General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Oxford Road Pharmacy, 270-274 Oxford Road, READING, RG30 1AD

Pharmacy reference: 1121905

Type of pharmacy: Community

Date of inspection: 27/06/2024

Pharmacy context

This is an independent community pharmacy. It is on a parade of local shops and businesses in Reading. 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. The pharmacy supplies medicines in multi-compartment compliance packs for people living at home who have difficulty taking their medicines. And it offers a seasonal flu vaccination service. And the NHS Pharmacy First service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.1	Standard not met	The pharmacy runs it services with several team members who have not had any training on a recognised training course.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy has a range of medicines for dispensing which have not been properly labelled and packaged. And so, there is a risk that these medicines may not be of the appropriate quality.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy adequately identifies and manages the risks associated with all its services. It has insurance to cover its services. And in general, 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 suitably. The pharmacy has written procedures in place to help ensure that its team members work safely. But it does not ensure that its team members read them so that they can follow them properly.

Inspector's evidence

The pharmacy had a system for recording its 'near miss' mistakes and errors. But the responsible pharmacist (RP), who was also the superintendent (SI), could not locate the records when the inspector first requested them. Once the records were found they showed that team members had not recorded any mistakes over the previous six months. The pharmacy had been extended and refurbished during this time. And the disruption had caused the team to fall behind with some of its day-to-day tasks such as recording near misses. And formally reviewing them. During its refurbishment, the pharmacy had installed a dispensing robot. And it used the robot for storing and dispensing most of its medicines. The robot used a highly automated barcode recognition system which was used for checking in and picking medicines. The robot dispensed full packs of medicines only. And so, split pack quantities had to be dispensed manually. And the remaining quantities from the split packs were stored separately in the dispensary. The pharmacy installed the robot to make its dispensing process efficient. And to reduce the risk of picking the wrong item. Since installing the robot, the team had not made many mistakes. But occasionally there had been mistakes with the quantity dispensed, or when a team member had manually input the wrong information into the system. The robot was linked to the pharmacy's electronic stock management system and its patient medication record system (PMR). It identified which medicine to pick from the label information which staff entered onto the PMR. And it used bar code recognition to pick the right one. It then passed the medicine down one of several chutes next to the appropriate workstation. The team member collected it, checked it and completed the dispensing process, before setting it aside for a final accuracy check. The team found that the robot had reduced the number of mistakes it made for the items stored in it. But the RP SI agreed that it was important to keep a record of any mistakes team members made. This was to help them identify what they could do differently to improve the safety of their procedures. He also agreed that keeping records would provide a more robust way for the team to reflect on any repeated mistakes and learn from them.

The pharmacy had a set of standard operating procedures (SOPs) to follow. Established team members had read the existing SOPs relevant to their roles. But newer team members had not. The RP SI agreed that the team may benefit if all its members had read the SOPs most relevant to their training. And he agreed that SOPs should also be read after something had gone wrong. The technician had worked at the pharmacy for several years. And was an established member of the team. And she consulted the RP SI when she needed his advice and expertise. Team members asked appropriate questions before handing people's prescription medicines to them. Or selling a pharmacy medicine. They did this to ensure that people got the right advice about their medicines. They were observed to attend to their allocated tasks, prioritising the most urgent prescriptions and using the pharmacy's PMR system competently. The RP SI had placed his RP notice on display where people could see it. The notice showed 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 also had a complaints procedure to follow. And the team could provide people with details of where they should register a complaint if they needed to. 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. Before the pharmacy had been upgraded, people had been unhappy that it had taken team members too long to locate their prescriptions. So, to help address this the owners had introduced an improved PMR system. The new system used a sophisticated bar-code cross checking tool which the team used to locate where a prescription was stored or where it was in the dispensing process. The system also gave times at which prescriptions were received, downloaded, dispensed and stored ready for collection. And since using it waiting times had reduced. Staff could now locate the prescriptions and update people on their progress more easily. 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 generally kept its records in the way it was meant to. And RP records were complete and in order. The pharmacy kept records of emergency supplies. But it did not always record a clear reason for making the supply as required by law. The pharmacy generally kept its private prescription records properly. The pharmacy kept its controlled drug (CD) registers in order. And it had records of people's CDs which had been returned to the pharmacy for safe destruction. The RP recognised that the pharmacy should ensure that all its essential records are complete and up to date. The pharmacy's team members understood the need to protect people's confidentiality. Established, trained team members had completed formal training. And newer team members had been briefed. Confidential paper waste was discarded into separate waste containers. And it was collected for confidential disposal by an appropriately licensed waste contractor. People's personal information, including their prescription details, were generally kept out of public view. The RP SI and the technician had completed appropriate safeguarding training. Other team members had been briefed although had not yet had any formal training. The RP SI agreed that team members should be appropriately trained. And they should understand the pharmacy's safeguarding responsibilities. The team could access details for the relevant safeguarding authorities online.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has not properly trained all its team members. And so, it does not have enough suitably trained and skilled team members for the tasks it carries out. Team members generally manage the workload adequately. And they support one another. They are comfortable about providing feedback to one another, so that they can improve the pharmacy's services.

Inspector's evidence

On the day of the inspection the SI RP worked with a trainee pharmacist, a technician, four trainee dispensing assistants (DAs). two trainee medicines counter assistants (MCAs). And an administrative assistant. A school student completing work experience worked on the shop floor. The pharmacy also had a business manager and a pharmacy manager present. The managers did not get involved in any dispensing activity. Three of the trainee DAs had worked at the pharmacy for more than three months but had not begun any formal training on a recognised training course. This included an overseas pharmacist. The fourth trainee DA had been employed for approximately two weeks and was working a probationary period. The inspector learned that a further three part-time trainee DAs, who were not present during the inspection, had also not started any formal training. And neither of the trainee MCAs present had begun any formal training.

The team attended promptly to people at the counter. And they supported one another, assisting each other when required. The team had the daily workload of prescriptions in hand. And while it tried to keep on top of its other responsibilities. It had fallen behind with some of its tasks since the refurbishment. Team members assisted each other when needed. And together they dealt with queries promptly. They described how they had regular one-to-one meetings with the RP SI or the managers as appropriate. And they discussed their work performance. They could raise concerns during these meetings. But in general, they discussed issues as they worked day-to-day. They described feeling supported in their work. And they could make suggestions about how to improve the general workflow. They could also raise concerns with the RP SI if they needed to. The SI was the regular RP. The technician worked alongside the RP SI, and she could discuss issues with him. And she felt supported by him. The RP SI was able to make day-to-day professional decisions in the interest of people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an environment which is adequate for people to receive its services. And they are sufficiently clean, tidy and secure.

Inspector's evidence

The pharmacy was on a small parade of shops serving the local community. It had a spacious layout due to its recent extension. The inspector discussed the new layout with the RP SI and the business manager. And it was agreed that they would inform the GPhC of the new layout and take advice about any impact this may have on the pharmacy's registered address. The pharmacy had installed its robot in the newly extended area. The pharmacy was clean, tidy and well maintained. And it was bright, well-lit and modern looking. The pharmacy had a part-time cleaner who cleaned floors, staff areas and worksurfaces. And team members also cleaned the pharmacy's worksurfaces regularly. The pharmacy had seating for waiting customers. It also had a consultation room with good access for people to have a private conversation if needed. The room was generally tidy and clutter free which allowed for the safe provision of the pharmacy's services.

The pharmacy had a medicines counter. And it kept its pharmacy medicines behind the counter. It also had a spacious dispensary. The accuracy checking area faced the retail space and the back of the medicines counter, so that team members could see people waiting. The dispensary occupied three distinct areas. The front facing area of the dispensary had dispensing benches on two sides and a central island. And it had storage facilities above and below the benches. The area to the rear had a second island and was often used for administrative tasks, including processing prescriptions at the end of the month. The pharmacy also had additional storage in this area. And a staff room and staff facilities. The largest area of the dispensary was the area occupied by the robot. The robot took up a significant proportion of the space here, which included its work surfaces and additional storage. It also had work benches and storage areas around the robot.

The pharmacy's extension and refurbishment included the development of a suite of consultation rooms on the first floor. The rooms were not yet in use. But the pharmacy owners hoped to offer a range of services related to health and wellbeing from the rooms. Including services delivered by other healthcare professionals. Pharmacists often used the single consultation room on the ground floor for private consultations with people. The pharmacy had air conditioning and heating systems. And at the time of the inspection the working temperature was comfortable and suitable for the storage of medicines.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not do enough to ensure that it keeps all its medicines for dispensing in appropriately labelled packaging. In general, the pharmacy stores its medicines properly. And it generally makes all 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 makes its services accessible for people. And it gets its medicines and medical devices from appropriate sources.

Inspector's evidence

The pharmacy had step-free access. And its customer area was generally free of clutter and unnecessary obstacles. It had a delivery service for people who found it difficult to visit the pharmacy. And it could also order people's repeat prescriptions for them if necessary. The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. And to prevent errors. It provided medicines in multi-compartment compliance packs for people living at home who needed them. The packs were assembled at another of the owner's pharmacies nearby. The pharmacy labelled its compliance packs with directions which gave the required advisory information to help people take their medicines properly. And a description of each medicine, including colour and shape, to help people to identify them. It supplied patient information leaflets (PILs) with new medicines. But it did not supply them routinely with repeat medicines. The inspector and RP SI discussed the importance of ensuring that people were given a PIL each time to ensure they had the additional manufacturers' information about the medicines they were taking. The pharmacy supplied methadone to people through its participation in local substance misuse services.

The RP gave people advice on a range of matters. And he would give appropriate advice to anyone taking high-risk medicines. The pharmacy had a small number of people taking sodium valproate medicines, none of whom were in the at-risk group. The RP was aware of the precautions he would need to take, and counselling he should give, if it were to be prescribed for someone new. He described how the pharmacy supplied valproate medicines in the manufacturer's original packs in line with up-to-date guidance. And team members were aware of the need to supply the appropriate warning leaflets and cards each time. 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 sore throats. The pharmacist had the appropriate protocols to follow. And he kept the necessary records for each supply. It was clear that he understood the limitations of the service and when to refer people to an alternative health professional.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team generally stored its medicines appropriately and in their original containers. But the inspector found many containers of tablets which were inadequately labelled. The team explained that many of these containers came from items prescribed and dispensed as split pack quantities. And after they had remained uncollected by people, the team had put them back into stock. And so, a significant number did not have necessary manufacturer's information such as batch number and expiry date. This increased the risk that the contents could not be properly identified. The inspector discussed this with

the RP. And while the containers had been stored separately to original packs, it was agreed that team members should review their understanding of the correct procedures to follow when dispensing a split-pack of medicines. And when putting medicines back into stock after dispensing. And after clearing uncollected prescriptions from shelves.

The pharmacy's robot checked the expiry dates on medicines through its bar code checking system. And team members checked the expiry dates of its other medicines and devices periodically. But its records were not robust enough to identify which medicines were short dated. Including those in split packs. And uncollected, previously dispensed medicines. This posed a risk that medicines due to expire soon were not taken out of stock. The pharmacy team members explained that they highlighted any short-dated stock when they found it. So that it could be easily identified during the dispensing process. The RP SI agreed that the team should conduct a full date check of all stocks as soon as possible. And keep a full audit trail. Where appropriate, the team recorded the date of opening on liquid medicines. But it did not always discard them within an appropriate time. But team members described how they checked expiry dates when they dispensed, and accuracy checked every medicine to ensure that the medicines they supplied were in date. The team put its out-of-date and patient-returned medicines into dedicated waste containers.

The team generally stored its CD items appropriately. And it had a fridge for storing its fridge items. It recorded fridge temperatures daily. But it did not fully reset the thermometer after the reading had been taken. And so, the records it kept did not accurately reflect the daily temperature range. The inspector discussed this with the team who agreed that all appropriate dispensing team members should be re-trained on how to read the maximum and minimum temperatures on the fridge thermometer. And on how to reset it every time a reading is taken. The team understood that keeping accurate records of fridge temperatures would ensure that they could monitor fridge temperatures properly and provide assurance that the medicines within it were being stored appropriately. The pharmacy responded promptly to drug recalls and safety alerts. And it kept records of these. 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. 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 team members had access to a range of up-to-date reputable reference sources. It had enough computer terminals in its dispensary. And it had a computer in the main consultation room. Computers were password protected. And were not in people's view. Team members had their own smart cards. But occasionally they shared each other's although they understood the importance of using their own smart cards to maintain an accurate audit trail. And to ensure that they had the appropriate level of access to records for their job roles. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in shelves which were out of people's view.

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.