General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: The Reading Pharmacy, 105 Wokingham Road, READING, Berkshire, RG6 1LN

Pharmacy reference: 1029006

Type of pharmacy: Community

Date of inspection: 13/09/2023

Pharmacy context

This is a local community pharmacy. It is one of two pharmacies with the same owner. And it is situated on a small parade of local shops and businesses in Reading. The pharmacy provides a range of services including dispensing prescriptions. And supplying medicines in multi-compartment compliance packs for people who need them. It has a selection of over-the counter medicines and other pharmacy related products for sale. It provides a core range of other services, including a medicines delivery service, a travel vaccination service and a seasonal flu vaccination service.

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 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 not all met	4.3	Standard not met	The pharmacy does not do enough to ensure that it stores all its medicines properly.
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 the risks associated with its services. And team members respond appropriately when mistakes happen. But they do not do enough to ensure that mistakes are properly recorded, reviewed and monitored. So that they can prevent similar mistakes in the future.

Inspector's evidence

The responsible pharmacist (RP) had been in her role for two months. The RP shared RP duties with the superintendent pharmacist (SI). And they covered the pharmacy's opening hours between them. 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 generally recorded its mistakes. But the team could not find the records at first when the inspector requested them. Team members agreed that if they were to keep the record book close to hand, they would be more likely to use it each time they made a mistake. The pharmacy manager, who was also a dispensing assistant (DA) usually reviewed the records every month. And with the support of the RP, she discussed her findings with the team. But she did not keep records of the reviews. This meant that the team may not always have a record of what actions had been agreed between one month and the next. And this may have made the ongoing review of those actions less effective. 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 by putting different products in between them. It had done this to reduce the risk of selecting the wrong one. 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 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 add to their own procedures to prevent future mistakes. The RP DA manager 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 assistants (MCAs) consulted the RP when they needed her advice and expertise. And they asked appropriate questions before handing people's prescription medicines to them. Or selling a pharmacy medicine. 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 had read it. During the inspection, the RP 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. The team had received positive comments from people with walk-in prescriptions. Where it was able to turn these around efficiently. But when people raised concerns, the pharmacy usually dealt with them at the time. The team 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 until after 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 private prescription 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. Its RP record was generally in order although it had some gaps where pharmacists had forgotten to log out at the end of their shift. Its emergency supply records were also in order, other than some entries which did not give a clear reason for the decision to supply. 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 then they had it destroyed appropriately. People's personal information, including their prescription details, were generally kept out of public view. The RP, ACT and DAs had completed appropriate safeguarding training. Other team members had been briefed although had not yet had any formal training. But they were aware that they should report any concerns to the RP. The team could access details for the relevant safeguarding authorities online. But they 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 suitably. 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 an accredited checking technician (ACT), the DA manager, two further DAs and the two trainee MCAs. A delivery driver was on duty delivering prescriptions. The trainee MCAs were working their probationary period. They had completed an in-house company induction and training programme. And they were progressing through the SOPs relevant to their roles. They also received regular reviews about their work performance. The pharmacy’s DAs and ACT were experienced team members. And they worked closely with the trainee MCAs and supervised them appropriately when they were looking for people’s prescriptions. And they coached them on the pharmacy’s systems. Team members attended promptly to people at the counter. And they tried hard to keep on top of their tasks. The team had the daily workload of prescriptions in hand, but it was a day behind with making the final checks and completing some prescriptions from the day before. The RP felt she could make day-to-day professional decisions in the interest of patients. And she felt that she could discuss concerns with the superintendent pharmacist. Team members had annual reviews. And they discussed issues as they worked. The team described feeling 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 retail space of a size typical of many community pharmacies. And it had seating for waiting customers. It also had a consultation room with good access for people to have a private conversation if needed. The room was generally tidy and clutter free which allowed for the safe provision the pharmacy’s services. The pharmacy had a medicines counter which supported a transparent screen to help reduce the risk of infections spreading. And it kept its pharmacy medicines behind the counter. The pharmacy had a compact dispensary. The dispensary had dispensing benches on three sides which team members used for most of the pharmacy’s dispensing activities. And it had storage facilities above and below the benches. The accuracy checking area faced the retail space and the back of the medicines counter, so that team members could see people waiting.

The pharmacy also had a large dispensing room to the rear. The room had a large central island. And it provided a significant amount of additional space for dispensing activity. It was used for dispensing repeat and large prescriptions. And the ACT checked repeat prescriptions here. The room was also used for general storage. The pharmacy was generally clean and tidy. Some of its worksurfaces and floors in the rear dispensing area were cluttered. But this did not pose a risk. The pharmacy’s team members were responsible for keeping the pharmacy clean. And they cleaned the pharmacy’s commonly used surfaces regularly. The premises were appropriately lit. And its room temperatures were appropriate for the storage of medicines. And for keeping staff comfortable. The pharmacy had a sink with running hot and cold water for hand washing and making medicines that were required to be mixed before handing out. The premises were secured overnight.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not ensure that it keeps all its medicines for dispensing in appropriate packaging. It also does not ensure that it stores them properly. And it does not make all 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 makes its services accessible for people. And it gets its medicines and medical devices from appropriate sources.

Inspector's evidence

The pharmacy had step free access. And its customer area was generally free of clutter and unnecessary obstacles. It 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. And to prevent errors. The pharmacy dispensed multi-compartment compliance packs to two care homes and approximately 40 people in the community. The care homes ordered their own medication but sent copies of the orders to the pharmacy so that it could track them. This allowed the team to identify any missing prescriptions. And follow them up with the surgery. The pharmacy had a file for each compliance pack patient. Each person's file had details of the medicines they were taking. And team members kept them up to date by adding any changes that had been made by the doctor or hospital. The team also recorded any changes to people's compliance pack medicines on their patient medication record (PMR). They did this to make it clear what had changed, the date of the change, and who had requested it. This meant that the pharmacy team could check people's new prescriptions against their current medication records and identify any changes or mistakes. Compliance packs were usually assembled by a DA and then checked by the ACT. Both the ACT and DA added their signatures to the packs to identify who had dispensed and checked them. The process for including a pharmacist's clinical check of repeat compliance pack prescriptions was that the RP routinely assessed people's compliance pack prescriptions before they were assembled. She assessed them for any clinical interventions which may be necessary. But there was no audit trail in place to show that this had happened. Following the inspection the team introduced a system where the RP provided a signature to show that she had made a clinical check. This was so that it was clear to the team that this step had been followed. The pharmacy labelled its compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And it supplied patient information leaflets (PILs) with new medicines and at the beginning of the cycle for people that may require additional information about their medicine. And 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 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 new. And team members were aware of the need to supply the appropriate warning leaflets and cards each time. The pharmacy provided a travel vaccination service. And it offered vaccinations for protection against Hepatitis A and B, Typhoid, Rabies and Cholera. It also offered vaccinations for protection against Meningitis (ACWY) and Diphtheria, Tetanus and Pertussis (DTP). It provided the service under individual patient group direction (PGD) for each vaccination. The PGDs in use were up to date. And the RP understood that only pharmacists named in the PGDs could provide the service. The pharmacy kept

appropriate records of each consultation. Records showed details of the vaccines administered, including their batch numbers and expiry dates.

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. 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 RP. 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.

The pharmacy checked the expiry dates of its medicines and devices every three months, but it didn’t keep records to show what had been checked, when they had been checked and who had checked them. The pharmacy had last date checked its stock approximately two weeks ago. But its records showed only the medicines that had expired or were due to expire in the next three months. And so, the record was not robust enough to identify which medicines were short dated. This posed a risk that medicines due to expire soon were not taken off the shelf. The pharmacy team members explained that they highlighted any short-dated stock with a red dot sticker so that it could be easily identified during the dispensing process. But, during the inspection, a random stock check found several medicines and devices which had expired. This was discussed with the team. And team members agreed that they should conduct a full date check of all stocks as soon as possible. And keep a full audit trail. Where appropriate, the team recorded the date of opening on liquid medicines. But it did not always discard them within an appropriate timeframe once opened. But team members described how they checked expiry dates when they dispensed, and accuracy checked every medicine to ensure that the medicines they supplied were in date. The team put its out-of-date and patient-returned medicines into dedicated waste containers.

The team generally stored its CD items appropriately. And it had a fridge for storing its fridge items. But when asked, team members were not able to read fridge temperatures properly. And so, the records it kept were not accurate. The inspector discussed this with the team who agreed that all dispensing team members should be re-trained on how to read the maximum and minimum temperatures on the fridge thermometer. And on how to reset it every time a reading is taken. The team understood that keeping accurate records of fridge temperatures would ensure that they could monitor fridge temperatures properly and provide assurance that the medicines within it were being stored appropriately. The pharmacy responded promptly to drug recalls and safety alerts. And it kept records of these. The team had not had any stock affected by recent recalls.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

In general, the pharmacy has the equipment and facilities it needs to provide services safely. And it generally 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. It used suitably calibrated and clean conical measures during the dispensing process. And it had separate conical measures and tablet counting triangles for higher risk medicines. This was to prevent cross contamination. Team members had access to a range of up-to-date reference sources. Including online versions of the BNF and medicines.org.uk. The pharmacy had enough computer terminals which it had placed in the compliance pack room and dispensary. Its computers were password protected. And out of people's view. Team members had their own smart cards to access patient medication records. And they understood that they should use their own smart cards to ensure that they had the appropriate level of access to patient records for their job roles. And to ensure an accurate audit trail. Team members used the consultation room to help protect people's privacy, when they needed advice or access to the pharmacy's services, such as the travel vaccination service. And they used cordless phones to help them have a private conversation if needed. The pharmacy stored people's dispensed prescriptions out of people's view. The team were aware of what would be classed as confidential waste. And how it should dispose of it. It stored its confidential waste separately. And it had arrangements in place to have it collected regularly for shredding by a third-party company. The pharmacy had not tested its electrical equipment for a few years, but it looked to be in good working order.

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.