General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Wootton Pharmacy, 7 Besselsleigh Road, Wootton, ABINGDON, Oxfordshire, OX13 6DN

**Pharmacy reference:** 1035882

**Type of pharmacy:** Community

**Date of inspection:** 20/02/2024

## Pharmacy context

The pharmacy is in a parade of businesses in a village. It sells medicines over the counter and provides health advice. The pharmacy dispenses private and NHS prescriptions. It supplies medicines in multi-compartment compliance packs for people who have difficulty managing their medicines. Its other services include: delivery, supervised consumption, blood pressure case-finding, seasonal flu and COVID-19 vaccination and Pharmacy First.

## 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's working practices are generally safe and effective. It has suitable written instructions in place which the team follows to manage the risks associated with providing its services. Team members learn from their mistakes and take steps to prevent them happening again. The pharmacy keeps the records it needs to by law to show it supplies its medicines and services safely. Members of the pharmacy team protect people's private information, and they understand their role in safeguarding the welfare of vulnerable people.

### Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The responsible pharmacist (RP) asked members of the pharmacy team to identify their own mistakes which they recorded on PharmSmart. They discussed mistakes to learn from them and reduce the chances of them happening again. The RP explained that medicines involved in incidents, or were similar in some way, such as sumatriptan and sertraline were generally highlighted and separated from each other in the dispensary. The RP had highlighted a trend in errors selecting the quantity of codeine phosphate tablets because the packs of 30 and 100 tablets were so alike. The pharmacy's medicines stock was arranged so fast-moving or frequently dispensed medicines were separated from other medicines which were less frequently dispensed. And this helped separate medicines such as atorvastatin which were available in several strengths. The pharmacy had a complaints procedure, and the team could report incidents through the pharmacy's computer system.

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 medicines. They highlighted interactions between medicines prescribed for the same person to the pharmacist. And assembled prescriptions were not handed out until they were checked by the pharmacist. Team members who prepared and checked prescriptions created an audit trail by initialling the dispensing labels. They highlighted prescriptions with high-risk medicines such as controlled drugs (CDs) with warning stickers. And they supplied warning cards such as for warfarin or lithium to make sure people had all the information they needed to use their medicines in the best way. These cards prompted team members to check recent blood test results and interventions were recorded on the patient medication record (PMR). Members of the team who handed out prescriptions confirmed the person's details on the address label on the bag and checked the date of birth if needed.

The pharmacy had standard operating procedures (SOPs) for the services it provided. 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 most recent SOP concerned dispensing controlled drugs (CDs). A member of the team described the sales protocol for recommending over-the-counter (OTC) medicines to people. The team members knew what they could and could not do, what they were responsible for and when they might seek help. A team member explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar medicines, such as medicines liable to abuse to a pharmacist.

Pharmacy team members had undertaken training in risk management for the pharmacy quality scheme (PQS). They had completed risk-assessments of the pharmacy and its team to make sure they were ready to provide the seasonal flu and COVID-19 vaccination services. And they had completed PQS audits of people who required more information to optimise how they used their asthma inhalers. The team completed an audit to help make sure people prescribed anti-coagulants had all the information they needed to take their medicines safely. And a third audit to monitor use of antibiotics had resulted in an intervention due to allergy. The pharmacy team were aware of the new rules when dispensing a valproate. The RP explained planned audits for the Pharmacy First service to monitor different parts of the service such as diagnosis, compliance with the patient group direction (PGD) pathway and signposting.

The pharmacy displayed a notice that told people who the RP was, and it kept a record to show which pharmacist was the RP and when. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It maintained an electronic controlled drug (CD) register and the RP demonstrated how records of supplies and receipts of CDs were entered. CDs were audited weekly. A random check of the actual stock of a CD matched the amount showing in the register. The pharmacy kept records for the supplies of the unlicensed medicinal products it made and generally made emergency supplies via the community pharmacist consultation service and NHS 111. It recorded these supplies on PharmOutcomes. The private prescription records were generally complete.

The pharmacy completed a Data Security and Protection Toolkit self-assessment to demonstrate practising good data security and that personal information was handled correctly. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Team members tried to make sure people's personal information could not be seen by other people and was disposed of securely. They used their own NHS smart cards and one of the team was in the process of getting their card unlocked. The pharmacy had a safeguarding SOP. And the RP had completed a level 3 safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. The contact details for the local safeguarding team were displayed and the team were signposted to the NHS safeguarding App.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy's team members are qualified or in training for the roles they have. Members of the team work well together to manage their workload. They can provide feedback and raise concerns relating to the pharmacy's services.

### Inspector's evidence

The pharmacy team consisted of the RP and a pharmacist to cover Saturdays, two full-time dispensing assistants, two full-time trainee apprentices, two part-time medicines counter assistants and a full-time delivery driver. The pharmacy relied upon its team to cover absences but at the time of the visit there was also a locum dispenser. All the team members were either qualified or enrolled on accredited training courses.

The RP described training completed to deliver the Pharmacy First service such as using the equipment, reading through the SOPs, the patient group directions (PGDs) and the guidelines. The master authorisation sheet was signed and retained in a folder with other Pharmacy First documentation. Members of the team could have protected learning time to undertake their training and some training was via eLearning for healthcare (elfh). Topics included those required for the pharmacy quality scheme (PQS), product training and protecting people's private information.

Members of the pharmacy team worked well together. So, people were served quickly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an OTC sales and self-care SOP which described the questions the team member needed to ask people when making OTC recommendations. And when they should refer to the RP. The RP organised regular team 'huddles' to plan the day ahead or tell the team about training they needed to complete. Members of the team were able to feedback to the RP and had discussed how they should deal with 'lookalike and soundalike (LASA). The RP explained that appraisals informal and ongoing. And team members could raise concerns.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy's premises are bright, secure and suitable for the provision of healthcare services. People can have a private conversation with a team member in the consultation room. The pharmacy prevents people accessing its premises when it is closed so it protects people's private information and its safe medicines stock is safe.

### Inspector's evidence

The registered pharmacy premises were clean, bright and secure. And steps were taken to make sure the pharmacy did not get too hot. The pharmacy had a retail area, a medicines counter, a dispensary and a storeroom all on the same level. The pharmacy had a consultation room which was signposted and the chaperone policy was displayed. So, people could have a private conversation with a team member. The dispensary was ‘L’ shaped with worksurfaces and storage available. The pharmacy team tried to avoid items being stored on the floor. And worksurfaces in the dispensary could become cluttered when the pharmacy was busy. The pharmacy had a sink. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy and its services are easily accessible to people with different needs. It generally provides its services safely and effectively. The pharmacy obtains its medicines from reputable sources and stores them securely at the right temperature so that they are fit for purpose. People taking high-risk medicines are provided with the information they need to use their medicines properly. The pharmacy team responds well to product recalls to help make sure people get medicines and medical devices that are safe to use.

### Inspector's evidence

The pharmacy had a single manual door and a slight step to the pavement. Someone who used a wheelchair could enter the building. The pharmacy team tried to make sure people with different needs could access the pharmacy services. The pharmacy had a notice showing when it was open. And notices in its window told people about some of the other services the pharmacy offered and health information. There was seating available for people who were waiting. Members of the pharmacy team were helpful. They could speak or understand German, Arabic and Tagalog to assist people whose first language was not English. They printed large font labels, so they were easier to read. And they signposted people to another provider if a service was not available at the pharmacy. And signposting notes were recorded on the patient medication record (PMR) if appropriate.

The pharmacy supplied medicines in a disposable multi-compartment compliance packs for people who had difficulty taking them on time. The pharmacy team checked if the medicines were suitable to be re-packaged if necessary. It provided a brief description of each medicine contained in the compliance packs, but it did not always provide patient information leaflets (PILS). This was discussed and the RP and the team gave assurances that moving forward PILs would be sent with each set of packs so people had the information they needed to make sure they took their medicines safely. The team managed re-ordering of prescriptions and checked them for changes in medication. High-risk medicines were generally supplied separately to the compliance pack. The pharmacy supplied medicines administration record charts to representatives of people who received compliance packs and provided counselling on medicines. Carers collected compliance packs for people in a care home.

Members of the team initialled dispensing labels so they could identify who prepared a prescription. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting. The RP counselled people on how best to use their medicines and supplied warning cards for high-risk medicines such as steroids. For people taking warfarin, the RP checked the INR was monitored and recorded the value on the PMR. The RP reminded people about foods and medicines which may affect their INR. The pharmacy team members were aware of the new up-to-date guidance and rules for supplying valproate-containing medicines which must always be dispensed in the manufacturer's original full pack. And no-one under the age of 55 – both men and women - should be started on a valproate unless two specialists independently agree and document that there is no other safe and effective medication, or that there are compelling reasons why the reproductive risks linked to valproate, do not apply.

The RP had liaised with the local surgery ahead of commencing the Pharmacy First service. In

preparation, the RP had completed training, risk-assessed the pharmacy's premises and consultation room. The pharmacy team had raised awareness of the service. The RP had prepared a Pharmacy First folder with information on people who were suitable to treat and red flags for those who were not and should be referred elsewhere. The pharmacy had already treated some people through the new service. The pharmacy offered the blood pressure case-finding service although there had not been any referrals yet. People who had accessed the new medicines service generally had follow up consultations by phone.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept medicines and medical devices in their original manufacturer's packaging. Liquid medicines were marked with the date of opening. The dispensary was tidy. The pharmacy team carried out regular date checks of stock. The pharmacy stored its stock, which needed to be refrigerated, between two and eight Celsius. And it stored its CDs securely in line with safe custody requirements. The pharmacy's waste medicines were kept separate from stock in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the pharmacist described the actions they took and explained what records they kept on PharmSmart when the pharmacy received a concern about a product.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately and keeps people's private information safe.

### Inspector's evidence

The pharmacy team had access to up-to-date and online reference sources. It had clean glass measures to measure liquid medicines. The pharmacy had fridges to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures for each fridge. The CD cabinets were fixed with bolts. The pharmacy team disposed of confidential waste appropriately. The pharmacy restricted access to its computers and PMR 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. And its team members made sure they used their own NHS smartcards.

## 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. |