General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Co-operative Healthcare, 6A High Street, CHIPPING NORTON, Oxfordshire, OX7 5AD

Pharmacy reference: 1035913

Type of pharmacy: Community

Date of inspection: 05/09/2019

Pharmacy context

The pharmacy is located on a busy high street. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include prescription collection and delivery, substance misuse and seasonal flu vaccination. The pharmacy has healthy living status.

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	1.1	Good practice	Staff could give examples of actions taken to protect patient safety
2. Staff	Standards met	2.2	Good practice	Staff are encouraged and supported to undertake ongoing learning
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy team reach out to the local community to make services accessible to the wider public
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 safe and effective. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy manages risk well and keeps people's information safe. The pharmacy has written procedures which tell staff how to complete tasks effectively. The pharmacy generally keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team members understand their role in protecting vulnerable people.

Inspector's evidence

Near misses were recorded, reviewed and actions taken to prevent a repeat near miss were completed for each incident. Monthly and annual patient safety reviews (PSR) were completed. 'Lookalike, soundalike' (LASA) medicines had been separated on the dispensary shelves to reduce picking errors. Spironolactone and levothyroxine had been separated due to similar packaging. Rivaroxaban and rosuvastatin were separated due to similar names and omeprazole 10mg and omeprazole 20mg had been separated following an incident.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. Labels were generated and medicines were picked from reading the prescription. Interaction labels were printed, and a 'pharmacist' sticker was attached to the prescription to alert the pharmacist. There were separate dispensing and checking areas. The pharmacist performed the clinical and final check of all prescriptions prior to completing the dispensing audit trail to identify who dispensed and checked medicines.

There was a procedure for dealing with outstanding medication. The original prescription was retained, and an owing slip was issued to the patient. For 'manufacturer cannot supply' items the patient was asked how urgently they required the medication and the doctor was pro-actively contacted to arrange an alternative if necessary.

Multi-compartment compliance aids were prepared for a number of patients according to a matrix. The pharmacy managed prescription re-ordering on behalf of patients. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance aid. The pharmacist visited new users of the service to check their understanding of using a compliance aid. Each patient had their own cardboard wallet to contain their notes and prepared compliance aids. There was a patient record sheet and information retained in a folder. Compliance aids were numbered 1 to 4 to clarify the weeks of the cycle.

Labelling included a description to identify individual medicines and patient information leaflets were supplied with each set of compliance aids. High-risk medicines such as alendronate were supplied separately from the compliance aid. The dates of CD prescriptions were managed to ensure supply within 28-day validity of the prescription. Levothyroxine and lansoprazole were supplied in compliance aids but counselling was provided about taking both medicines before other food and medication. Sodium valproate was generally supplied separately due to stability issues.

The practice leaflet was on display. The annual patient questionnaire had been conducted and had

resulted in positive feedback. Members of the public did comment that a second till would reduce queues to pay. In the moment feedback could be recorded online. The standard operating procedures (SOPs) were newly reviewed and staff were up-to-date with training in procedures. The staff member who served at the medicines counter said she would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. Hydrocortisone cream would not be sold for use on the face.

To protect patients receiving services, there was valid professional indemnity insurance in place provided by the NPA. The responsible pharmacist notice was on display and the responsible pharmacist log was completed. Records for private prescriptions, emergency and special supplies were generally complete. The CD and methadone registers were complete and the balance of CDs was audited regularly in line with the SOP. A random check of actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. For receipt of CDs the supplier name was recorded but not always the address and invoice number. FP10MDA prescriptions were endorsed at the time of supply and there was a discussion about an intervention regarding missed doses of CDs which had not been recorded on the patient medication record (PMR). Patient returned CDs were recorded in the destruction register for patient returned CDs.

Staff had read the information governance policy and signed confidentiality agreements. They were aware of procedures regarding General Data Protection Regulation (GDPR). A privacy notice was displayed. The Data Security and Protection toolkit had been completed centrally. Confidential waste paper was collected for safe disposal and there was a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly. There was a major incident plan to follow if such an issue arose. Staff had undertaken safeguarding and dementia friends training and the pharmacist was accredited at level 2 in safeguarding training for 2019 Quality Payment Scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy and works well together. The team members are supported in keeping their knowledge up to date. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time and one part-time pharmacist, two full-time dispensers, one part-time dispenser and one part-time trainee dispenser also accredited as a medicines counter assistant (MCA) and one trainee MCA who covered Saturdays. There was a part-time delivery person.

The pharmacist had completed Quality Payments Scheme training in LASA (CPPE), Sepsis and safeguarding training for 2019. Staff had protected learning time to study via an eLearning portal and topics included Nexium, confidentiality and dealing with customers. Staff performance was monitored through annual documented appraisals. Staff were able to provide feedback and had suggested rationalising stock and organising the deliveries in a better way. There was a whistleblowing policy and a freephone number to provide feedback to 'Talk to Me'. Staff said targets and incentives were set but not in a way that affected patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally clean, secure and suitable for the provision of its services. People are signposted to the consultation room that can be used for a private conversation with the pharmacist.

Inspector's evidence

The premises were clean, tidy and presented a professional image. There was a staff area in the basement. Lavatory facilities were clean and handwashing equipment was provided. There were two consultation rooms. One did not have a covered roof meaning a private conversation might be overheard, but the pharmacist said it was not used very often. The other consultation room protected patient privacy and there were health related posters on display such as cancer in young people. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. The pharmacy gets its medicines from reputable sources to protect people from harm. The pharmacy team takes the right action if any medicines or devices need to be returned to the suppliers. The pharmacy's team members are helpful and give advice to people about where they can get other support. They also make sure that people have all the information they need so that they can use their medicines safely. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe and effective.

Inspector's evidence

There was wheelchair access via a ramp at the entrance. There was a doorbell to alert staff. A hearing loop was in place to assist hearing impaired people and large font labels could be printed to assist visually impaired patients. Staff could converse in Urdu, Punjabi and Kutchi to assist patients whose first language was not English. Patients were signposted to other local services including dementia and local mental health support, podiatrist and the optician. Interventions were recorded in a triplicate book so a copy could be supplied to the doctor and the patient.

The pharmacist was aware of the procedure for supply of sodium valproate to people in the at-risk group and information on the pregnancy prevention programme (PPP) would be explained. The intervention was recorded on the PMR. The pharmacist explained the procedure for supply of isotretinoin to people in the at-risk group. The prescriber would be contacted regarding prescriptions for more than 30 days' supply of CD. Stickers were attached to prescriptions to alert the pharmacist to inform the patient about change of dose or expiry date. Prescriptions were highlighted with warning stickers to indicate that the pharmacist should provide counselling on high risk medicines. For schedule 4 CDs the date was highlighted so the CD was supplied within the 28-day validity of the prescription.

When supplying warfarin people were asked to produce their record of INR along with blood test due dates. INR was recorded on the PMR. Advice was given about side effects of bruising and bleeding. Advice was given about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were reminded about the weekly dose and when to take folic acid. People were advised to seek medical advice if they developed an unexplained fever, or dark urine.

The pharmacist had attended a local charity event for three years and provided blood pressure and glucose monitoring and health advice to members of the public. The pharmacy had healthy living status and there were health campaigns to raise public awareness of Stoptober, alcohol and sugar awareness. There were planned campaigns on anti-microbial resistance and sepsis. There was a health zone with a display of sun and skin care and the gondola end displayed cold and flu treatments. Audits were conducted including for referral for prescription of a proton pump inhibitor for gastric protection while taking a non-steroidal anti-inflammatory drug (NSAID), both phases of the sodium valproate audit and use of asthma inhalers. Staff had completed children's oral health and risk management in the previous Quality Payments Scheme and risk assessed the LASA medicines and lose wiring in the dispensary.

Medicines and medical devices were delivered outside the pharmacy via a Prodel App on a mobile

phone. Delivery information was loaded onto the App and the patient signed the screen indicating a safe delivery. The route was prepared via satellite navigation device. The driver had trained in the SOP and signed a confidentiality agreement.

Medicines and medical devices were obtained from Alliance, AAH and Alexon. Floor areas were clear, and stock was stored on the dispensary shelves. Stock was date checked and recorded. Short-dated stock was marked. No date-expired medicines were found in a random check. Liquid medicines were marked with the date of opening and medicines were stored in original manufacturer's packaging. Cold chain items were stored in two medical fridges. Uncollected prescriptions were cleared from retrieval every six weeks. Waste medicines were stored separate from other stock. Falsified medicines directive (FMD) hardware and software had been installed but was not 'live' at the time of the visit. Drug alerts were annotated and filed after checking stock for affected batches.

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 keeps people's private information safe.

Inspector's evidence

Current reference sources included BNF, C&D and Drug Tariff. The dispensary sink was clean and there was a range of clean stamped glass measures to measure liquids including separate marked measures for methadone. The medical fridges were in good working order. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinets were fixed with bolts. The blood glucose and pressure monitors were new and in date. Confidential waste paper was collected for safe disposal and there was a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly.

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.