General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Southcote Pharmacy, 34-36 Coronation Square, Reading, Berkshire, RG30 3QN

Pharmacy reference: 9012409

Type of pharmacy: Community

Date of inspection: 07/11/2024

Pharmacy context

This is an independently owned community pharmacy. The pharmacy is in a small local shopping centre alongside other shops and businesses. It provides a prescription dispensing service. And it supplies medicines in multi-compartment compliance packs to people who need them. The pharmacy has a selection of over-the-counter medicines and other pharmacy related products for sale. And it provides the NHS Pharmacy First service, a flu vaccination service and a travel vaccination 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 adequate 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 well. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

Inspector's evidence

Approximately six months prior to the inspection the pharmacy had extended its premises into the retail unit next door and the whole premises had been refurbished. The new layout provided much needed space for the team to work safely and efficiently. The pharmacy had introduced a new electronic patient medication record (PMR) system approximately two and a half years previously to improve the safety and effectiveness of its dispensing processes. The system used a highly automated Quick Response (QR) code recognition system which staff used to cross check medicines dispensed with their prescriptions. And it allowed a further barcode cross check between the bag label on dispensed prescriptions and the prescription itself. This helped ensure that the right medicines were given out to the right person. The team found that it had made significantly fewer mistakes since introducing the new system. Mistakes occasionally occurred if a team member put the wrong information into the system or when a split pack of medicine had accidentally been selected in place of a full one. The responsible pharmacist (RP) had worked at the pharmacy before and had been brought in to replace the regular pharmacist who had left at short notice the week before. The superintendent pharmacist (SI) was working alongside the RP on the day of the inspection to provide additional support. The RP and SI described how the system required the pharmacist to do an initial clinical check on all prescriptions as they came through. After completing the clinical check, the pharmacist would annotate the system to show that this had been done. The pharmacist would then either highlight the prescription to proceed through the dispensing process without further intervention from her or highlight it to show that her intervention was required at the final accuracy checking stage. This would usually happen for higher risk medicines such as controlled drugs (CDs), split packs and any items which did not have a QR code.

The RP and SI described how they generally highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistakes from happening again. The team did not appear to make many mistakes. And pharmacists felt that this was due to a combination of factors including the automated checks provided by the PMR system. And having enough trained staff and the additional support of the SI when needed. But occasionally mistakes happened if an item had been left out of someone's bag in error. And where a split pack had not been clearly marked to show they were not full. And when the incorrect information had been put into the system. Record keeping mistakes could also arise when pharmacists were not familiar with the system. Pharmacists reviewed the team's mistakes as they happened. And they reviewed them with the team each month, to raise awareness and reduce the risk of a reoccurrence. It was clear that the team acted in response to its mistakes. And it discussed what had gone wrong. The RP, SI and inspector discussed the detail of what the team recorded on its near miss records. And how records should show what its team members had learned and how they would improve further. A on-off mistake was picked up

during the inspection where data had been put into the system to show that four-month supply of lorazepam tablets were to be dispensed instead of a four-week supply. This was quickly corrected. And the individuals who had input the information and dispensed and checked the prescription were advised. They were then required to reflect on the incident and learn from it.

The pharmacy had a set of standard operating procedures (SOPs) for its team members to follow. The SI agreed that some of the older SOPs were due for a review. Team members had read them. And they appeared to understand and follow them. The dispensing assistant (DA) consulted the RP or SI when they needed their advice and expertise. And they 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. The DA was observed to attend to their allocated tasks, prioritising the most urgent prescriptions and using the pharmacy's patient medication record system (PMR) competently. The RP had placed her RP notice on display where people could see it. The notice showed her 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 did not receive many complaints. But it 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. 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 and SI commented that, at times, people were unhappy that their medicines were not available. These issues were often out of the pharmacy's control, as the problem often arose with medicines which were unavailable from the manufacturer. But the team worked closely with local surgeries to ensure that people did not go without essential medicines. It chased prescriptions up when there was a delay. And it arranged for alternatives when it received a prescription for an item it could not supply. It also tried to keep people's preferred brands of medicines in stock so that they did not have to wait while the team ordered them. 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 record, its private prescription records, its records for emergency supplies. And its controlled drug (CD) registers. It kept a record of its CD running balances. And a random sample of stock checked during the inspection matched the total recorded in the register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. The register was complete and up to date. It was clear that the team understood the importance of ensuring that all the pharmacy's essential records were in order.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They shredded any confidential paper waste as they worked. The team also kept people's personal information, including their prescription details, out of public view. Team members had completed appropriate safeguarding training. 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 had any concerns to report.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained and skilled team members for the tasks it carries 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 services.

Inspector's evidence

On the day of the inspection the RP and SI worked with the DA and a medicines counter assistant (MCA). Team members attended promptly to people at the counter. They were efficient and calm. And they supported one another, assisting each other when required. The team had the daily workload of prescriptions in hand. And it kept on top of its other tasks. And together they dealt with queries promptly. Team members had either completed an accredited course for their role or were in the process of completing one. The team appeared to be well led and well supported. And team members worked well together to keep on top of their dispensing tasks. At the same time, they dealt with people waiting for prescriptions or advice.

The MCA was observed asking people appropriate questions when selling a cough mixture. And she assisted the dispensing team by being able to check if people’s prescriptions were at the pharmacy. And where they were in the dispensing process. Staff reported they were required to complete training on any new services, as well as health and safety. And any other company wide training. And they had recently trained on the winter flu vaccination service and the covid vaccination service, so that they could ensure that people who wanted to be vaccinated were eligible for it. Team members passed on information informally throughout the day. And a messaging service was used to share important information with the whole team and with the pharmacy’s two other branches. The SI described how she held whole team meetings when necessary. And on occasion they would close the pharmacy for a short period to complete any training or to share important information. The pharmacist was not set any business targets. And the pharmacy team felt comfortable to exercise their professional judgement to raise concerns if they needed to. Staff were aware of the whistleblowing policy and felt comfortable to use this if necessary. Team members had periodic appraisals about their work performance. But they discussed issues as they worked. 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 or SI if they needed to.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was in a square of shops and businesses serving the local community. It had a spacious customer area with seating for waiting customers. And three consultation rooms which were close to the waiting area. And so, it provided places for people to receive pharmacy services or have a private conversation with one of the pharmacists. The pharmacy planned to use the extra consultation rooms for additional, private services in the future. But it had not formalised this yet. The pharmacy also had a spacious dispensary. And four other stock storage areas and rooms. The pharmacy had a long pharmacy counter. And it kept its pharmacy medicines behind the counter. The area behind the counter opened into the dispensary for staff and authorised visitors. This provided easy access for staff retrieving prescriptions for people. The counter had been built with a lower level at one end suitable for wheelchair users.

The pharmacy had enough space for team members to dispense the pharmacy's multi-compartment compliance packs. And its other prescriptions. The dispensary had enough dispensing worksurfaces, with a long bench overlooking the retail space and the back of the medicines counter. And team members working here could see people waiting. It had a hatch at one end for people to receive supervised services or general counselling from the pharmacist when collecting their prescriptions. The dispensary also had two central islands. And further dispensing work surfaces in its additional rooms which were all used for the pharmacy's dispensing activities, including the dispensing of multi-compartment compliance packs. It had storage facilities above and below these work surfaces. The pharmacy had a cleaning routine. And it kept its worksurfaces tidy and organised. It cleaned its work surfaces and equipment regularly. Team members cleaned floors periodically and they kept them tidy. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. The pharmacy team gets its medicines and medical devices from appropriate sources. And in general, team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy generally ensures that all its medicines are stored correctly and safely.

Inspector's evidence

The pharmacy had information on its windows promoting its services. And its doorway had step-free access. Its customer area was free of unnecessary obstacles, making it suitable for people with mobility issues. The pharmacy could also order people's repeat prescriptions if required. And it had a delivery service. But the pharmacy tried to prioritise the service for people who were housebound. And had no other way of getting their medicines. The team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. It also supplied medicines against private prescriptions, some of which came from private online prescribing services.

The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. Prescriptions were processed by dispensing assistants after the pharmacist's clinical check. The pharmacist also provided a final accuracy check for this service. 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 team supplied compliance packs with patient information leaflets (PILs) with each month's supply. And it included the required British National Formulary (BNF) advisory information on compliance pack labels. So, people received the necessary information to help them to take their medicines properly. Compliance packs had also been labelled with a description of each medicine, including colour and shape, to help people to identify them. The inspector and SI discussed the importance of ensuring that descriptions given were accurate. Pharmacists gave people advice on a range of matters. And they would give appropriate advice to anyone taking higher-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. The pharmacy had a small number of people taking sodium valproate medicines. The RP understood that she must counsel people when supplying the medicine to ensure that they were aware of the risks associated with it. And to ensure they were on a pregnancy prevention programme as appropriate. The RP also knew to provide warning cards and information leaflets with each supply. And she was aware of the law about supplying valproate medicines in their original packs.

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. 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 service was proving popular with local people. The pharmacy also provided seasonal flu and covid vaccination services. Team members provided these services according to National Protocols. And they were only signed off as being able to deliver the service after receiving the

appropriate training. And then spending a day delivering the service under the supervision of the SI. This was to provide further assurance that they were competent to deliver the services safely.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. And the team stored its medicines, appropriately. And stock on the shelves was tidy and organised. Staff had reviewed their procedures for dispensing split packs to ensure they were clearly marked to show that they were not full. This was to prevent the team from supplying fewer than prescribed by mistake. The team generally stored its medicines in the manufacturer's original packaging. But it had some medicines which had been removed from the original packs. And they had not been labelled with all the manufacturer's details such as the batch numbers, product licence numbers and expiry dates. This meant that team members could not be sure that it would be appropriate to supply them. Staff had put these items back into stock after dispensing, when they had not been collected by people or when prescriptions requesting a split pack quantity had been dispensed. The inspector and RP discussed this. And the team agreed that all medicines should be stored in the manufacturer's original packaging where possible. And while this did not present a high risk of error, it may mean that the strips could be missed if subject to a recall or an expiry date check. The RP agreed that the team should review its understanding of the procedures to follow when putting medicines back into stock after dispensing.

The pharmacy checked the expiry dates of its stock, regularly. And team members reported that the PMR system electronically checked expiry dates when they dispensed each item. When the team identified any short-dated items it highlighted them. And it removed them from stock. 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 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. 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 generally clean. Team members had access to a range of up-to-date reference sources. The pharmacy had several computer terminals which had been placed in the consultation rooms and in the dispensary. Computers had password protection. Team members used 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 the dispensary 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.