General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Eton Pharmacy, 30 High Street, Eton, WINDSOR, Berkshire, SL4 6AX

Pharmacy reference: 1029048

Type of pharmacy: Community

Date of inspection: 05/10/2021

Pharmacy context

This traditional community pharmacy is situated in the centre of Eton. Most people who use the pharmacy are from the local area and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines. It offers other pharmacy services such as flu and travel vaccinations. The inspection was undertaken during the covid-19 pandemic.

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 generally manages the risks associated with its services and it keeps the records required by law. It has written procedures to help the team members work safely. But some team members have not read or been properly trained on these procedures, so they may not fully understand their responsibilities or what is expected of them. The pharmacy encourages team members to discuss their mistakes so that they can learn from them. Team members understand the importance of keeping people's confidential information secure, and they have basic understanding of safeguarding and how to protect and support vulnerable people.

Inspector's evidence

The pharmacy had appropriate infection control measures in place to protect the public and the pharmacy team during the pandemic. A screen had been installed on the front counter and hand sanitiser was available. The dispensary size was large enough for the pharmacy team members to keep a safe distance from each other most of the time. Team members completed regular lateral flow tests and wore face masks when working.

The pharmacy had standard operating procedures (SOPs) covering the main activities. Most were implemented when the pharmacy changed ownership in May 2019. Some additional procedures had been introduced at the start of the pandemic to help with contingency planning and infection control. SOPs were not always specifically tailored to more atypical aspects of business such as the supply of medicines to Eton College, which meant the pharmacy was reliant on regular team members' knowledge of these services. Team members working at the time the SOPs were implemented had signed so indicate they had read them. But newer team members, including the pharmacy assistant and the delivery driver, were not familiar with the SOPs and they had not signed them.

The pharmacy was part of a small independent group of four pharmacies. The superintendent pharmacist (SI) effectively managed the business and he worked at the pharmacy at least one day a week. Regular locums and relief pharmacists worked as the responsible pharmacist (RP) on the other days and provided day-to-day supervision. The pharmacy assistant was able to correctly explain what activities required pharmacist supervision and gave examples of when she would refer to them.

Pharmacists dispensed most prescriptions medicines themselves. The pharmacist explained how she tried to take a mental break between assembly and checking to mitigate the risks of lone working. There was an audit trail on dispensing labels identifying the pharmacist responsible for each supply. The pharmacy had systems for recording dispensing errors and near misses and a few examples were seen including one which had been reported to the National Reporting and Learning System. The team usually discussed any errors when they happened, so everyone was made aware of them. Some dispensing error records did not show any evidence of analysis indicating why the mistake happened or what action had been taken to prevent a future reoccurrence of a similar incident, so the team couldn't clearly demonstrate this and may be missing additional opportunities to learn. The pharmacy had a complaints procedure. The pharmacist felt that serious concerns were uncommon, and most issues were resolved at the time, but the SI was informed and would provide a formal response to customer complaints if necessary.

The pharmacy had professional indemnity insurance for the services it provided. A notice was displayed so people could identify the RP. The pharmacy maintained the records required by law for the RP, controlled drugs (CDs), private prescriptions and unlicensed medicines. Prescription supplies were recorded on a standard patient medication record system (PMR). Records checked were generally in order although occasional prescriber details were missing on the private prescription register. CD balances were maintained, and periodic audits were completed.

The pharmacy had an information governance folder with relevant policies and procedures covering the principles of the General Data Protection Regulation and included some staff confidentiality agreements. The pharmacy assistant and delivery driver had been briefed on the importance of maintaining people's confidentiality, but they had not signed an agreement confirming this. The SI confirmed that staff confidentiality agreements were kept at head office in the employee's file, and the pharmacy assistant and delivery driver had subsequently completed them. Confidential material was generally stored securely and out of public view. A shredder was used to destroy confidential paperwork. Pharmacists used their own NHS security cards to access people's electronic prescriptions and health data. A privacy notice was available in the pharmacy.

The pharmacist had completed level 2 safeguarding training and gave an example of a safeguarding concern relating to a vulnerable adult that had prompted the pharmacy team to take action.
The pharmacy assistant had not completed any formal safeguarding training but understood the basic principles. She confirmed she would report any concerns regarding children and vulnerable adults to the pharmacist working at the time.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage the services it provides. The team works well together and the pharmacy has a positive culture. Pharmacy team members have access to appropriate training. But the pharmacy's informal approach to staff training means team members may sometimes take too long acquiring the necessary qualifications for their roles.

Inspector's evidence

A regular relief pharmacist was working as the RP. She was supported by a pharmacy assistant working on the counter. The pharmacy's delivery driver was also present for a small amount of time. The pharmacist explained a second assistant worked part-time and would usually provide support on the counter, but they were currently not able to work due to covid-19 infection. A third assistant provided support of Saturdays. Footfall was reasonably low, and the workload appeared to be manageable despite the pharmacy having less staff than usual. The team members could contact the SI to request additional support if needed.

The pharmacy assistant had worked at the pharmacy since the previous September. She mainly worked on the counter but had started to progress to complete some dispensary tasks such as putting stock away. Her induction involved practical hands-on training. A training folder included details of online training modules that team members had completed. But there was no evidence of team members being enrolled on accredited courses or having completed any formal training. The pharmacy assistant was allocated regular protected training time and had not had a formal review since she had started working at the pharmacy. The SI subesequently confirmed that the two part-time assistants were already enrolled on medicines counter assistant courses. And following the inspection, he enrolled the pharmacy assistant on a combined medicines counter assistant and dispensing course, and the delivery person on a course enttitled 'Delivery medicines safely and effectively'.

The team worked well together. The pharmacist provided effective supervision. The pharmacy assistant spoke openly about her role and was enthusiastic about her work. She felt confident raising issues with the pharmacist or SI if needed. A whistleblowing policy was included with the SOPs. The pharmacist felt the culture in the pharmacy was patient focused and she did not feel under any pressure to make sales or offer services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a professional environment for people to receive healthcare services. It has a private consultation room that gives people the opportunity to have confidential conversations.

Inspector's evidence

The pharmacy was situated in an older style retail unit with a traditional frontage. The retail area had been recently refitted. It was bright and well-presented. A spacious well-equipped consultation room was available for confidential conversations and the provision of services such as vaccinations. The consultation room was easily accessible from the retail area. The consultation room door was out of sight the counter and dispensary, and it was not kept closed or locked when not in use. The equipment it contained, including sharps bins and patient sensitive information, was not properly secured which presented a potential risk to patient safety. The pharmacist took immediate action to remedy this and agreed to raise this issue with the wider team.

The dispensary was spacious with a reasonable amount of bench space. A stock room to the rear was also used as a staff rest area and toilet facilities were situated at the back of the premises. The dispensary and stock room fittings were older and worn in places, but mostly in a reasonable state of repair.

Work areas were reasonably clean and clear although the dispensary was cluttered in places. The retail area had air conditioning. Rear areas had portable heaters to help maintain the ambient room temperature.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and people receive effective care. It obtains its medicines from licensed suppliers and it stores them appropriately, so they are fit to supply. The pharmacy team carries out some checks to make sure stock medicines are kept in good condition. But expiry date checks are not always effective. So there is a risk that out of date medicines could be supplied to people by mistake.

Inspector's evidence

The pharmacy was open 9am to 6pm Monday to Friday and 9am 2pm on Saturday. There was a slight step at the entrance to the pharmacy, but a bell could be used to alert staff for assistance if needed. The pharmacist people with buggies or wheelchairs could usually access the pharmacy with some help. The pharmacy's services were promoted on signs in the window. Staff could signpost people to other healthcare services locally.

The pharmacy served the local community including residents, and pupils and staff at Eton College. It also supplied medicines to staff at Windsor Castle. The pharmacy also supplied monthly medicines to three care homes in Reading. Cares homes used racking systems or monitored dosage systems (MDS) and Medication Administration Charts (MARs) were supplied with all medicines. Interim medicines were supplied by the company's pharmacy in Reading as this was more convenient for the care homes. The two pharmacies liaised close to sure the continuity of care of these patients. The pharmacy also managed some people's repeat prescription medication and provided a small number of community MDS. Informal assessments were made about a person's suitability when initiating MDS. There were some basic systems and audit trails in place to help manage repeat prescriptions and MDS patients, but these were not always straightforward and easy to follow. Patient information leaflets were supplied with most medication but care home and MDS patients only recived them if a new medicine was initiated . This could mean they might not have easy access the information they need about their medicines. The pharmacist made some additional checks when supplying high risk medicines such as lithium, methotrexate and warfarin. She was aware of the valproate pregnancy prevention programme and the additional counselling and information that was needed for those in the at-risk group. Interventions were sometimes recorded on the PMR but this was not done consistently.

Deliveries were mostly undertaken on foot and the process had been adapted during the pandemic to minimise contact. Basic paper audit trails and logs were in place so deliveries could be tracked.

Flu and travel vaccines were offered under patient group directions. NHS and private flu vaccinations were offered and these could be provided on a walk-in basis, Travel vaccines were offered on an appointment basis and they were provided by the SI and one of the other regular pharmacist who had completed the necessary training. The pharmacy also offered covid-19 PCR testing in association with a UKAS accredited provider. Other NHS services provided by the pharmacy included the Community Pharmacist Consultation Service and the New Medicine Service.

The pharmacy assistant was clear which medicines could be sold in the presence and absence of a pharmacist. Pharmacy medicines were stored behind the medicine counter so that sales could be

controlled. The assistant was aware which type of medicines could be abused including codeine containing medicines. She reported that the team had noticed an increase in requests for Phenergan Elixir earlier in the year. They knew this could be abused and she explained how they had taken additional steps to make sure sales were controlled.

The pharmacy supplied some medicines stock to some of the Eton Colleges. P medicines and occasional POMs were requested by signed order from a doctor. A recent supply of stock for the college medical centre had been recorded in the private prescription register. The pharmacy did not have a Wholesalers Dealer's Authorisation and it was unclear whether the possible need for one had been explored with the MHRA.

Recognised licensed wholesalers were used to obtain medicines. CDs were stored in a CD cabinet which was securely fixed to the wall and access was restricted to pharmacists only. Obsolete CDs were segregated in the cabinet. Patient returned CDs were recorded and destroyed using denaturing kits. Medicines were stored in their original containers on dispensary shelves. The pharmacist confirmed date checking was carried out and some short-dated stock was highlighted. Expired medicines and sharps were segregated and placed in designated bins. A random check of medicines stock found a couple of recently expired items including some expired adrenaline injections used for anaphylaxis. This indicated the date checking system was not as robust as it could be. Alerts and recalls were received to the pharmacy email directly from the MHRA. These were actioned by the pharmacist. An audit trail was kept so the pharmacy could demonstrate this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. Equipment is appropriately maintained so that it is safe to use, and it is used in a way that protects privacy.

Inspector's evidence

The pharmacy team had access to the internet and appropriate reference sources including the latest versions of the British National Formularies (BNF). The dispensary sink clean had hot and cold running water. There was a selection of glass liquid measures with British standard and crown marks. The pharmacy had equipment for counting loose tablets and capsules and suitable containers for dispensing medicines.
There was a medical fridge for storing medicines. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in working order.

The pharmacy team had access to personal protective equipment and sundries necessary for the provision of vaccinations services such as sharps bins and needles. Computer screens were located out of public view and telephone calls could be taken out of earshot of the counter.

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.