General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Avicenna Pharmacy, 172 Kennington Road, Kennington, OXFORD, Oxfordshire, OX1 5PG

Pharmacy reference: 1035957

Type of pharmacy: Community

Date of inspection: 14/04/2023

Pharmacy context

The pharmacy is in the residential area of Kennington on the outskirts of Oxford. It dispenses NHS and private prescriptions and provides health advice. Services provided by the pharmacy include Community Pharmacist Consultation Service (CPCS), delivery, discharge medicines service (DMS), new medicines service (NMS), blood pressure case-finding and seasonal flu vaccination service. The pharmacy supplies medicines in multi- compartment compliance aids for people who have difficulty managing their medicines.

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

Overall, the pharmacy's working practices are generally safe and effective. It has suitable standard operating procedures in place to make sure its team members work safely. Pharmacy team members follow an effective procedure of initialling dispensing labels so they can easily show who completed each step of the process if there is a query. They discuss the mistakes they make while dispensing medicines, but they do not always record them so they may be missing the opportunity to learn from them and help stop the same mistake happening again. The pharmacy mostly keeps the records it needs to by law. 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 discussed the mistakes they made to learn from them and reduce the chances of them happening again. But they did not always record them or the lessons they learnt from them. So, they could be missing opportunities to spot patterns or trends with the mistakes they make. A member of the team explained that medicines involved in incidents, or were similar in some way, may be separated from each other in the dispensary or highlighted with 'lookalike and soundalike (LASA)' shelf labels. So, team members were alerted to potential mistakes when they were selecting medicines. The pharmacy team had sorted medicines stock into 'fast movers' so medicines which were dispensed most frequently were located where they were easily accessed. The pharmacy displayed a complaints procedure although incidents were initially reported to the pharmacy manager.

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). Team members initialled the dispensing labels to identify who dispensed and checked each medicine. The RP checked interactions between medicines prescribed for the same person. And making sure interventions were recorded on the patient medication record (PMR) was discussed in case the team had to refer to the PMR later. A member of the pharmacy team explained the process for checking people's details to make sure prescription medicines were given to the right person. The pharmacy had stickers and warning cards to highlight high-risk medicines that required monitoring or additional counselling.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these were due to be reviewed around July 2023. Members of the pharmacy team had read the SOPs relevant to their roles and signed a training record to show they understood them and would follow them. Members of the pharmacy team knew what they could and could not do, what they were responsible for and when they might seek help. Their roles and responsibilities were described in the SOPs. A team member explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer to the pharmacist about repeated requests for medicines liable to misuse. The pharmacy had a keypad at the counter with a variety of options for people to rate their experience during the visit to the pharmacy. People also gave verbal feedback. The pharmacy had risk-

assessed the impact of COVID-19 upon its services and the people who used it to help reduce the risks of infection with the virus. And team members followed an SOP to make sure they washed their hands regularly and used hand sanitising gel when they needed to. The delivery driver described the procedure for delivering medicines to people's homes ensuring the medicines were delivered to the right people. The delivery service was audited regularly.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. 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 a controlled drug (CD) register and the recorded stock levels were checked monthly. But the SOP referred to weekly audits of CDs and the pharmacy computer displayed a message if the audit was due. A random check of the actual stock of a CD matched the recorded quantity. The pharmacy kept records of its unlicensed medicines and emergency supplies. It had an electronic register for the private prescriptions it dispensed. These generally were in order, but the name and address of the prescriber were sometimes incorrectly recorded.

The pharmacy displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. A member of the team explained how they tried to make sure people's personal information could not be seen by other people and was disposed of securely. Support staff including the delivery person had been trained in protecting patient confidentiality by a pharmacist. The pharmacy had a safeguarding SOP and was involved in the ANI (Assistance Needed Immediately) scheme that helped to provide a safe way for victims of domestic abuse to access support. Some members of the team had undertaken safeguarding training in line with the pharmacy quality scheme (PQS) and would make the RP or the pharmacy manager aware if they had concerns about the safety of a child or a vulnerable person. Team members were signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

On the day of the visit, the pharmacy's team members worked well together to manage their workload. The pharmacy provides them with ongoing training to develop their skills, although it does not generally give them protected learning time. Team members are comfortable about providing feedback about services to the pharmacist and they know how to raise concerns.

Inspector's evidence

The pharmacy team explained that the pharmacy did not have a regular pharmacist but had been running on locum pharmacists recently. The regular team consisted of a full-time trainee dispensing assistant, the pharmacy manager who was a part-time accuracy checking technician (ACT) and a part-time trainee dispensing assistant and a part-time delivery driver. The pharmacy relied upon its team to cover absences. The RP was supported at the time of the inspection by two trainee team members.

Members of the pharmacy team were enrolled on accredited training relevant to their roles and they mostly studied in their own time. The pharmacy kept records for training undertaken for the PQS such as safeguarding level 3, inhaler technique, weight management and obesity and treating respiratory tract infections. The pharmacy team worked well together serving people and helping the RP with processing prescriptions. 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 its team followed. This described the questions to ask people when making OTC recommendations. And when they should refer requests to a pharmacist. The pharmacy team had appraisals with the pharmacy manager to monitor their progress. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are secure and suitable for the provision of healthcare. The pharmacy protects people’s private information and keeps its medicines safe when it is closed.

Inspector's evidence

The registered pharmacy premises were 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 and a storeroom. Some fixtures were dated. The pharmacy had signposted its consultation room so people could have a private conversation with a team member. The dispensary had different workbench areas to accommodate and separate activities such as preparing multi-compartment compliance aids or checking off the medicines deliveries. The pharmacy’s sink required treatment to remove limescale. 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 services are easily accessible to people with a range of needs. Its working practices are generally safe and effective. And it gets its medicines from reputable sources. It stores them securely at the right temperature to make sure they are fit for purpose and safe to use. The pharmacy team knows what to do when medicines have to be returned to the suppliers. Members of the team 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.

Inspector's evidence

The pharmacy did not have an automated door but its entrance was level with the outside pavement. So people who found it difficult to climb stairs, such as someone who used a wheelchair, could enter the building. The pharmacy team tried to make sure people could use the pharmacy's services. The pharmacy displayed notices that told people when it was open. And about some of the services the pharmacy offered such as recycling certain medical appliances. The pharmacy had seating for people who wanted to wait. Members of the pharmacy team could speak or understand Bengali, Urdu and Punjabi for people whose first language was not English and there was a hearing loop to help people who had difficulty hearing. Team members signposted people to another provider if a service was not available at the pharmacy such as the COVID-19 vaccination service.

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 delivery person was aware of reporting any safeguarding concerns to the RP. The pharmacy received CPCS referrals via NHS 111 for people to get advice and treatment for some minor illnesses, or for an urgent supply of a previously prescribed medicine. It also provided the new medicine service to help people take newly prescribed medicines in the best way. The pharmacy used disposable packs to supply medicines to people who received their medicines in compliance aids. There was a white board for the team to record messages relating to preparation of compliance aids such as listing people who had been admitted to hospital. The pharmacy team members checked whether a medicine was suitable to be re-packaged and provided a brief description of each medicine contained in the compliance aids. But they did not always provide patient information leaflets (PILs). Team members gave an assurance that moving forward PILs would be supplied to make sure people had the information they needed to take their medicines safely.

The pharmacy had a process for dealing with outstanding medicines which were owed to people. It removed uncollected prescriptions regularly and texted people to check if they still needed the medicines. Members of the pharmacy team initialled the dispensing labels to show which of them 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 was aware of the valproate pregnancy prevention programme and explained that girls or women in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed.

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. The pharmacy team checked the expiry dates of medicines a few times a year, but some expired medicines were found on the shelves amongst in-date stock. These were quickly removed during the inspection. And checking the expiry date of dispensed medicines as part of the final check was discussed. 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 had procedures for handling the unwanted medicines people returned to it. And these medicines were kept separate from stock or were placed in one of its pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And members of the team described the actions they took and demonstrated what 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 had a plastic screen on its counter and hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had glass measures for use with liquids, and some were used only with certain liquids. The pharmacy team had access to up-to-date reference sources. The pharmacy's head office replaced its blood pressure monitor regularly. A member of the team demonstrated how to check maximum and minimum temperatures of the medical fridge. The pharmacy team collected confidential waste to be disposed of safely. 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. Some of the team had their own NHS smartcards which were in use. But some other team members required 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.