General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Triangle Pharmacy, 88 - 90 School Road, Tilehurst, READING, Berkshire, RG31 5AW

Pharmacy reference: 1028996

Type of pharmacy: Community

Date of inspection: 24/08/2022

Pharmacy context

This is a community pharmacy belonging to an independently run group of 25 pharmacies. The group operates a central dispensing 'hub' to which it sends many of its prescriptions for dispensing. 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 range of other services, including a COVID-19 vaccination service and a winter flu vaccination service.

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 procedures to identify and manage risk. It has written procedures in place to help ensure that its team members work safely. It has insurance to cover its services. The pharmacy keeps people's private information safe. And 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 worked at the pharmacy on several occasions before. She described how she and her pharmacist colleagues 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. In response to several near miss mistakes, team members had separated look-alike sound-alike medicines (LASAs), such as amlodipine and amitriptyline onto different shelves. They had also introduced a section for fast- moving lines to differentiate and separate the more commonly prescribed medicines from similar but less commonly prescribed medicines. But while the team recorded its mistakes, it did not record what it had learned or what it 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 contact points regularly. And it had a cleaner to clean floors and common areas twice weekly. 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 and a safe COVID-19 vaccination service. The pharmacy had a set of standard operating procedures (SOPs) to follow. The SOPs were up to date. And newer team members were in the process of reading the SOPs relevant to their roles. And staff appeared to understand their roles and responsibilities. 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 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 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 pharmacists 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 generally kept its records in the way it was meant to, including its controlled drugs (CD)

register and its private prescription record. The pharmacy maintained and audited its CD running balances. And the quantity of a random sample checked by the inspector matched the total recorded in the CD register. 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). 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. 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 had a CD destruction register for patient-returned medicines which was in use and 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 separate 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. The team could access details for the relevant safeguarding authorities online.

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

The inspector conducted the inspection during the pharmacy's usual trading hours. In the absence of a regular employed pharmacist the pharmacy delivered its services using locum pharmacists, two of which worked at the pharmacy regularly. The RP on duty was one of those regular pharmacists. She worked alongside a trainee pharmacist three dispensing assistants (DAs), a trainee DA and a healthcare assistant (HCA). Overall, team members appeared to work effectively with one another. And they supported one another to complete their tasks. The RP explained that during the pandemic the pharmacy had felt the pressures of a heavier-than-usual workload. And it had also had staff shortages. But its team members covered extra shifts to help out when they could. The pharmacy team had recently raised concerns about staff shortages with its line managers. Following those requests several new, trained members of staff had been recruited to the team. And while they had not worked at the pharmacy for long, they were working with original team members to re-organise stock and catch up on tasks which the team had previously fallen behind with, such as date checking. The pharmacy's daily workload of prescriptions was in hand and team members attended to customers promptly. Pharmacists were able to make day-to-day professional decisions in the interest of patients. And the pharmacy had not had any unplanned closures. Team members could discuss their concerns with the RP and the superintendent pharmacist (SP). And they felt supported in their work. They kept their knowledge up to date when they could by reading training material. Pharmacists could make their own professional decisions in the interest of people and did not feel under pressure to meet business or professional targets.

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 clean, organised and secure. The pharmacy has made sensible adjustments to help reduce the risk of the spread of viral infections. And its workspace is tidy and organised.

Inspector's evidence

The pharmacy was on a small parade of shops and local businesses. It had a spacious customer area. And so, during the pandemic it had split the customer area in two to create a COVID-19 vaccination suite. The vaccination suite was clearly signposted. It had a waiting area and an observation area. And a single vaccination booth with a curtain for privacy. At the time of the inspection the service was not in demand. But this was expected to change during the winter months when the pharmacy would offer both COVID-19 vaccinations and flu jabs. The remaining customer area stocked a variety of items related to health care or personal care. It had a pharmacy counter topped with transparent plastic screens to help reduce the risk of transmitting viruses. And it had a small waiting area. It kept its pharmacy medicines behind the counter. And people could also hand in or collect their prescriptions here. The pharmacy had a step up from the counter area into the dispensary behind. And it had measures in place to prevent unauthorised access.

The dispensary was an appropriate size and it had additional working and storage space in the stock room behind it. The dispensary had a curved workbench along one side overlooking the customer area. And it had a smaller workbench next to the sink. And storage shelves on its other walls. Workbenches also had storage areas above and below. And they were tidy and free of unnecessary clutter. The pharmacy stored its dispensed items and prescriptions so that people's information was out of view. The pharmacy also had a consultation room. The consultation room had an entrance from the customer area next to the counter. The team kept the consultation room locked when not in use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible for people. And it has appropriate procedures to ensure that it supplies its services safely and effectively. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members generally make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing. The pharmacy team ensures that the medicines it supplies have the information that people need so they can take their medicines properly

Inspector's evidence

The pharmacy had posters on its windows promoting its services. And it had a doorway which provided step-free entry. It had clear signposting at its entrance which directed people either left towards the vaccination service or right towards the pharmacy's main day-to-day services. The pharmacy's customer area was free of unnecessary clutter, making it suitable for people with mobility issues. The pharmacy could also order people's repeat prescriptions if required. And it could deliver them. 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. And pharmacists would explain to people how to use their compliance packs when they first started having their medicines this way. The RP described how the team assessed people's needs before giving them a compliance pack. It did this to ensure that a compliance pack was suitable for them. The pharmacy managed the service according to a four-week rota. And it had a dedicated member of the team who's task it was to run the service with the help of the RP. The team checked and verified any changes to prescriptions each time it dispensed a pack. And it updated people's records. The team labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And its 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 RP discussed the importance of ensuring that people had all the information they needed about their medicines.

The pharmacists gave people advice on a range of matters. And they would give appropriate advice to anyone taking high-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 knew about the precautions she would need to take, and counselling she would give, if the pharmacy was to supply it to someone new.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And its stock was tidy and organised. It stored its medicines appropriately and in their original containers. The pharmacy team date-checked the pharmacy's stocks regularly. And it kept records to help it manage the process effectively. But random sample of stock checked by the inspector was out of date. It was an opened bottle of liquid which had been missed during the last date check. But on further examination of stock the inspector saw that team members generally identified and highlighted short-

dated stock. And they put the pharmacy's out-of-date and patient-returned medicines into dedicated waste containers. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that it kept the medication inside within the correct temperature range. The pharmacy's delivery driver understood the pharmacy's delivery procedures. He knew to ask the pharmacist for any CD items or fridge items which were due for delivery. 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 its services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And for dispensing into multi-compartment compliance packs. And its equipment was clean. The pharmacy team had access to appropriate up-to-date information resources. And it had access to PPE, in the form of sanitiser, face masks and gloves, which were appropriate for use in pharmacies if it needed them. The pharmacy had several computer terminals which had been placed in the consultation room, back shop area and in the dispensary. Computers were password protected. Team members had their own smart cards to maintain an accurate audit trail. And to ensure that team members had the appropriate level of access to records for their job roles.

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.