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: 24/08/2023

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 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 new regular responsible pharmacist (RP). And the pharmacy manager. He had just started working at the pharmacy that week. And was four days into the role. The technician described how RPs generally 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 it usually 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 several near miss mistakes with LASAs it had separated several of these products to different areas of the dispensary. It had done this to reduce the risk of selecting the wrong one. But the team recognised that preventing such mistakes required ongoing monitoring and intervention. And while it was clear that the team discussed what had gone wrong. And it acted in response to its mistakes, it did not record what its team members had learned or how they would improve. And they did not always identify the steps they could introduce to their own procedures to prevent future mistakes. The RP, technician and inspector discussed this and agreed that it was important to ensure that all near miss mistakes should lead staff to reflect on their own dispensing procedures. And improve them. And that this would also help the RP to monitor learning and improvement more effectively.

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 trainee medicines counter assistant (MCA) consulted the RP when she needed his advice and expertise. And she asked appropriate questions before handing people's prescription medicines to them. Or selling a pharmacy medicine. She 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 had read it. 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 its workload had increased following the recent closure of another local pharmacy. And there had been some teething problems with ensuring continuity of prescriptions and supplies of medicines. But the team had worked closely with local surgeries to ensure that people did not go without essential medicines. And it arranged for alternatives when they received a prescription for an item that they could not get. It also tried to keep people's preferred brands of medicines in stock so that they did not have to wait while the team ordered them.

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 emergency supply records. And its controlled drug (CD) registers. It kept a record of its CD running balances. And a random sample of stock checked during the inspection matched the total recorded in the register. The pharmacy 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. But 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. But it had not had any concerns to report.

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 services.

Inspector's evidence

On the day of the inspection the RP worked with the technician and the trainee MCA. A delivery driver was also on duty delivering prescriptions. The technician had recently completed her training. And had applied to the General Pharmaceutical Council to become registered. The trainee MCA had completed two months of her probationary period. And had received in house company training. The technician had worked at the pharmacy for some time and was an experienced team member. She worked closely with the trainee MCA and supervised her appropriately when she was looking for people's prescriptions. And she coached her on the pharmacy's systems. Despite the additional workload gained from the closure of the other pharmacy, the team was efficient and calm. It attended promptly to people at the counter. And it tried hard to keep on top of its other tasks. But it was in the process of adjusting to its new workload. And its new patients. And while it had the daily workload of prescriptions in hand it was two days behind with making the final checks and completing them ready for collection. The RP and technician assisted the trainee MCA when needed. Without being asked. And together they dealt with queries promptly.

The technician also supported the RP when required, as he became used to the pharmacy. The RP felt he could make day-to-day professional decisions in the interest of patients. And he felt that he could discuss concerns with the regional director or the superintendent pharmacist. Or ask them for assistance. Team members had annual reviews about their work performance. And they discussed issues as they worked. The team reported that it could also raise issues with different people in senior management according to issues with governance, operations, services, or administration. And it felt well supported.

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. The pharmacy generally kept its worksurfaces tidy and organised. But it had a significant number of stacked baskets of prescriptions awaiting a final accuracy check from the RP. The pharmacy had a cleaning routine. And it cleaned its most used surfaces regularly. Team members cleaned floors periodically and they tried to keep them tidy. 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 provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. 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. But 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.

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 tried to prioritise the service for people who had no other way of getting their medicines. 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. The technician processed the prescriptions for the compliance packs. And these were then sent to the company's 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 dispensed at the hub. And so, people may not have all the necessary information about their medicines to help them to take their medicines properly. 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 understood that he must 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 pharmacy also referred people back to their GP where further medical intervention was required. Pharmacists 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 team 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. 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.