

Registered pharmacy inspection report

Pharmacy Name: Windsor Pharmacy, 41 St Leonards Road,
WINDSOR, Berkshire, SL4 3BP

Pharmacy reference: 1029050

Type of pharmacy: Community

Date of inspection: 10/07/2024

Pharmacy context

This pharmacy is located in Windsor close to the town centre. Most people who use the pharmacy are from the local area. The pharmacy sells a range of over-the-counter medicines, and it dispenses NHS prescriptions. Some people receive their medicines in weekly multi-compartment compliance packs to help make sure they take them safely, and the pharmacy also supplies medicines to local care homes. The pharmacy provides a seasonal flu vaccination service and some other NHS funded services including the Pharmacy First Service, the Hypertension Case Finding service, and the New Medicine Service. And it has a private travel vaccination clinic.

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 suitably manages the risks associated with the services it provides. It generally keeps its records up to date, so it can show it is providing services safely. And it protects people's personal information. The pharmacy has some written procedures to make sure its team members know what is expected of them. Pharmacy team members discuss and record their mistakes so that they can learn from them. And team members understand their responsibilities in safeguarding children and vulnerable people.

Inspector's evidence

The pharmacy had Standard Operating Procedures (SOPs) for its operational activities and the services it provided. SOPs had last been reviewed in April 2023. Some SOPs had been updated or introduced since the last review. For example, SOPs for supplying valproate containing medicines and the NHS Pharmacy First service. Pharmacy team members were required to read SOPs appropriate to their roles and they signed to confirm they had done this. Roles and responsibilities of staff were set out in SOPs. All team members except for the medicines counter assistant (MCA), who was a new starter, had signed the SOPs. The MCA was able to explain their responsibilities and understood the limitations of their role. He was due to read the SOPs as part of their induction. A responsible pharmacist (RP) notice identified the pharmacist on duty although it was displayed on a higher shelf, so some people might not be able to easily read it. The pharmacy's professional indemnity insurance was provided by a recognised insurer and a copy of the certificate was provided.

Dispensing labels were initialled by team members involved in the assembly and checking processes so there was a clear audit trail. The team recorded any near miss errors and dispensing incidents. The pharmacist explained how they discussed mistakes or incidents with team members to identify any contributing factors and promote learning. The superintendent reviewed near miss records each month to identify any common trends. Shelf markers were used to highlight some common picking errors. Different strengths of amlodipine had been recently separated on the shelves following an error to reduce the likelihood a similar mistake. The pharmacy had a complaints procedure.

The pharmacy used a recognised patient medication record (PMR) system to record prescription supplies. The team maintained all of the records required by law, including RP records, controlled drugs (CD) registers, private prescriptions records, and 'specials' records relating to supplies of unlicensed medicines. Records were generally in order, but private records did not always include the accurate prescriber's details. And specials records were not consistently maintained when unlicensed medicines were supplied. For example, supplier and batch information relating to supplies of unlicensed medicines on private prescriptions had not been recorded at the time the supply was made. This could make harder to the team to show that it supplies medicines in a safe manner. The superintendent agreed to discuss this with the team and make sure these record keeping issues were resolved. The pharmacy's CD registers were held electronically, and they were suitably maintained. One CD balance checked was found to match the quantity in stock. And all CD register balances were audited regularly. The pharmacy used a book to the receipt and destruction of patient returned CDs.

Team members understood the principles of data protection and the requirements of the General Data

Protection Regulation. A privacy notice was displayed in the pharmacy. Pharmacists used individual NHS smartcards for accessing personal healthcare data. Confidential paper waste was separated and shredded. Other confidential material was stored out of public view. The MCA knew what information could not be shared and described how he would take steps not to disclose personal information, for example when handing out prescriptions if several people were waiting to be served.

The pharmacist was safeguarding accredited. Team members knew to report any concerns to the pharmacist. The pharmacy had a chaperone policy, and this was displayed. Safeguarding contacts and information were available in the consultation room.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. It supports team members to complete essential training, and they receive support in their roles. Pharmacy team members work well together, and they are comfortable discussing issues and providing feedback to the pharmacist.

Inspector's evidence

The team members present included the RP who was the superintendent pharmacist, a dispenser, and an MCA. The superintendent worked as the regular pharmacist. The dispenser and MCA both worked full-time. The superintendent explained that an overseas qualified pharmacist had recently started working at the pharmacy as a dispenser, but it was their day off. And another team member undertook home deliveries and provided occasional support if needed. A pharmacy undergraduate student worked on Saturdays. Locum pharmacists provided cover when the superintendent was off. The superintendent explained that he also engaged locum dispensers to cover staff absences if needed.

The pharmacy was busy, and a steady stream of people presented to collect their dispensed prescriptions and purchase medicines during the inspection. Team members worked well together to manage the workload. The MCA felt well supported and was able to ask other members of the team for help. The dispenser had just completed a dispensary assistants' course and felt supported in his role. A learning and development review had been completed with the superintendent earlier in the year, so the dispenser had received feedback on his progress in his role. The superintendent was intending to enrol the MCA and the new dispenser on accredited courses once they had completed their probationary period. The team member responsible for deliveries had completed a training module specific to their role as well as an introductory module for pharmacy workers. The superintendent was accredited to use patient group directions (PGDs) for the NHS Pharmacy First service and travel vaccinations.

Principle 3 - Premises ✓ Standards met

Summary findings

Overall, the pharmacy is suitable for the services it provides. But the restrictive building layout means that some areas of the pharmacy are less well organised. And the décor and fittings in the dispensary and consultation room need updating. This detracts from the overall professional image of the pharmacy.

Inspector's evidence

The pharmacy was situated in a traditional retail unit alongside other local shops. It was suitably secured when it was closed. There was retail area with a medicines counter and dispensary to the rear. The retail area was well presented. The dispensary consisted of two adjoining rooms which led to a third room which was used as a consultation room. The layout was not ideal as people had to be escorted through the dispensary to get to the consultation room. The external sign at the front of the premises identified the pharmacy under its previous trading name which could be confusing for people visiting the pharmacy. The superintendent explained that the council had recently approved his application to change the sign and display the correct name, and this work was due to be completed. The pharmacy did not have air conditioning installed as a planning application had been refused. The superintendent was considering monitoring the room temperature and using portable air conditioning units during warmer weather to make sure medicines were stored at a suitable temperature and the working conditions were appropriate.

The retail area was well presented, clean and tidy. The dispensary and consultation room were less well organised, and the lack of bench and storage space meant some areas were cluttered and untidy. The décor in rear areas was showing signs of wear and the flooring was stained.

There was a large basement accessed by stairs from the dispensary. Whilst this was in a reasonable state of repair, but it had not been decorated or maintained for many years. One of the rooms was being refurbished at the time of the inspection with the intention of using this as an office.

The pharmacy had a website <https://windsorpharmacy.uk>. It was operated by a third party provided. The website contained information about the pharmacy and its services.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are effectively managed, so people receive appropriate care. It obtains its medicines from licensed suppliers and stores them appropriately. And the team carries out some checks to make sure medicines are safe for people to use.

Inspector's evidence

The pharmacy had a manual door and a step at the entrance. A door buzzer alerted staff if people entered the pharmacy or needed assistance. A home delivery service was offered to people in need, and staff could signpost to other pharmacy services available locally. Services were promoted using signs in the window and on the website. People could contact the pharmacy by telephone, email or using a contact form on the website.

The team dispensed a mixture of walk-in and repeat electronic prescriptions. Dispensed medicines were appropriately labelled, and patient leaflets were routinely supplied. Interventions were recorded on the PMR. The MCA described the handout process and what checks were completed to make sure the prescription was handed to the right person. The superintendent was aware of the Pregnancy Prevention Programme for people at risk taking valproate containing medicines and the associated dispensing requirements. Prescriptions were marked if additional counselling was required. Interventions were usually recorded on the PMR. Basic records of deliveries were kept, and signatures were obtained when CDs were delivered.

The pharmacy dispensed a number of private prescriptions including prescriptions for CDs. It also regularly supplied small volumes of stock medicines to a local GP surgery and veterinary surgery, although it did not have a wholesale dealer's licence. The superintendent agreed to make enquiries with the MHRA regarding licensing requirements.

A number of people received their medicines in weekly compliance packs. Each person had a record showing how packs should be assembled and noted medication changes and preferences. Assembled packs were suitably labelled and patient leaflets were supplied each month. Only one pack in each cycle had descriptions of the medicines on the labels, which meant people may find it harder to identify medicines on the other packs. The superintendent had tried to reassess some compliance pack patients to check whether it was still the most suitable option, but most people preferred to still receive them.

Protocols and patient group directions were available for reference. The superintendent demonstrated how he accessed the travel PGDs, completed his assessment of the person, and recorded any vaccinations that he administered.

Medicines were sourced from licensed wholesalers and suppliers. Medicines were stored in the dispensary on open shelves. The pharmacy had a large stock holding. CDs were stored in suitably secured cabinets. Cold chain medicines were stored in fridges. Unwanted and obsolete medicines were separated into designated bins prior to collection by an authorised contractor. The MCA correctly described the process for handling patient returned medicines. The team completed medicine stock expiry date checks periodically. A random check of the dispensary shelves found no expired items. But

shelves were muddled and untidy in places. Some medicines were not stored in original packs, including foil off-cuts without batch and expiry details. These items were removed for disposal. The superintendent agreed to remind team members of the labelling requirements and check the remaining stock for other medicines which may not be suitable for use. Some old pharmaceutical ingredients were stored in the basement. Some of these were potentially hazardous and the superintendent was recommended to dispose of them via a suitable waste contractor. Drug and device alerts and recalls were received through a portal and actioned by the pharmacist. An electronic record was kept showing these had been actioned.

Pharmacy medicines were stored behind the counter. The MCA described how he handled requests for over-the counter medicines to make sure the medicine was suitable for the person. He knew what questions to ask and when to refer to the pharmacist. He was aware of the restrictions on codeine containing medicines and which medicines were considered higher risk.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. Team members take steps to maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacy team had access to the internet and appropriate reference sources. Disposable medicines containers were used. Triangles were available for counting tablets and measures were available for dispensing liquids. There were sinks in the dispensary and consultation room. The staff toilet had handwashing facilities.

Equipment for provision of additional services was available including vaccination sundries, blood pressure meters and an otoscope which had been obtained from recognised suppliers. The pharmacy's computer systems were password protected. There was a PMR terminals in the dispensary and another one in the consultation room.

Two CD cabinets were in use. CD keys were suitably secured. There were two medical fridges for storing cold chain medicines. Both fridge temperatures were in a suitable range at the time of the inspection. Records indicated that the maximum and minimum temperatures were checked daily to ensure they remained within a suitable range.

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.