

# Registered pharmacy inspection report

**Pharmacy Name:** Broadway Pharmacy, 3 Broadway, Kingston Road,  
STAINES, Middlesex, TW18 1AT

**Pharmacy reference:** 1035138

**Type of pharmacy:** Community

**Date of inspection:** 29/06/2022

## Pharmacy context

This is an NHS community pharmacy set on a parade of shops in a residential area of Staines. The pharmacy opens six days a week. It sells over-the-counter medicines and some health and beauty products. It dispenses people's prescriptions. And it delivers medicines to people who can't attend its premises in person. People can get a flu jab (vaccination) from the pharmacy. And the pharmacy team can check a person's blood pressure. The pharmacy offers a needle exchange service and substance misuse treatments. And it provides multi-compartment compliance packs (compliance packs) to some people who need help managing their medicines.

## 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 |
|--|-------------------|------------------------------|------------------|-----|
| <b>1. Governance</b>                               | Standards met     | N/A                          | N/A              | N/A |
| <b>2. Staff</b>                                    | Standards met     | N/A                          | N/A              | N/A |
| <b>3. Premises</b>                                 | Standards met     | N/A                          | N/A              | N/A |
| <b>4. Services, including medicines management</b> | Standards met     | N/A                          | N/A              | N/A |
| <b>5. Equipment and facilities</b>                 | Standards met     | N/A                          | N/A              | N/A |

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy generally manages its risks appropriately. It has written instructions to help its team work safely. It largely keeps the records it needs to by law. And it has appropriate insurance to protect people if things do go wrong. People who use the pharmacy can provide feedback to help improve the services they receive. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They mostly keep people's private information safe. They understand their role in protecting vulnerable people. And they record the mistakes they make and talk to each other about them. So, they can learn from them.

### Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. And they were being reviewed at the time of the inspection as they hadn't been for a while. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. The pharmacy had considered the risks of coronavirus. And, as a result, it completed an occupational risk assessment for its team members and put a plastic screen at its counter to try and stop the spread of the virus. Members of the pharmacy team were encouraged to self-test for COVID-19. They had the personal protective equipment they needed. And hand sanitising gel was available too.

Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were checked by a pharmacist. The pharmacy had processes to review the dispensing mistakes that were found before reaching a person (near misses) and dispensing mistakes where they had reached the person (dispensing errors). Team members discussed and documented the mistakes they made to learn from them and reduce the chances of them happening again. But they didn't routinely review them or the lessons they learnt from them. So, they could have missed opportunities to spot patterns or trends with the mistakes they made. The pharmacy team generally separated medicines involved in dispensing mistakes or were similar in some way, such as look-alike and sound-alike drugs, to help reduce the risks of the wrong product being picked.

The pharmacy displayed a notice that told people who the responsible pharmacist (RP) was. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. But their roles and responsibilities weren't clearly described within the SOPs. A team member explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints process. And it had a leaflet that told people how they could provide feedback about it and its services. The pharmacy received feedback from people online. It asked people for their views and suggestions on how it could do things better. And, for example, it tried to keep a person's preferred make of a prescription medicine in stock when its team was asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record to show which pharmacist was the RP and when.

The pharmacy kept a controlled drug (CD) register which was generally in order. But some stock levels in the CD register hadn't been checked for a while. So, the pharmacy team could have missed opportunities to spot and correct mistakes. The pharmacy kept records of the supplies of the unlicensed medicinal products it made. But occasionally it didn't record when a product was received or who it was supplied to and when. The pharmacy adequately recorded the emergency supplies it made electronically. It used a private prescription register to record the private prescriptions it supplied. And the entries seen in this register were in order.

People using the pharmacy couldn't see other people's personal information. But their details weren't always removed or obliterated before the medicines they returned to the pharmacy were disposed of. The pharmacy gave information governance assurances to the NHS each year using an online data security and protection toolkit. It had an information governance policy which its team needed to read and sign. And arrangements were in place to make sure confidential information was stored and disposed of securely. The pharmacy had safeguarding procedures. And its team members knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy generally has enough people in its team to deliver safe and effective care. Members of the pharmacy team do the right training for their roles. They work well together and make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy and its services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

### Inspector's evidence

The pharmacy team consisted of the pharmacist owner, two pharmacists, a trainee pharmacist, a pharmacy technician, a medicines counter assistant (MCA) and a trainee MCA. The pharmacist owner was responsible for managing the pharmacy and its team. The pharmacy relied upon its team members and the pharmacist owner to cover absences. Members of the pharmacy team sometimes struggled to do all the things they were expected to do. But they supported each other so people were served as quickly as possible and their prescriptions were processed safely. The RP, the pharmacist owner, the pharmacy technician, the MCA and the trainee MCA were working at the time of the inspection. The pharmacists supervised and oversaw the supply of medicines and advice given by the pharmacy team. A team member described the questions they would ask when making over-the-counter recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding, people who were old and people with long-term health conditions to one of the pharmacists.

The pharmacist owner confirmed that each pharmacy team member had completed or was undertaking accredited training relevant to their role. Members of the pharmacy team discussed their performance and development needs with their manager when they could. They shared learning and were kept up to date during informal team meetings. They were encouraged to ask questions and familiarise themselves with new products. The pharmacy didn't set targets for its team. And it didn't incentivise its services. Members of the pharmacy team felt able to make decisions to keep people safe. And they didn't feel under pressure to do the things they were expected to do. Team members were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. And their feedback led to prescription medicines being stored in alphabetical order in the dispensary.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy provides an adequate, professional and a secure environment to deliver its services from. And people can receive services in private when they need to. But its team don't always have the space they need to work in when it's busy.

### Inspector's evidence

The pharmacy had been refurbished since the last inspection. It was air-conditioned, bright, clean, and adequately and professionally presented. But the main area its team used to make up people's prescriptions was cluttered. And its worksurfaces and available storage space were limited. This meant that items were sometimes stored in boxes on the floor. And the pharmacy team didn't always have the space it needed to work in when the pharmacy was busy. The pharmacy did have another area the back of the premises which could be used to store medicines and make up people's prescriptions. But this area wasn't being utilised at the time of the inspection as it needed to be decluttered and tidied. The pharmacist owner gave assurances that both areas would be cleared and reorganised after the inspection. The pharmacy had a consulting room for the services it offered. And this could be used if people needed to speak to a team member in private. People's conversations in the consulting room couldn't be overheard outside of it. The consulting room was locked when it wasn't being used. So, its contents were kept secure. Members of the pharmacy team were responsible for keeping the premises clean. The pharmacy had the sinks it needed for the services its team delivered. And the premises had a supply of hot and cold water too.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides services that people can access. Its working practices are generally safe and effective. And its team members are helpful. The pharmacy gets its medicines from reputable sources. And it stores most of them appropriately and securely. Members of the pharmacy team usually dispose of people's waste medicines properly. And they carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose.

### Inspector's evidence

The pharmacy had an automated door. Its entrance was level with the outside pavement. And it had wide aisles. These things made access to the pharmacy, and its services, easier for people who used wheelchairs or mobility scooters. The pharmacy had a notice in its window that told people when it was open. And it had a small seating area for people to use if they wanted to wait in the pharmacy. Members of the pharmacy team were helpful. They took the time to listen to people. So, they could advise and help them. And they signposted people to another provider if a service wasn't available at the pharmacy.

The pharmacy offered a delivery service to people who couldn't attend its premises in person. And the pharmacist owner generally delivered prescriptions to people in person. This meant that people could ask the pharmacist delivering their prescription for advice about their medicines and their health if they wanted to. The pharmacy kept a record to show when a person's prescription was delivered. The pharmacy generally used a disposable and tamper-evident system for people who received their medicines in compliance packs. But its team could do more to assess requests to supply medicines in a compliance pack to make sure this was appropriate for the patient. The pharmacy routinely kept an audit trail of the people who had assembled and checked each compliance pack. But a brief description of each medicine contained within the compliance packs wasn't always provided. And patient information leaflets weren't given on every occasion. So, people sometimes didn't have all the information they needed to make sure they took their medicines safely. Members of the pharmacy team knew that women or girls able to have children mustn't take valproate unless there was a pregnancy prevention programme in place. They knew that people in this at-risk group who were prescribed valproate needed to be counselled on its contraindications. And they had access to the valproate educational materials they needed.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices in their original manufacturer's packaging. But some loose blister strips and unlabelled medicines found on the shelves were removed and disposed of during the inspection. Team members were required to check the expiry dates of medicines regularly and before they dispensed them. And they marked products which were soon to expire. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy had a book to record the destruction of the CDs that people returned to it. But the pharmacy team didn't always record what was returned to the pharmacy when it was received as required by the SOPs. The RP made sure the patient-returned CDs found during the inspection were recorded. The pharmacy kept out-of-date and patient-returned CDs separate from in-date stock. The pharmacy had procedures for the handling and disposal of its out-of-date stock and the unwanted medicines people brought back to it. And these

medicines were generally disposed of appropriately or were kept separate from the pharmacy's in-date stock. But the pharmacy team had allowed these unwanted medicines and out-of-date stock to build up. And hadn't sorted and separated these products into the appropriate pharmaceutical waste bin for a while. The pharmacist owner gave assurances that the pharmacy team would promptly deal with these after the inspection. The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they took and what records they made when they received a drug alert.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide its services safely. And its team makes sure the equipment it uses is clean.

### Inspector's evidence

The pharmacy had several glass measures to measure out liquids. And it had equipment for counting loose tablets and capsules too. Members of the pharmacy team made sure they cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had a medical refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the refrigerator's maximum and minimum temperatures. The pharmacy recently replaced the monitor its team used to check a person's blood pressure. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. But its team could do more to make sure their NHS smartcards were stored securely when they weren't working.

### 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.  |