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: 25/03/2024

Pharmacy context

This is an independently owned local community pharmacy. It is situated on a small parade of local shops and businesses in Reading. The pharmacy provides a prescription dispensing service. And it sells a selection of over-the-counter medicines. It gives general healthcare advice. And provides a range of other services such as a hypertension case finding service, a travel vaccination service and the Pharmacy First service. The pharmacy also supplies medicines in multi-compartment compliance packs for people who need them.

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 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 responds well to feedback. The pharmacy completes the records it needs to by law. And its team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy 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 pharmacy had a system for recording its mistakes. And it generally reviewed them each month. The responsible pharmacist (RP) worked three to four days a week at the pharmacy. She 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 mistake from happening again. In general, records for individual near misses showed what the mistake was. And factors which may have contributed to it. But they did not reflect what the team member had learned or what they would do differently next time to improve. The inspector discussed this with the team. And they agreed that near miss records should be used to encourage team members to learn and improve their dispensing practise. But it was clear that the team acted in response to its mistakes. It had discussed the risk of making mistakes with look-alike sound-alike medicines (LASAs). It had also separated common products which could be mistaken for each other. These included medicines such as allopurinol and atenolol. And risperidone and ropinirole. The RP generally made the team aware when a prescription for a LASA medicine came in. She did this to ensure that team members looked out for the LASA medicine. And to ensure that they thoroughly checked the item selected when dispensing it. This approach had helped team members to significantly reduce the risk of making a mistake with a LASA medicine. The RP reviewed the near miss records regularly to monitor any trends or repeated errors. And she discussed her findings with the team. So that as a group they could suggest ways of preventing them.

The pharmacy had an up-to-date set of standard operating procedures (SOPs) for its team members to follow. Team members had read and signed them. And they appeared to understand and follow them. The pharmacy had introduced a new SOP for split-pack dispensing and team members could describe the process to follow to ensure that all split packs were clearly marked. And to ensure that medicines were kept in their original manufacturer's pack. Team members consulted the RP when they needed her advice and expertise. And they asked appropriate questions before handing peoples prescription medicines to them. Or selling a pharmacy medicine. They also gave appropriate advice to people whose medicines were unavailable. They did this to ensure that people could choose to go to another pharmacy. And to ensure that, where possible, they did not go without their medicines. 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 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 team had responded well to feedback from a previous inspection by the General Pharmaceutical Council (GPhC). And it had put measures in place to ensure that it managed its medicines appropriately. This included the introduction of the new SOP for split-pack dispensing. 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 RP records, 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 private prescription records were also mostly in order. But many entries did not give the prescriber's details, giving an address only. The pharmacy kept appropriate records for any emergency supplies it made. And team members understood the need to include a clear reason for making the 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. And they shredded much of it as they worked. Remaining confidential waste was collected regularly by a licensed waste contractor for secure disposal. Team members kept people's personal information, including their prescription details, out of public view. And they used the consultation room when they needed to discuss people's medicines or other private information with them. The team had also completed appropriate safeguarding training. And it knew to report any concerns to the pharmacist. It 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 has enough suitably trained and skilled team members for the tasks it carries 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 two dispensing assistants (DAs). And a trainee DA. Both trained DAs had worked at the pharmacy for some time and were established members of the team. And they were observed to support the trainee with her tasks. One of the DAs also had management responsibilities for the pharmacy. Team members all attended to their allocated tasks. Their tasks included the dispensing of multi-compartment compliance packs, downloading and preparing the days electronic prescriptions or completing prescriptions with outstanding items to be dispensed. The DA responsible for managing and dispensing compliance packs had read the relevant compliance pack SOP. And she followed the steps described in the SOP. The team attended promptly to people at the counter. And they supported one another, assisting each other when required. The team had the daily workload of prescriptions in hand. And it kept on top of its other responsibilities. Team members assisted each other when needed. And together they dealt with queries promptly.

Team members had regular one-to-one meetings with the RP to discuss their work performance. And they could raise concerns during these meetings. But in general, they discussed issues as they worked day-to-day. They described feeling supported in their work. And they could make suggestions about how to improve the general workflow. They could also raise concerns with the SI if they needed to. The RP often worked alongside the SI, and she could discuss issues with him. And she felt supported by him. She had a small number of NHS targets to meet, such as for the Pharmacy First service. But she felt that these targets were manageable. And she felt able to make day-to-day professional decisions in the interest of people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provide an environment which is adequate for people to receive its services. And they are sufficiently clean, tidy and secure.

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. 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 clean and tidy. 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 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. The pharmacy ensures that all its medicines are stored correctly and safely.

Inspector's evidence

The pharmacy had step-free access. And its customer area was generally free of clutter and unnecessary obstacles, making it suitable for people with mobility issues. The pharmacy could also order people's repeat prescriptions if required. And it had information on its windows promoting its services. 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 dispensed multi-compartment compliance packs to people in care homes and 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 pharmacist. The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. Completed compliance packs had been labelled with a description of each medicine, including colour and shape. Team members agreed that it was important to ensure that the descriptions accurately described the medicine, to help people to identify them. The pharmacy supplied patient information leaflets (PILs) with new medicines and with regular repeat medicines. And so, people had all the necessary information about their medicines to help them to take them properly. The RP 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. And it had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP counselled people when supplying the medicine to ensure that they were aware of the risks associated with it. And where appropriate she would counsel them to ensure they were on a pregnancy prevention programme. The RP also provided warning cards and information leaflets with each supply. And she was aware of recent changes in the law about supplying valproate medicines in their original packs.

The pharmacy offered the recently introduced NHS Pharmacy First service. This allowed people to access medicines for seven common conditions after an appropriate consultation with the pharmacist. And without having to see a GP. The pharmacy had received requests directly from people. And from its local GP surgeries. The pharmacist had the appropriate protocols to follow. And she kept the necessary

records for each supply. It was clear that she understood its limitations and when to refer people to an alternative health professional. The pharmacy offered a hypertension case finding service. The RP had referred people to their GPs following a high blood pressure reading. And she kept appropriate records. People identified as not suitable for the service had been referred to another healthcare professional where appropriate.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And the team stored its medicines, appropriately. And stock on the shelves was tidy and organised. The pharmacy checked the expiry dates of its stocks, regularly. And it kept records so that team members knew what had been checked. And when. This meant that the team could monitor the pharmacy's entire stock for expiry dates effectively. When the team identified any short-dated items it highlighted them. And it only dispensed them with the patient's agreement where they could use them before the expiry date. 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 properly to ensure that the medication inside it was kept within the correct temperature range. The pharmacy had recently reviewed its procedures for storing its dispensed prescriptions. It had done this to ensure that it did not have a backlog of uncollected prescription items on its shelves taking up unnecessary space. This also made it easier to find the ones they wanted. The pharmacy responded appropriately to drug recalls and safety alerts. But 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.

Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. It also had the equipment it needed for the Pharmacy First service. Team members had access to a range of up-to-date reference sources. The pharmacy had several computer terminals which had been placed in the consultation room and in the dispensary. Computers had password protection. And they had a time-out function to ensure they did not remain accessible when unattended for any length of time. Team members understood the importance of using their own smart cards. And they understood that this was necessary to ensure that they each had the appropriate level of access to records for their job roles. And to maintain an accurate audit trail. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in the dispensary 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.