

# Registered pharmacy inspection report

**Pharmacy Name:** Festival Pharmaceutical Services, Richfield Avenue,  
READING, Berkshire, RG1 8BD

**Pharmacy reference:** 1124585

**Type of pharmacy:** Festival / Temporary

**Date of inspection:** 21/08/2023

## Pharmacy context

The pharmacy's owner provides a temporary pharmacy service at various music festivals throughout the UK. And so, this pharmacy operates during the Reading festival only. In 2023 the pharmacy is open around the clock from midday on Wednesday 23 August until midday on Monday 28 August. The pharmacy is in a portacabin in the field medical and wellbeing centre at the festival. It dispenses private prescriptions written by healthcare professionals at the medical centre and by in-house pharmacist independent prescribers. And it sells medicines for a range of common ailments. Most of the prescriptions it dispenses are for people who need short-term treatment such as antibiotics or emergency hormonal contraception (EHC). And for people who may not have their regular medicines with them. Approximately 100,00 people attend the festival each year.

## 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	1.1	Good practice	The pharmacy has good systems in place to deliver its services safely and effectively. It works collaboratively within its own team and with other healthcare professionals to identify and minimise the risks associated with its services.
		1.8	Good practice	The pharmacy team works well with other healthcare professionals to ensure that people are properly safeguarded. And it ensures that their health and wellbeing are well cared for.
<b>2. Staff</b>	Standards met	2.2	Good practice	The pharmacy trains its team members in advance. It does this in a way that ensures they are well prepared for the work they do.
		2.5	Good practice	The pharmacy's team members are encouraged to give feedback about the quality of the pharmacy's services. And they are comfortable about raising concerns and discussing issues to develop services and improve them in the future.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	4.1	Good practice	The pharmacy promotes its services well. And it makes sure that everyone can access them. The team works well with other healthcare professionals to ensure that people get the most appropriate care.
		4.2	Good practice	The pharmacy's systems and procedures ensure that people routinely get medicines which are safe and appropriate for them.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy provides its services safely and effectively. It has good systems in place to identify and manage the risks associated with its services. Pharmacy team members analyse the cause of any incidents and errors made. And they share learnings with the wider team and other healthcare professionals they are working closely with. The pharmacy has written procedures in place to help ensure that its team members work safely. And these procedures are reviewed and updated regularly. The pharmacy proactively asks people for their feedback on its services and responds appropriately. It has the required insurance in place to cover its services. And it keeps all the records required by law. The pharmacy keeps people's private information safe. The pharmacy offers good advice to people to help keep themselves safe at the festival. And they refer people to other healthcare services for a wide range of support when a need is identified.

### Inspector's evidence

The pharmacy had robust processes in place to identify, manage and reduce its risks. It had standard operating procedures (SOPs) in place. And the company owner, who was also a pharmacist had reviewed each SOP earlier in the year before the festival season began to ensure they were still appropriate. Each team member had been sent copies of SOPs in advance of the festival, so they had time to read and understand them. The owner also printed the SOPs out and stored them in a folder for team members to refer to if they needed to. Team members had all worked at the festival sites before. And they understood their job roles. The pharmacy had risk assessments in place to cover its activities.

The pharmacy had a system in place for recording its mistakes. And it analysed any incidents or mistakes made during the dispensing process in depth. The owner described how individual pharmacists highlighted and discussed 'near misses' and errors as soon as possible within the team on duty to help prevent the same mistake from happening again. And they were also discussed with all team members at a future date, so that they could take robust follow up action to prevent a reoccurrence at this and any future festivals. The company carried out a full review of all services provided at the end of the festival. And it circulated the outcomes to all team members who had worked at the pharmacy. Following a review of the previous year's festivals, the company sent the pharmacy's SOPs to all team members electronically, in advance of the opening date. This had allowed them to monitor whether each team member had read and understood them in advance and to answer any queries they had.

The pharmacy team worked closely with a range of other healthcare professionals at the field medical centre. And they openly shared and contributed to learnings from any incidents. The pharmacy had a documented procedure in place for handling complaints. They were dealt with by the pharmacists on duty and escalated to the company owner as needed. The pharmacy proactively sought feedback from people accessing its services. Team members asked people waiting in the queue for their feedback and responded appropriately. All team members were asked to give feedback about their experiences of working at the pharmacy when the festival was over. The company then reviewed all this feedback to inform any changes which may be beneficial at future festivals. The pharmacy kept a record of who had acted as the responsible pharmacist (RP) for each shift. And displayed the correct RP notice.

The pharmacy's records were not available at the time of the inspection when services were not in full

operation. But the company generally kept its pharmacies records in the way it was meant to, including their controlled drugs (CD) register and their RP records. The pharmacy maintained and audited its CD running balances. It completed running balance checks before and after each festival. And it rectified any discrepancies promptly. The pharmacy had a register for patient-returned CDs. So that it could account for the receipt and destruction of patient-returned CD medicines. But it rarely received any. The pharmacy also kept appropriate records of its private prescriptions on its electronic patient medication record (PMR) system. And it kept appropriate records of its emergency supplies, although it had not had many emergency supplies to record. People who forgot their medicines would often be prescribed with what they needed rather than receiving an emergency supply.

All team members had completed training on information governance and general data protection regulations. The pharmacy team shredded its confidential paper waste. And it worked with online systems which had been encrypted. People did not generally enter the pharmacy, so people's prescription details could be kept secure.

All team members had been trained to an appropriate level on safeguarding. Every pharmacist had completed the Centre for Postgraduate Pharmacy Education (CPPE) level 2 safeguarding training. The pharmacy worked closely with the field medical centre safeguarding team. And the welfare team. Both teams were easily accessible and available to provide any required support. The pharmacy generally displayed a range of posters giving information about how people could protect themselves at the festival. And team members referred people to other healthcare providers, such as mental health support, when needed. The pharmacy also had the contact details of other support agencies and hospitals off site and referred people to them if needed.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough trained and skilled team members for its workload. And it is good in the way it trains them for the tasks they carry out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's service.

### Inspector's evidence

The pharmacy was one of two operating at Reading festival. And the sole owner of this pharmacy was the principal company director of the other. Both companies employed a total of approximately 50 pharmacists. And a number of pharmacy technicians, dispensers and administrative team members. During the festival, a team of around 30 of these pharmacists and a registered technician covered shifts at both on site pharmacies from the Wednesday to the following Monday.

Each team member was given a full induction before starting work. The owner sent the SOPs electronically to them in advance. And they were required to confirm that they had read and understood them. The company ran a training session prior to opening to ensure all team members knew how to operate the PMR system and other technology. Pharmacists generally worked two eight-hour shifts over the course of the festival. A pharmacist independent prescriber was generally allocated to work on each shift. In total, there were usually between two and five team members on duty for each shift. But this could be varied as needed. The number of staff allocated to each shift had been based on previous experience at this and other festivals. So that the workload could be managed comfortably. At each shift changeover, the pharmacy had a handover meeting to ensure the new team were aware of any issues.

Team members were encouraged to give ad hoc feedback about how the pharmacy operated. And their opinions and suggestions were well received by the company. The team worked well together and individuals supported each other. They were asked to give feedback about their experiences after the festival to see how operations could be improved in the future.

The pharmacy had systems for staff to raise concerns. And it did not put under any pressure on them to complete tasks that they were not comfortable with. For example, independent prescribers were strongly encouraged to only prescribe within their scope of practice. Team members could make day-to-day professional decisions in the interest of patients and did not have any targets to meet.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises present a professional image to people and are properly maintained. The pharmacy has appropriate facilities to provide its services and protect people's privacy and confidentiality.

### Inspector's evidence

The pharmacy was a purpose built portacabin in the field medical centre at Reading Festival. It was situated next to the large tent structure which comprised the main medical centre. The company had completed a health and safety audit and risk assessment prior to opening. The public could not enter the pharmacy and were served through a hatch. The portacabin had a narrow gated-off walkway down one side, where people could talk more privately with a team member if they needed to. Team members could also use a consulting space in the field hospital to have conversations with people if needed.

The pharmacy was clean and hygienic. And photographs showed that when completed it would have a run of shelving and workbench space to provide sufficient workspace. Team members were required to clean the premises regularly throughout the day. The pharmacy had an external sink which was out of public access and kept under cover. This too was cleaned regularly.

The premises had adequate heating, lighting and ventilation. And air temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines. The team also had access to an air-conditioning unit for warmer days. The pharmacy stored its medicines in a tidy, organised and secure way. And it kept people's information safe.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides its services safely. And it makes them easily accessible for everyone. And it ensures that the medicines it supplies are suitable for people. The pharmacy gets its medicines and medical devices from appropriate sources. And it makes 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 stores its medicines properly.

### Inspector's evidence

The pharmacy advertised the availability of its services around the festival site. And pre-event information sent to festival goers contained details of how to access pharmacy services. Festival staff could assist people with mobility issues who needed access to pharmacy services. And they transported people to the pharmacy and other festival medical services when needed. The pharmacy produced large print labels for people who were visually impaired. And it displayed posters with information to help people remain safe and well whilst at the pharmacy.

The pharmacy dispensed private prescriptions which had been written by either healthcare professionals from the medical centre or by pharmacist independent prescribers (PIPs) at the pharmacy. Each prescription was accompanied by two copies. The pharmacy kept the original prescription as required by law. The prescriber kept one copy with the patient's notes and gave the remaining copy to the patient. The team advised people to take their copy to their GP, so that the information could be added to their patient records. But it currently did not routinely share prescription information directly with people's GPs. Instead relying on the patient to do this themselves. The pharmacy kept a list of all the medical prescribers' details and signatures for reference.

The pharmacy did not have an NHS contract and could not access the NHS spine. If people requested a prescription for a regular medication that they had forgotten to bring or misplaced, the pharmacy required evidence of prescribing. It usually did this by asking people to produce their prescription details on their NHS app. Occasionally the pharmacy dispensed prescriptions which people brought with them, but as it could not dispense NHS prescriptions. It converted them to private prescriptions where appropriate. And it supplied the medicines that way. The PIPs did not issue prescriptions for CDs or high-risk medicines. Any requests for these were referred to the field hospital. PIPs ensured that they prescribed within their scope of practice. Most requests were for medicines such as inhalers, blood pressure medicines, anti-depressants and antibiotics. The festival's medical services also had an onsite microbiologist who could make appropriate checks for someone requiring treatment for an apparent urinary tract infection. This was to ensure that a supply of antibiotics was appropriate or refer them for the most appropriate treatment.

The pharmacy team gave additional advice to people receiving higher-risk medicines. It had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy gave appropriate advice and counselling to ensure that anyone in the at-risk group taking the medicine understood the risks associated with it. And to ensure they were on a pregnancy prevention programme (PPP). Team members supplied the appropriate leaflets and warning cards each time. This included supplies of split packs where smaller quantities had to be removed from their original packaging. The pharmacy team took care not to apply labels over the warning cards on the boxes of

valproate products when dispensing. The pharmacy had a clear flow to ensure prescriptions were dispensed safely. Each dispensed item was checked by a pharmacist and the labels initialled to create an audit trail.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. It generally stored its medicines appropriately and in their original containers. And it date-checked its stock prior to the pharmacy opening. The pharmacy had agreed an extensive formulary with the field medical prescribers. So, this meant that it generally had the medicines they prescribed in stock. And the team's experience from previous years meant that they knew what items to keep in stock and in what quantities. But if a medicine was not in stock, the pharmacy could order it from the wholesaler for next day delivery. They could order up until Friday evening for delivery on the Saturday.

The pharmacy stored items in a CD cabinet and fridge as appropriate. And it monitored its fridge temperatures to ensure that it kept the medication inside within the correct temperature range. It ensured that it stored its CDs as required by law by storing them in a certified cabinet that had prior approval from the local police force. The pharmacy kept a core range of medicines that could be purchased over the counter. The pharmacy team checked weather forecasts in advance to see what type of medicines would be requested to ensure they had adequate supplies. The pharmacy also held supplies of antihistamines, condoms and emergency contraceptives. The pharmacy responded promptly to drug recalls and safety alerts. But it 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 pharmacy 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 it kept this equipment clean. The pharmacy had up-to-date reference resources available including the British National Formulary (BNF). But team members generally had the BNF 'app' on their smartphones for easy reference. The pharmacy had a good internet connection. So, team members had access to the internet to support them in obtaining up-to-date, reputable information. The pharmacy stored people's prescriptions out of view from any visitors to the pharmacy. And it had sufficient computer terminals for its workstations. The pharmacy's computer system was password protected. And information displayed on computer monitors was suitably protected from unauthorised 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.