

Registered pharmacy inspection report

Pharmacy Name: Thames Pharmacy, Farnham Road Surgery, 301
Farnham Road, Slough, SL2 1HD

Pharmacy reference: 1111526

Type of pharmacy: Community

Date of inspection: 02/07/2024

Pharmacy context

This pharmacy is situated in a medical centre in a residential area on the outskirts of Slough. Most people who use the pharmacy are from the local area and a home delivery service is available. The pharmacy is open extended hours over seven days. It mainly dispenses NHS prescriptions, and it provides other NHS funded services including the Pharmacy First service. The pharmacy supplies some medicines in multi-compartment compliance packs to help support people to take their medicines at the right time. And it sells a small range of over-the-counter 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
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 keeps the records it needs to by law, and it protects people's personal information. The pharmacy has some written procedures to make sure the team members know what is expected of them. Its team members record their mistakes so that they can learn from them. And they take action to try and stop the same sort of mistakes from happening again. Team members understand their responsibilities in safeguarding children and vulnerable people.

Inspector's evidence

The pharmacy changed ownership in April 2023. The superintendent had implemented standard operating procedures (SOPs) when first taking over the role, and the SOPs had been reviewed by the pharmacy manager again earlier in the year. SOPs were available as paper versions in the pharmacy. The SOPs covered the pharmacy's main activities and working processes although a few SOPs appeared to be missing. For example, SOPs covering dispensing processes and assembly of compliance packs. Most of the team members had signed and dated signature sheets to show they had read and agreed the SOPs, although one of the newer team members had not yet done this. But she had been given verbal instructions and she was able to explain some of the pharmacy's systems and processes.

Team members could explain their roles and they worked under the supervision of the pharmacist. A responsible pharmacist (RP) notice was displayed near to the medicines counter. The pharmacy's professional indemnity insurance was provided by a recognised insurer and a copy of the certificate was displayed on a notice board in the waiting area.

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. Records seen included some recent entries. Dispensing errors were reported on the national reporting system. The pharmacist explained how they discussed any mistakes or incidents with team members to identify any contributing factors and promote learning. Records available highlighted some learning points although the level of details was sometimes lacking. The pharmacist said the superintendent reviewed near miss records each month to identify any common trends which were shared with the team. Shelf markers were used to highlight some common picking errors.

The pharmacy had a complaints procedure which was explained in a SOP. A notice was displayed advising people how to report a concern or provide feedback to the pharmacy. The pharmacist explained that most issues were resolved at the time, but anything more serious was reported to the pharmacy manager and superintendent to deal with.

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. Records were generally in order, but private records did not always include the prescriber's details and some specials record had information missing. CD registers were well maintained. One CD balance checked was found to match the quantity in stock. And all CD register balances were audited regularly. The methadone liquid registers were

audited daily. 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. The new starter confirmed that she completed training on this, and staff signed a confidentiality clause when commencing employment. Dispensary staff had individual NHS smartcards for accessing personal data. Confidential paper waste was separated and shredded. Other confidential material was stored out of public view. The pharmacist was level three safeguarding accredited. Team members had completed eLearning on safeguarding, so they knew what signs to look for and how to report any concerns. The pharmacy had a chaperone policy, and this was displayed on the waiting area notice board.

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 for their roles, and they can access additional training resources to help keep their knowledge up to date. Pharmacy team members work well together, and they are comfortable discussing issues and providing feedback to the pharmacists.

Inspector's evidence

The team members present included the RP who was a regular locum, and three dispensers. A foundation pharmacist arrived towards the end of the inspection. The dispensers all worked part-time. Pharmacist duties over the week were shared between the pharmacy manager, the superintendent pharmacist and the locum pharmacist. The RP usually worked whole day shifts. The pharmacy closed for an hour at lunchtime so they could take a rest break without interruptions. The pharmacy also employed a part-time delivery driver and two other part-time team members who worked as dispensers. Another dispenser had recently left employment. The pharmacy was in the process of recruiting a replacement dispenser or pharmacy technician, as well as an additional medicines counter assistant. The pharmacist felt the recent staffing changes hadn't impacted on the team too much as a couple of the team members worked extra hours when needed. Holidays were planned so not more than one team member was away at a time, and the pharmacy had a contingency plan for unexpected closures or service delays.

The pharmacy was busy and there was a steady stream of people presenting to collect their dispensed prescriptions. The team members worked well together to manage the workload. They felt they could discuss issues or concerns with any of the pharmacists. The pharmacy had a whistleblowing policy so staff knew how to raise concerns externally, however this could not be located during the inspection. No formal targets were set for the team and the pharmacist was not under any pressure to provide services.

Pharmacists were accredited to provide other services and could supply medicines as part of the NHS Pharmacy First service under patient group directions (PGDs). The foundation pharmacist felt his experience at the pharmacy was positive and he felt well supported. One of the dispensers had completed her training under the previous owner. The other two dispensers, including one who was a pharmacy undergraduate, were enrolled on a combined medicines counter and dispensing assistant's course. Team members completed additional eLearning modules to help to keep their knowledge up to date, but comprehensive training records were not available. The superintendent pharmacist subsequently confirmed that all team members had completed or were enrolled on training courses relevant to their roles.

Principle 3 - Premises ✓ Standards met

Summary findings

Overall, the pharmacy premises is suitable for the services it provides. But the lack of space and poor layout means that some areas of the pharmacy are less well organised. This detracts from the professional image of the pharmacy and may affect the working environment.

Inspector's evidence

The pharmacy had a separate entrance to the medical centre, as it was sometimes open when the medical centre was closed. There was a very small pharmacy reception area with some seating and a counter. When the pharmacy was open in the evenings during winter months when it was dark, the team sometimes used a hatch from the dispensary to serve people as a security measure.

The counter restricted access to the dispensary which occupied the remainder of the registered area. Lighting in the dispensary was adequate, and the room temperature was controlled using a portable air conditioning unit. The dispensary was long and narrow. It had three sections which created more bench and storage space. Team members did their best to make sure they worked in a safe environment. But the pharmacy generally lacked space considering the volume of work and some areas were cluttered and untidy. Fixtures and fittings were worn in places. The dispensary sink was clean but stained. Unused shop fittings had been left on the front counter which presented a hazard. These factors detracted from the professional image.

The lack of space and the layout of the counter was not conducive to confidential conversations. A small consultation room was available for private discussions and provision of other services. The consultation room lighting was dim, and it was cluttered so it wasn't a particularly welcoming space. And the room wasn't big enough to accommodate a wheelchair or buggy. The pharmacist said they used one of the medical centre rooms if necessary. For example, when conducting Pharmacy First consultations. Consultation facilities weren't obviously promoted, so people may not be aware of this option. Team members used the medical centre's staff facilities as the pharmacy didn't have any of its own.

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 was open extended hours over seven days. There was a ramp from the medical centre car park to the pharmacy entrance and a non-automated door. The pharmacy could be accessed from the medical centre if needed but the shutter between the two premises was usually closed. The external hatch could be used if people preferred or they couldn't easily access the premise, and a home delivery service was available. There was a notice board in the reception/ waiting area and some health promotion resources.

The team dispensed of mixture of walk-in and repeat electronic prescriptions. The pharmacy managed repeat prescriptions for some people. The pharmacy's PMR system was linked to the medical centre's system which facilitated this process. Dispensed medicines were appropriately labelled, and patient leaflets were routinely supplied. Interventions were recorded on the PMR.

A number of people received their medicines in weekly compliance packs. Each person had a record showing how packs should be assembled and noting medication changes and preferences. Packs were usually assembled during quieter periods in the rear part of the dispensary away from distractions. Assembled packs were suitably labelled.

The pharmacy supplied regular instalment prescriptions to some people who use drugs. Pharmacists managed this service and worked closely with the local drug and alcohol team.

The team members were aware of the Pregnancy Prevention Programme for people at risk taking valproate containing medicines and the associated dispensing requirements. Stickers were used to highlight prescriptions for higher risk medicines so extra checks could be completed. The delivery driver used a handheld device to record deliveries. This meant team members could easily confirm the status of deliveries on the system if needed. A form with additional information was completed when CDs were delivered, and a signature was obtained as proof of delivery.

The regular pharmacists were all accredited to provide the NHS services including the Pharmacy First service so this could be offered without interruptions. The pharmacy had good working relationship with the medical centre. Medical centre staff often referred people with minor ailments to the pharmacy in the first instance. A folder with the different protocols and patient group directions was available for reference. The pharmacy also offered the NHS hypertension case finding service and the New Medicine Service.

Medicines were sourced from licensed wholesalers and suppliers. The pharmacy had a large stock holding. Medicines were stored in the dispensary on open shelves. Shelves were muddled and untidy in

places. 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 team completed medicine stock expiry date checks periodically, and checks were documented. A random check of the dispensary shelves found no expired items. But a few medicines were not stored in original packs. The expiry date had been written on some of the containers, but batch numbers were not always included. And some uncollected medicines had been returned to stock which had not been properly assessed as suitable for reuse. They included mixed batches and foil off cuts without sufficient batch and expiry details. These items were removed for disposal and the pharmacist agreed to remind team members of the labelling requirements and check the remaining stock for other medicines which may not be suitable for use.

Pharmacy medicines were stored behind the counter. One of the team members explained how she handled requests for over-the counter medicines to make sure the medicine was suitable for the person. She knew what questions to ask and when to refer to the pharmacist. She was aware of the restrictions on codeine containing medicines and which medicines were considered higher risk. Drug and device alerts and recalls were received by email and actioned by the pharmacist. A record was kept showing these had been actioned.

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. A couple of cylinders were made of plastic, and they did not appear to be standardised measures. The pharmacist agreed to discuss this with the pharmacy manager and replace them with appropriate glass British Standard approved measures.

Equipment for provision of additional services was available including blood pressure meters and an otoscope. The pharmacy's computer systems were password protected. There were three PMR terminals in the dispensary and a laptop could be used to access the system and make records in the consultation room. The pharmacy's paper shredder was not working, and a replacement was being sourced. But all other electrical equipment appeared to be in working order.

Two CD cabinets 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.