacist when she needed her advice and expertise. 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 could give feedback on the quality of the pharmacy's services directly to the pharmacy's team members. They could also give feedback directly to the area manager or the superintendent pharmacist (SP). Recent customer comments indicated that many people were unhappy if the pharmacy did not have their medicines in stock. And so team members spent time contacting GPs to arrange alternatives so that people did not go without their medicines. The trainee pharmacist described an incident where someone complained because the team was unable to supply a pharmacy (P) medicine along with a

prescription delivery. And it refused the sale. Following the complaint the area manager explained the process to follow. So the team can now offer the service to other delivery patients who cannot get to the pharmacy. So it was clear that the pharmacy team could provide people with details of where they should register a complaint if they needed to. And if necessary, they could also obtain details of the local NHS complaints procedure online. But team members generally dealt with people's concerns 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 did not keep all of its records the way it was meant to, including its controlled drugs (CD) register. Examples were seen of CD registers which had been made up of pages torn from other registers. The pharmacy had then stapled these loose pages together. And so its page numbers were out of sequence. This meant that the registers' pages could be tampered with. The pharmacy had also combined its registers by adding a CD of a different strength to the back pages of an existing register. And while the pharmacy had some patient returned medicines in its CD cabinet, the pharmacy team could not find a register for patient-returned CD's. So, these medicines were unaccounted for. The pharmacy team could not locate any emergency supply records. But it could not recall making any emergency supplies in recent times. This was due to them being able to supply medicines in an emergency under its community pharmacy consultation service (CPCS). But it had made emergency supplies to several people for whom they had not yet received their prescriptions but who had run out their medicines. It kept records of these supplies. But it did not identify them as emergency supplies. And it had yet to obtain the prescriptions for these supplies as necessary. The pharmacy generally kept its responsible pharmacist records up to date, but the records had some omissions where RPs had not signed out at the end of their shift. Not all of the pharmacy's private prescription records had details of the prescriber. And so the records were missing some of the details required by law. The pharmacy team agreed that all of the pharmacy's essential records should have all the necessary details and that they should be up to date.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed training on confidentiality. They discarded confidential paper waste into waste baskets as they worked. And then into separate waste bags. The confidential waste bags which were collected regularly for safe disposal by a licensed waste contractor. 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 one of the pharmacists or the area manager. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not train its team members according to General Pharmaceutical Council (GPhC) guidance. And so it does not properly train them for their job roles. But team members support one another well. And they adequately manage the pharmacy's workload. Team members are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's service

Inspector's evidence

The pharmacy had a regular part- time responsible pharmacist (RP). And it used locums to cover its remaining shifts. At the time of the inspection the pharmacy had a locum RP who had not worked at the pharmacy before. She was supported by a trainee pharmacist, two trainee dispensing assistants (DA)s and a trainee medicines counter assistant (MCA). But, except for the trainee pharmacist, none of the trainees had begun any formal training. This had been highlighted at the last inspection and raised as an action point. Both trainee DAs had been registered on a recognised dispensing training course. But neither had started any of the modules. This was even though one of the trainees had worked as a DA for a year. The second trainee DA had worked at the pharmacy for 6-8 weeks. But had the responsibility of managing the repeat prescription requests for people including those on multi-compartment compliance packs. The trainee MCA had also worked at the pharmacy for a year. But, contrary to guidance from the General Pharmaceutical Council (GPhC), the pharmacy had not yet registered her on a recognised course. The area manager attended the pharmacy part way through the inspection. He explained that as a result of work pressures and staff shortages during the pandemic there had been little time for training. But he agreed that it was essential to properly train staff so that they could support the pharmacist effectively. It was clear that team members understood their tasks, and it was clear that they had been coached on their job roles. But the absence of any formal training along with an absence of an up-to-date set of SOPs leaves the pharmacy's team with gaps in its essential knowledge. And locum pharmacists may not always be aware of this.

But team members worked regularly together. And they made up a small, close-knit team. Overall, team members were seen to work effectively with one another. And it was clear that they supported one another to carry out their tasks. They kept the daily workload of prescriptions in hand, and they attended to customers promptly. And pharmacists could make day-to-day professional decisions in the interest of patients. The area manager explained that during the pandemic the pharmacy had felt the pressures of a heavier-than-usual workload. But it had not had any unplanned closures. Team members could discuss their concerns with the RP, the area manager and the SP. And they felt supported in their work. They did not have any formal reviews on their work performance. But they had regular discussions as they worked day-to-day with the regular RP.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. And they are sufficiently secure. But some areas of the pharmacy are cluttered. And not all areas are clean and tidy enough.

Inspector's evidence

The pharmacy was on a small parade of shops serving the local community. It had a consultation room and a small retail area with seating for waiting customers. The consultation room was close to the counter and dispensary. And its door was kept closed when not in use. The pharmacy had a short pharmacy counter which was open on one side. The opening provided access to the dispensary and the area behind the counter for staff and authorised visitors. The opening at the counter also connected the retail space to the back shop area. With a prescription storage area and a staff area in between. This provided easy access for staff retrieving prescriptions for people. It had a medicines counter which supported a transparent screen to help reduce the risk of spreading viral infections. It kept its pharmacy medicines behind the counter.

The pharmacy had a compact dispensary. But it also had additional dispensing and storage space in a larger room off the main dispensary. Team members dispensed the pharmacy's multi-compartment compliance packs here. The main dispensary had dispensing benches on three sides which were used for most of the pharmacy's dispensing activities. And it had storage facilities above and below the benches. One of the dispensary's workstations faced the retail space and the back of the medicines counter, so that team members could see people waiting. But the pharmacy's worksurfaces were generally cluttered with stock and prescription baskets with incomplete prescriptions and paperwork. The pharmacy had a cleaning routine. And it cleaned its most commonly used surfaces regularly. Team members cleaned floors periodically, but floors had dust and debris on them at the time of the inspection. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is not thorough enough in ensuring that it keeps all its medicines for dispensing in the appropriate packaging. And it does not do enough to ensure that all the medicines it supplies have the information that people need so they can take their medicines properly. In general, the pharmacy makes its services accessible for people. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make adequate checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacy had a doorway which provided step-free entry. And its customer area was generally free of clutter and unnecessary obstacles. The pharmacy had a delivery service for people who found it difficult to visit the pharmacy. And it could also order people's repeat prescriptions for them if necessary. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. 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. The trainee DA processed the prescriptions for the compliance packs. And these were then sent to the dispensing hub. Compliance packs were dispensed and checked at the hub. And they were sent back to the pharmacy where the RP generally rechecked them before they were bagged ready for supply. Compliance packs had been labelled with a description of each medicine, including colour and shape, to help people to identify them. While the pharmacy supplied patient information leaflets (PILs) with new medicines it did not supply them with regular repeat medicines. And so people may not have all the necessary information about their medicines to help them to take their medicines properly.

The RP gave people advice on a range of matters. And she would give appropriate advice to anyone taking high-risk medicines. The pharmacy had additional leaflets for 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 was aware of the precautions she would need to take, and counselling she should give, if it were to be prescribed for someone. But other team members needed to update their understanding of the procedures to follow when dispensing a valproate medicine.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines appropriately and in their original containers. And stock on the shelves was generally tidy and organised. But the inspector found packs of medicines which contained mixed batches of different brands of the same medicine. This meant that the information on the outside of the packs did not accurately describe what was inside them. And this increased the risk of mistakes. This could happen if some of the contents had been recalled. And expiry dates on individual strips could be missed during the usual checks. The inspector discussed this with the team. It was agreed that team members should review their understanding of the correct procedures to follow when dispensing a split-pack of medicines. And when putting medicines back into stock after dispensing.

While the team had previously carried out regular date checks it had not done any checks in recent

months. And it had not completed any records. But a random sample of stock checked by the inspector was in date. In general, short-dated stock was identified and highlighted to help team members to spot them. And the trainee pharmacist and trainee DA described how they usually checked expiry dates every time they dispensed an item. The team put its out-of-date and patient-returned medicines into dedicated waste containers. The team stored its fridge items appropriately. The pharmacy generally responded promptly to drug recalls and safety alerts. And it kept records of these. But it had not acted on a recent recall for Mebeverine 135mg. And so it had not checked whether it had any of the affected batches in stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. The team uses its facilities and equipment to keep people's private information safe. But the pharmacy is not thorough enough in keeping some of its equipment and facilities clean and hygienic.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was generally clean. But some of its measuring flasks needed further cleaning. The pharmacy's dispensary sink was also in need of further cleaning. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of sanitiser, face masks and gloves, if they needed them. The pharmacy had several computer terminals which had been placed in the consultation room, back shop area and in the dispensary. Computers had password protection. And the pharmacy stored its prescriptions in the dispensary out of people's view. Staff used their own smart cards. They did this to ensure that team members had the appropriate level of access to patient records. And to ensure that it had an appropriate audit trail around access to records. The pharmacy also had hand sanitiser for team members and people to use at the counter and in the dispensary.

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.