General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Chalgrove Pharmacy, 60 High Street, Chalgrove, OXFORD, Oxfordshire, OX44 7SS

Pharmacy reference: 1035952

Type of pharmacy: Community

Date of inspection: 11/07/2024

Pharmacy context

The pharmacy is in a village in Oxfordshire. 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 taking their medicines at the right time. Its other services include delivery, substance misuse, blood pressure case-finding, seasonal flu vaccinations and Pharmacy First.

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's working practices are mostly safe and effective. It has suitable written instructions for members of the team to follow. And these are reviewed and updated to help make sure the risks in providing services are managed. The pharmacy identifies prescriptions for high-risk medicines and controlled drugs. And this helps its team members to supply these safely and make sure people use them properly. The pharmacy keeps the records it needs to by law to show how 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) generally returned prescription baskets to the person who had dispensed the prescription to identify and record their own mistake and discuss actions taken to avoid the same mistake happening again. Medicines which were involved in incidents, or were similar in some way, for instance such as doxycycline and doxazosin, were generally separated from each other in the dispensary to minimise picking errors. The pharmacy had a complaints procedure to report incidents to the superintendent pharmacist (SI).

The team downloaded Electronic Prescription Service (EPS) prescriptions regularly throughout the day, generated dispensing labels and re-ordered medicines. If people presented a prescription at the medicines counter, the medicines counter assistant (MCA) completed a legal check of prescriptions to make sure the required fields were filled in. The pharmacy team members used coloured baskets to separate each person's medicines and to help prioritise the workload. And they referred to prescriptions when labelling and picking medicines. The RP checked interactions between medicines prescribed for the same person. If necessary, they contacted the prescriber regarding queries on prescriptions. The pharmacy had a standard operating procedure (SOP) for dealing with interventions and it made a record of the intervention on the patient medication record (PMR) in case it was queried at a later date.

When the medicines order was delivered the RP could dispense any outstanding medicines. Assembled prescriptions were not handed out until they were checked by the RP. The team members initialled the dispensing labels to create an audit trail of who dispensed and checked the prescription. The RP highlighted prescriptions which contained high-risk medicines and may require additional checking or counselling. For instance, controlled drugs (CDs) prescriptions which are only valid for 28 days. And the RP supplied warning cards such as for warfarin or prednisolone to make sure people had all the information, they needed to use their medicines effectively. When members of the team handed out prescriptions, they confirmed the person's name and address on the address label on the prescription bag in line with the handing out standard operating procedures (SOPs).

The pharmacy had SOPs for the services it provided. Archiving the SOPs no longer in use was discussed. The MCA described the sales protocol for recommending over-the-counter (OTC) medicines to people. And the MCA knew what she could and could not do, what she was responsible for and when she should refer to the pharmacist. She explained that she would not hand out prescriptions or sell

medicines if a pharmacist was not present. And she would refer repeated requests for the same or similar medicines, such as medicines liable to abuse to a pharmacist. Along with the complaints procedure, the pharmacy team invited feedback from people who used the pharmacy and its services by putting a feedback box on the counter from time to time. The team could describe examples of positive feedback which they had received.

Risk management was part of the clinical governance SOP and this included cleanliness of the pharmacy and signposting the consultation room. The pharmacy had risk-assessed the premises to manage pharmacy services safely during COVID-19 and providing the seasonal flu vaccination services and Pharmacy First. This included checking the suitability of the consultation room, vaccines storage, training, record keeping, hygiene control and dealing with clinical waste. Risk assessments were completed in preparation for commencing the NHS Pharmacy First service and took account of factors such as pharmacist training to provide the service and support from local doctors. The RP had monitored the length of time consultations were taking and if this would affect other pharmacy services when the pharmacy received referrals. The RP had read the patient group directions (PGDs) and completed face-to-face training in how to use the otoscope. Records were kept on PharmOutcomes. The most common conditions the RP treated were insect bites and urinary tract infections.

The RP had completed an audit for the Pharmacy Quality Scheme (PQS) to monitor how people managed asthma control and inhaler technique. Another audit monitored how people used antibiotic medicines and resulted in advice to finish the course of medication. The pharmacy team members encouraged people to participate in the hypertension or elevated blood pressure case-finding service. Team members invited people who did not believe they had higher blood pressure to participate in the service and have their blood pressure measured over 24 hours. The results were recorded on PharmOutcomes and people were signposted to their doctor. The pharmacy team had completed a clinical audit of people taking valproates and they were aware there were new rules for dispensing a valproate and recently updated guidance for dispensing topiramate.

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 a controlled drug (CD) register and CDs were audited regularly to check stock levels. A random check of the actual stock of a CD matched the amount recorded in the register. Patient-returned CDs were recorded in a separate register. The pharmacy kept records for the supplies it made of private prescriptions although the prescriber details were not always correctly recorded. The pharmacy kept records for the supply of unlicensed medicines ('specials') in line with the specials SOP. The pharmacy’s records for Pharmacy First service and people’s consent were seen on PharmOutcomes.

The pharmacy was registered with the Information Commissioners Office (ICO). The pharmacy team collected confidential wastepaper to be disposed of securely. Members of the team used their own NHS Smartcards. The pharmacy displayed a privacy notice. The RP had recently completed the NHS Data Security and Protection toolkit. The RP had completed level 3 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 pharmacy team was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together to manage the workload and to deliver services safely. They are suitably qualified or in training to have the appropriate skills for their roles. The pharmacy team feel able to provide feedback to improve the pharmacy's services.

Inspector's evidence

At the time of the visit, the pharmacy team comprised: the RP who covered two days per week, three part-time dispensing assistants and two part-time medicines counter assistants. The superintendent pharmacist (SI) covered the rest of the week. The dispensing assistants shifts overlapped with when both pharmacists were working. The delivery person was part-time. Team members were qualified or enrolled on accredited training. The RP was signposted to GPhC guidance on requirements for training support staff (Oct 2020) and the GPhC Knowledge Hub.

The RP had completed training to deliver the Pharmacy First service. The pharmacy had a staff induction folder for people who were newly recruited. And it contained the safeguarding SOP and information on manual handling, slips and trips, display screen equipment, work related stress, violence at work and first aid at work. The pharmacy team members could have protected learning time if needed. They had previously trained in pharmacy quality scheme (PQS) training topics such as dementia. And they had industry publications to read to try to keep their skills and knowledge up to date.

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. 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 they knew when to refer to the pharmacist. Team members felt able to give the SI and RP feedback and this included where they would have a team night out. The whistleblowing SOP was in the SOP folder.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are bright, clean, secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so people's private information is protected and its medicines stock is safe. The consultation room is signposted and used regularly by people accessing the pharmacy’s services or who want a private conversation with the pharmacist.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. The pharmacy had undergone a refit since the previous inspection so the layout and workflow had been improved. There were seats available for people who wanted to wait. And action had been taken to make sure the pharmacy and its team did not get too warm. The pharmacy had a large retail area with a medicines counter to one side of the pharmacy where people could buy medicines or other sundry items. The dispensary was on the same level behind the medicines counter, and the RP had a good view of the medicines counter and the rest of the pharmacy. The pharmacy’s consultation room was signposted, and people could have a private conversation with a team member. It was tidy and clean. Team members kept the pharmacy clean and tidy. Although they did not keep records to show this.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy and its services are easily accessible to people with a range of needs. Its working practices are generally safe and effective. The pharmacy obtains its medicines from reputable sources. It stores them securely at the correct temperature to help make sure they are fit for purpose and safe to use. The pharmacy team provides people with the information they need to help them use their medicines properly. The pharmacy team members carry out checks when they receive medicine alerts and recalls. This makes sure people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy entrance had a ramp from the pavement into the pharmacy to make it easier for people who used a wheelchair to enter the building. The team tried to make sure people with different needs could access the pharmacy services. Services information was displayed and there was seating available for people who were waiting. Members of the pharmacy team were helpful. They could speak Urdu and Punjabi to assist people whose first language was not English. And they could assist people with sign language. They signposted people to another provider, such as out of hours service, and there was a folder of support organisations such as Samaritans or MIND. The pharmacy's delivery person delivered medicines to people who could not attend the pharmacy in person three times a week. There was a delivery SOP and a delivery audit trail to show medicines had been delivered to the right person.

The RP was seeing people who were referred by the surgery or NHS 111 accessing the Pharmacy First Service. The pharmacy offered all areas of treatment. Records of the consultation were entered onto PharmOutcomes. The pharmacy had liaised with local surgeries to raise awareness about the service and potential benefits. The RP described confirming people's details and presence of exclusion criteria such as allergies, pregnancy or being prescribed antibiotics frequently. The RP could get consent to check the National Care Record Service. Consultations notes were recorded on PharmOutcomes and each consultation took around 20 minutes. The RP was complying with the patient group direction (PGD) pathway and said the most common conditions were insect bites and urinary tract infections. Shingles and impetigo were least often identified and treated. When treatment was not available people were signposted elsewhere such as to sexual health.

The pharmacy supplied medicines in multi-compartment compliance packs for people who had difficulty taking them on time. The pharmacy team prepared the packs according to a matrix to make sure they were ready to go out to people when they were needed. The pharmacy team re-ordered prescriptions for most people and checked them for changes to their medicines since the previous time. The RP generally supplied high-risk medicines separately and not in the compliance pack. The pharmacy provided a brief description of each medicine contained in the compliance packs and patient information leaflets (PILS) with each set of packs to help ensure people had the information they needed to take their medicines safely. Following a patient's hospital stay, the pharmacy sometimes received a discharge summary via PharmOutcomes showing changes in treatment.

Members of the team initialled dispensing labels to identify who prepared a prescription. And highlighted some prescriptions to show 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 such as

isotretinoin. The RP provided the new medicines service (NMS) and a follow up consultation to help people take new medicines effectively. The pharmacy was offering the blood pressure case-finding service at the time of the visit and asked people who matched the criteria if they would like their blood pressure measured. The RP was aware of the new up-to-date guidance and rules for supplying valproate-containing medicines and recently updated guidance for topiramates.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It generally 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 and marked short-dated items. 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. The SOP described the risks of cleaning up a spillage and using protective gloves. There were marked bins to use for different types of waste medicines.

The pharmacy was signed up to MHRA alerts and Central Alerting System. It checked the alert with our stock then file the alert in a special e-mail folder to refer back to them if needed. And it checked alerts from the suppliers when they put them on the invoices. It separated stock and returned it to the supplier if needed. When appropriate patients were contacted depending on the level of alert. Alerts were printed and displayed when needed to make people aware.

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 measures to measure liquid medicines stored near the dispensary sink. The pharmacy stored its pharmaceutical stock requiring refrigeration between two and eight Celsius which its team regularly checked and recorded. The CD cabinet was fixed securely. Marking the blood pressure monitor with the date of when it was due to be recalibrated was discussed. The pharmacy had the equipment it needed to provide Pharmacy First such as an otoscope with spare disposable ear-pieces, contactless thermometer and masks. The pharmacy team collected confidential wastepaper to be disposed of securely. 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.