General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Allied Pharmacy Eynsham, 64 Acre End Street, Eynsham, Oxford, Oxfordshire, OX29 4PD

Pharmacy reference: 1035929

Type of pharmacy: Community

Date of inspection: 23/01/2024

Pharmacy context

The pharmacy is on the high street in a rural town near Oxford. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance packs (blister packs) for people who have difficulty managing their medicines. Services include prescription delivery, substance misuse, blood pressure case-finding and seasonal flu vaccination services. The pharmacy changed ownership in September 2023.

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 adequate standard operating procedures in place to manage risks and make sure its team members work safely. The pharmacy team members do discuss their mistakes and take action to prevent them happening again. The pharmacy mostly keeps the records it needs to by law showing it supplies medicines and provides services safely. Members of the pharmacy team protect people's private information, and they are appropriately trained in how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. 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 products. And assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP). If a mistake was identified, the RP gave the prescription and medicines back to the member of the team who dispensed it so they could correct it. The pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. They did not always record mistakes so they could be missing opportunities to spot patterns or trends with the mistakes they made. The RP explained that medicines involved in incidents, or were similar in some way, such as olanzapine and prednisolone, were generally separated in the dispensary to help minimise the chance of picking errors.

Members of the pharmacy team initialled the dispensing labels so they knew which of them prepared a prescription and the RP completed the clinical and final checks. Checking interactions between medicines prescribed for people and recording interventions was discussed. They marked some prescriptions to highlight when the RP needed to speak to the person about the medication they were collecting or if other items needed to be added. And they checked the name, address and date of birth before handing out a prescription.

The pharmacy team members conducted clinical audits in line with the pharmacy quality scheme (PQS) such as use of anti-coagulants and inhaler technique. They had recently completed an audit regarding people who take medicines containing valproate and the RP was aware of the current rules on dispensing a valproate. And they knew that girls or women in the at-risk group who were prescribed valproate needed to be counselled on its contraindications and the pregnancy prevention programme (PPP). The pharmacy had a folder of recently prepared risk assessments (RAs) which helped identify and mitigate risks in providing pharmacy services. For instance, the vehicle and driving safety RA identified hazards and risks and how to reduce them when delivering prescriptions to people in their homes. There was a business continuity plan to help the pharmacy provide services if there was a systems failure.

The pharmacy had recently prepared standard operating procedures (SOPs) for most of the services it provided. Members of the pharmacy team were required to read SOPs relevant to their roles and sign training records to show they understood the SOPs and would follow them. They knew what they could and could not do if the RP was present or absent, 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 products, such as medicines liable to misuse to a pharmacist. The pharmacy had a complaints procedure via the pharmacy's head office.

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. The pharmacy had controlled drug (CD) registers. And the stock levels recorded in the CD register were checked regularly. A random check of the actual stock of a CD matched the recorded amount in the register. And FP10MDA prescriptions were endorsed at the time of supply of a CD. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. It recorded the emergency supplies it made and the private prescriptions it supplied electronically. And these generally were in order.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. The team tried to make sure people's personal information could not be seen by other people and was disposed of securely. The pharmacy computer was password protected and members of the team were using their own NHS cards. The pharmacy team and the RP had completed safeguarding training. 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 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 so they have the skills to carry out their roles. They work well together managing their workload. Members of the team are aware of the potential misuse of some OTC medicines and ask appropriate questions and offer suitable advice when they sell medicines.

Inspector's evidence

The pharmacy team consisted of two locum pharmacists (one was the RP on the day of the visit), two full-time dispensing assistants, two part-time medicines counter assistants and a part-time delivery driver. The pharmacy relied upon its team to cover absences. But it sometimes used a dispensing assistant who was a student from a local university to help with its workload too. The RP was supported at the time of the inspection by three team members. All the team were enrolled or had completed accredited training in line with their roles.

The RP explained training preparation in SOPs and patient group directions (PGDs) for the Pharmacy First service. The pharmacy's head office or area manager emailed the pharmacy team about training such as new SOPs or PQS topics such as infection control and antibiotic stewardship. Members of the team had a monthly meeting and could communicate via a WhatsApp group. They 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 over-the-counter (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 requests to a pharmacist. As the pharmacy had been newly taken over, members of the team had not provided feedback yet.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are bright, secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe, and people's private information is protected.

Inspector's evidence

The registered pharmacy premises had been re-fitted recently and were clean, bright and secure. And steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a retail area, a medicines counter, a dispensary on the same level and a storeroom. The pharmacy's consulting room was signposted and lockable. So, people could have a private conversation with a team member. The dispensary had sufficient workspace, so team members had room to accommodate different work activities such as dispensing and checking. The pharmacy had a sink and a supply of hot and cold water. 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's working practices are generally safe and effective. It tries to make sure people with different needs can easily access the pharmacy's services. Members of the pharmacy team mark prescriptions so the pharmacist knows which people require more information and support to use their medicines properly. The pharmacy obtains its medicines from reputable sources, so they are fit for purpose and safe to use. It stores medicines securely, at the correct temperature. The pharmacy team members know what to do when they receive a drug alert or recall.

Inspector's evidence

The pharmacy entrance was up a slight slope from the outside pavement to make it easier for people who used a wheelchair. The pharmacy team tried to make sure people could access the pharmacy services. The pharmacy had a notice that told people when it was open. And other notices in its window told people about some of the other services the pharmacy offered. The pharmacy had seating for people to use if they wanted to wait and a hearing loop to assist people who had difficulty hearing. Members of the pharmacy team were helpful and could advise people or signpost them to another provider if a service was not available at the pharmacy.

The pharmacy provided a delivery service to people who could not attend its premises in person. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person. The pharmacy used a disposable multi-compartment pack for people who received their medicines in compliance packs. It maintained a matrix for ordering prescriptions and preparing the packs. Checking if some medicines were suitable to be re-packaged was discussed. Team members provided a brief description of each medicine contained within the compliance packs. And they provided patient information leaflets. So, people had the information they needed to make sure they took their medicines safely.

Members of the pharmacy team completed a dispensing audit trail so they knew who prepared prescriptions. They marked prescriptions if the pharmacist needed to speak to the person about the medication they were collecting. Uncollected prescriptions were cleared from the retrieval system after five weeks and people were contacted to see if they still needed the medicines. The pharmacy team was aware of the updated rules for dispensing valproates. And counselling people in the at-risk group prescribed valproates on the contraindications and the PPP. The pharmacy had the valproate educational materials it needed. The pharmacy team received referrals and recorded supplies through PharmOutcomes for the community pharmacist consultation service (CPCS). The RP explained the checks and interventions to be recorded when dispensing high-risk medicines such as warfarin or isotretinoin.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. And liquid medicines were marked with a date of opening. The dispensary was tidy and the expiry dates of medicines were checked regularly. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs securely in line with safe custody requirements. The pharmacy stored waste medicines separate from stock in pharmaceutical waste bins. It had a procedure

for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took and records they kept 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 reference sources. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. A member of the team demonstrated how they checked the maximum and minimum temperatures of the fridge. The pharmacy's head office was supplying a new blood pressure monitor. And the team knew the location of the nearest defibrillator. Confidential wastepaper was collected for secure disposal. The pharmacy restricted access to its computers and patient medication record 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 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.