

Registered pharmacy inspection report

Pharmacy Name: Bedfont Pharmacy, 380 Staines Road, Bedfont, Feltham, Middlesex, TW14 8BT

Pharmacy reference: 1034899

Type of pharmacy: Community

Date of inspection: 16/07/2024

Pharmacy context

This is an independently owned local community pharmacy. The pharmacy is on parade of local shops and businesses. And it is in a residential area of Feltham. 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 the NHS Hypertension Case Finding service, a winter flu vaccination service. And it provides the NHS Pharmacy First Service.

Overall inspection outcome

✓ **Standards met**

Required Action: None

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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 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 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 responsible pharmacist (RP) was the regular RP. And he was also the manager. The pharmacy provided a range of services, but its main activity was its prescription dispensing service. The RP described how he generally highlighted and discussed prescription 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistakes from happening again. The team recorded its mistakes electronically. And the system allowed the RP, superintendent (SI) and pharmacist directors to do an in-depth analysis of what had gone wrong and any trends that may be developing. When the RP identified a mistake, the team member recorded it on the near miss reporting system. The system required team members to identify the type of mistake from a list. And the reasons for it. And it required them to reflect on what action they would take to prevent a re-occurrence. The RP, SI and pharmacist directors then reviewed the records monthly. The team had introduced a system of thoroughly checking the item selected after they had picked it. And before they had labelled it. And this had led to a reduction in mistakes. The team had been made aware of the risk of confusing look-alike sound-alike medicines (LASAs). And it was in the process of producing new warning stickers to put on the shelf edges in front of them. This included amitriptyline and amlodipine. It had done this to reduce the risk of selecting the wrong medicine. The team recognised that preventing such mistakes required ongoing monitoring and intervention. It was clear that the team discussed what had gone wrong. And it acted in response to its mistakes. Team members agreed that near misses should lead them to identify the steps they could introduce to their own procedures to help them learn and improve.

The pharmacy had a set of standard operating procedures (SOPs) for its team members to follow. But these SOPs had been carried forward from the previous owner. The SI had produced a new, updated set of SOPs which were more appropriate for the pharmacy under its new ownership. And team members were in the process of reading them. Team members understood their roles and responsibilities. And they followed the appropriate procedures for selling pharmacy medicines and general items. And when handing out people's prescriptions. The medicines counter assistant (MCA) asked people appropriate questions before selling a medicine or handing out a completed prescription. And he asked the pharmacist for his expertise when he needed it. He did this to ensure that people got the correct medicine or treatment. The dispensing assistants (DAs) worked with the RP to get prescriptions ready for people. And they consulted him when they needed his advice and expertise. They asked people appropriate questions about their prescriptions, to ensure they got what they needed. And they accessed, used and updated the pharmacy's electronic records competently. The RP placed his RP notice on display showing his 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 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. This included details for the SI. If necessary, they could also obtain details of the local NHS complaints procedure online. But the team usually dealt with any concerns at the time. The RP commented that when the new owner took over the pharmacy it had a backlog of prescriptions. And people complained that they had to queue and wait too long to have them dispensed. And so, the pharmacy recruited new team members to ensure it had enough staff for its workload. Since recruiting additional staff, people no longer had to wait for long when they came to collect their medicines. The team also uploaded any undispensed prescriptions from the previous three months or more back to the NHS spine. To ensure that their prescription tokens were not causing unnecessary clutter in the pharmacy. And if appropriate, people could still have their medicines dispensed if they needed them. The team chased prescriptions up when they could. And they also worked closely with local surgeries to arrange for alternatives when they received a prescription for an item that they could not get. The small team was observed handling people's queries well. And the technician and DAs stepped in, unprompted, to support each other when needed. 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 kept its records in the way it was meant to, including its RP records, its records for emergency supplies. And its CD register. The pharmacy kept a record of its CD running balances. And random sample of CD stock checked by the inspector matched the running balance total in the CD register. It had a controlled drug (CD) destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. This was complete and up to date. The pharmacy's private prescription records were generally in order. But some records did not show the prescriber's details. The team agreed that it must ensure that all the pharmacy's essential records were complete.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed appropriate training. They shredded confidential paper waste throughout the day, as they worked. And they kept people's personal information, including their prescription details, out of public view. The RP had completed appropriate training on safeguarding vulnerable adults and children. And team members had been briefed. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. But it had not yet had to make any safeguarding referrals.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has put suitable measures in place to ensure it manages its workload safely and effectively. And its team members support one another. Team members are comfortable about providing feedback to one another so they can maintain the quality of the pharmacy's services. And they have the right skills and training for their roles.

Inspector's evidence

The responsible pharmacist (RP) was the regular RP. And he had worked at the pharmacy since the new owner took over three months previously. Other team members present included the pharmacy technician, a DA trainee technician, a DA. And the MCA. One of the company's pharmacist directors arrived part-way through the inspection. The pharmacy was on top of its workload. And its daily prescription workload was in hand. The team kept on top of its other tasks. And it dealt promptly with people waiting for prescriptions or advice. Several team members had been employed by the previous owner and were getting used to their new employer. But they had asked the RP and SI if they could continue to work to the previous SOPs until they had got used to the pharmacy's new patient medication record (PMR) system. The RP and SI had accepted the suggestion. And the RP described how he would introduce the new SOPs gradually.

Staff described feeling supported in their work by their colleagues. And since being taken into new ownership the team had been supported by their colleagues from the owner's other branch. The colleagues attended the pharmacy to coach and support them while they learned to work with the pharmacy's new systems. Including its new PMR system and near miss reporting system. After the initial coaching sessions, team members had been encouraged to call their colleagues if they were unsure about how to do something or had forgotten. And so, they felt supported. Team members worked effectively with one another. They described being able to have one-to-one meetings with the RP, the directors and their colleagues as they worked, or in private. Team members described how they had got together to review the way in which they managed the prescription workflow. They did this to ensure that they could get people's prescriptions ready for them more quickly when they came in to collect them. They also agreed to vary each team member's tasks, sharing them to provide variety and maintain interest and concentration. The RP made day-to-day professional decisions in the interest of people. And he did not feel under pressure to meet any business targets.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. And they provide an adequate amount of space for those services. The pharmacy is sufficiently clean and secure. The team keeps its workspace and storage areas appropriately tidy and organised.

Inspector's evidence

The pharmacy was on a parade of local shops and businesses in Feltham. It had a retail space with a consultation room and a small seating area for people waiting. The pharmacy displayed its pharmacy medicines on the backwall behind its medicines counter. The dispensary extended behind the counter. And its prescription checking area overlooked the shop floor, over the counter. This allowed staff working there to oversee the customer space. And so, they could see when people needed attention. And when their colleague on the counter might need assistance. Remaining worksurface was more out of view. And staff could work here with fewer interruptions. This provided a slightly quieter area for team members to work.

The pharmacy generally had the workbench and storage space it needed for its workload. It had storage areas above and below its work benches. It also had a run of pull-out drawers and shelves for storing medicines and completed prescriptions for collection. The pharmacy stored its dispensed items and prescriptions so that it kept people's information out of view. And it stored its medicines in a tidy, organised way. People could not view the pharmacy's dispensing benches from the customer area. And this helped the team to keep people's prescription information confidential. The team cleaned the pharmacy's work surfaces and contact points regularly. And in general, it kept the premises tidy and organised. The consultation room was near the counter. People outside the consultation room could not hear conversations taking place inside it. The pharmacy had staff facilities. And a large storeroom. It had a fire door to the back.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy makes its services accessible for people. And its procedures ensure that its services are supplied safely and effectively. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members 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 it gives people the information they need so they can take their medicines properly.

Inspector's evidence

The pharmacy promoted a selection of its services and its opening times on its windows and doors. It had step-free access and a button operated automatic door. And the team kept the retail area relatively free of clutter and unnecessary obstacles. The pharmacy had a delivery service for people who could not visit the pharmacy to collect their prescriptions. And it also ordered some people's repeat prescriptions for them. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing to help avoid errors.

Pharmacists gave people advice on a range of matters. They gave advice to anyone taking higher-risk medicines. And they attached warning cards to bags of dispensed high-risk medicines. They did this to remind team members to alert the pharmacist when handing out one of these medicines to people. So that they could counsel them properly. And give them the advice they needed about how to take their medicines safely. The pharmacy dispensed prescriptions to a small number of people taking sodium valproate medicines. This did not include people in the at-risk group. But team members described the counselling they would give when supplying the medicine to ensure that at-risk people taking it were on a pregnancy prevention programme. And to ensure that they were aware of the risks associated with it. The pharmacy also supplied the appropriate patient cards and information leaflets each time. And the team was aware of the rules around the packaging of each supply.

The pharmacy offered the 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. Its most common requests were from people seeking treatment for uncomplicated urinary tract infections (UTIs). Pharmacists had the appropriate protocols to follow. And they kept the necessary records for each supply. It was clear that they understood the limitations of the service and when to refer people to an alternative health professional. The pharmacy also provided the NHS New Medicines Service (NMS). And it kept the appropriate records. Records showed that the pharmacy had made the necessary follow up calls to ensure that people knew what their medicines were for and how to take them. The RP described how he frequently received calls from people to ask for his advice.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. And it updated people's records. The pharmacy supplied patient information leaflets (PILs) with new medicines and with regular repeat medicines. And people had all the necessary information to help them to take their medicines properly. But completed compliance packs had not been labelled with a description of each medicine. Team members agreed that compliance pack medicines should be given an accurate description including colour and shape, to

help people to identify them.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And in general, the team stored its medicines, appropriately. And stock on the shelves was mostly tidy and organised. But it had a plain, white carton of a commonly prescribed medicine which was labelled with a description of the item and an expiry date only. It had a further dispensing bottle containing loose tablets with a description of the contents only. And no other manufacturer's information. Staff had put these items back into stock after people had not collected them. The inspector and RP discussed this and agreed that stock stored this way should be removed if team members had not had the confidence in the quality of the medicines to dispense them again after a short period of time. The team agreed that all medicines should be stored in the manufacturer's original packaging where possible. The pharmacy had processes to date-check its stocks regularly. All stock had been checked for expiry dates when the new owner took over the pharmacy. The team were aware that stock needed to be date-checked again soon. And regularly after that. The team identified and highlighted any short-dated items. 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 to ensure that the medication inside each of its fridges was kept within the correct temperature range. 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 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 its equipment was clean. Team members had access to a range of up-to-date reference sources, including access to the internet to provide it with up-to-date clinical information. The pharmacy had several computer terminals which had been placed in the consultation room and the dispensary. Computers were password protected to prevent unauthorised access. And team members had their own smart cards to maintain an accurate audit trail when accessing people's records. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable the team to hold private conversations with people.

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.