General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Roundway Pharmacy, 3 The Roundway, Headington, OXFORD, Oxfordshire, OX3 8DH

Pharmacy reference: 1091128

Type of pharmacy: Community

Date of inspection: 25/01/2023

Pharmacy context

The pharmacy is in a parade of businesses at a large roundabout on the outskirts of Oxford. It is near a residential area with some available parking for people with cars. 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 delivery, COVID-19 and flu vaccinations, travel clinic, supervised consumption, needle exchange, community pharmacist consultation service (CPCS) and new medicines service (NMS).

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	Members of the pharmacy team actively manage the risks associated with providing services to protect the safety and wellbeing of people who use the pharmacy.
		1.2	Good practice	The pharmacy team members continually monitor the safety and quality of the pharmacy's systems and procedures so the services they provide remain safe.
2. Staff	Standards met	2.2	Good practice	Pharmacy team members are encouraged to complete training relevant to their roles and to develop their skills .
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy tries to make its services easily accessible to people who use the pharmacy.
		4.2	Good practice	The pharmacy team members actively manage services to ensure people receive safe and effective care.
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. Members of the team follow clearly written instructions to help them make sure they work safely. The pharmacy monitors its services and reviews the risks involved in providing its services. Pharmacy team members record and discuss their mistakes to learn from them and avoid the same mistakes happening again. The pharmacy has business continuity arrangements in place so it can deal with an emergency. And it keeps the records it needs to show that medicines are supplied safely and legally. Members of the team make sure they protect people's private information and they are 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. And to reinforce the learning the person who made the mistake re-dispensed the item correctly. The responsible pharmacist (RP) recorded details of mistakes and shared learnings in a patient safety review. The pharmacy had a complaints procedure to deal with incidents such as dispensing errors.

A dispensing assistant (DA) explained the prescription workflow around the dispensary. There were designated dispensing and checking areas and members of the pharmacy team responsible for making up people's prescriptions used coloured baskets to separate each person's medication and to help them prioritise their workload. They referred to prescriptions when labelling and selecting medicines. And assembled prescriptions were not handed out until they were accuracy and final checked by the responsible pharmacist (RP). The pharmacy team members had introduced an extra check during preparation of compliance aids. Team members showed the RP interactions between medicines prescribed for the same person. A member of the team described highlighting an interaction when someone was prescribed a new medicine, but the medicine it was replacing was not cancelled. During the visit, the DA queried a repeat prescription which had been issued with the initial instructions to titrate the dose instead of the actual dose. The RP recorded interventions on the patient medication record (PMR). Pharmacy team members were trained to identify people collecting prescriptions by asking set questions to help make sure they gave the medicines to the right people.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these had been reviewed recently. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and followed them. The pharmacy team members explained the sales protocol which included questions to ask people when making an over-the-counter (OTC) recommendation for a medicine. The most recent SOPs related to COVID-19. People using the pharmacy could give feedback on the pharmacy via details on the practice leaflet, the community pharmacy patient questionnaire (CPPQ) and the pharmacy's complaints procedure.

The pharmacy had completed COVID-19 risk assessments for the workforce and workplace to manage the impact of the virus upon its services and the people who used it. The RP kept records of risk assessments online. The team members could wear fluid resistant face masks to help reduce the risk of

infection. They washed their hands regularly and applied hand sanitising gel. To help protect against COVID-19, screens had been fitted at the medicines counter. The pharmacy team also audited services. For instance, owing medicines were audited and checked weekly. The results helped the pharmacy plan stock holding and plan introducing new services. The RP explained that in relation to a clinical audit Terence Higgins Trust leaflets were displayed on the counter and the free condom service was to be reintroduced. The planned outcome was to improve sexual health. The pharmacy had also undertaken audits in line with the pharmacy quality scheme.

The pharmacy displayed a notice that told people who the RP was and 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. The stock levels recorded in the CD register were checked every month so the pharmacy team could spot mistakes quickly. A random check of the actual stock of a CD matched the recorded amount in the CD register. The RP planned to transfer to electronic CD registers. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. The private prescriptions it supplied were recorded electronically. And these generally were in order. But the name and address of the prescriber were sometimes incorrectly recorded. The RP demonstrated a private group direction (PGD), its SOP and keeping records of the vaccinations administration. The RP was a pharmacist independent prescriber (PIP) trained in treating minor ailments and providing travel clinic medicines along with the other services available. The RP made appointments for people who wished to attend the pharmacy to access its services. The appointment information included the person's name, contact details and the service being delivered. The RP could optimize how the available time was managed to manage the workload.

The pharmacy was registered with the Information Commissioner's Office. The RP was printing a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team members. They tried to make sure people's personal information could not be seen by other people and was disposed of securely. Team members described how they protected people's private information. The PMR was password protected. The pharmacy had a safeguarding SOP. And the RP had completed a safeguarding training course at level 3. The team members were trained and knew what to do if they had concerns about the safety of a vulnerable child or adult. The RP was aware of the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work well together to manage the workload. They understand their roles and responsibilities. They are encouraged to complete training relevant to those roles and to develop their knowledge. Members of the team are comfortable about giving feedback to improve services. And they know how to raise concerns.

Inspector's evidence

The pharmacy team consisted of the RP who was also superintendent pharmacist and a pharmacist independent prescriber (PIP), one regular locum pharmacist who covered the RP's days off, two full-time trainee dispensing assistants, a part-time dispensing assistant who was on probation and a part-time delivery driver. At the time of the visit, a trainee pharmacist from the nearby hospital was attending the pharmacy for work experience in community pharmacy. The RP was supported at the time of the inspection by the trainee dispensing assistants. Members of the pharmacy team were enrolled on accredited training relevant to their roles on completion of their probationary period. The inspector signposted the team to the GPhC guidance on training requirements for support staff and the GPhC Knowledge Hub.

Along with training as a PIP the RP had completed training to deliver other services such as flu and COVID-19 vaccinations. Team members had protected learning time. The RP had organised training for members of the team in first aid and travel advice so that they could deal with people's enquiries and direct their calls. The RP planned to enrol the team on training online and to start them training on the topics specified for the pharmacy quality scheme (PQS). Members of the pharmacy team worked well together. People were served quickly, and their prescriptions were processed safely. If the RP had a service appointment, they alerted the RP to any queries and placed prescriptions in baskets at the checking area in the dispensary for the RP to deal with after the appointment.

The pharmacy had an OTC sales and self-care SOP which its team followed. This described the questions the team member needed to ask people when making OTC recommendations. Team members knew when to refer requests to a pharmacist and they could make decisions to help keep people safe. They knew what they could and could not do and when to seek help. They understood their roles and responsibilities which 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 repeated requests for the same or similar products, such as medicines liable to misuse to a pharmacist.

The RP conducted annual appraisals to monitor each team member's performance and training needs. The pharmacy team members were comfortable sharing ideas on how to improve the pharmacy and its services. And had suggested endorsing the prescriptions for people who were waiting or calling back and putting them in different coloured baskets to prioritise tasks and manage the workload. 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 bright, clean and suitable for the provision of healthcare. The pharmacy is secured when it is closed to protect people’s private information and keep the pharmacy’s medicines safe.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure and presented a professional image. The pharmacy was well lit with electric and natural lighting. And it had a medicines counter and a large retail area with seating available for people to wait. The dispensary and a kitchen area were on the same level behind the retail area. The pharmacy had a clean, tidy consulting room which was clearly signposted. So, people could have a private conversation with a team member. The dispensary had a workbench around its perimeter and equipment which the team kept tidy and clean. Some tote boxes were stored on the floor until they were emptied. Members of the pharmacy team were responsible for keeping the pharmacy’s premises and equipment clean and tidy. The pharmacy surfaces were cleaned daily, equipment was wiped down after use and the pharmacy was deep cleaned regularly.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of services, and it tries to make sure its services are easily accessible to people with different needs. Its working practices are safe and effective, and it obtains its medicines from reputable sources. The pharmacy's team members make sure they store medicines securely at the right temperature. They keep records of regular checks to show medicines are fit for purpose and safe to use. They know what to do if any medicines or devices need to be returned to the suppliers. Pharmacy team members actively highlight prescriptions with high-risk medicines and make sure people get the information they need to use their medicines safely.

Inspector's evidence

The pharmacy did not have an automated door. Its entrance was fitted with a ramp to make it level with the outside pavement. This was helpful to people who found it difficult to climb stairs or who used a wheelchair, to enter the building. And the pharmacy team tried to make sure these people could use the pharmacy services. If someone could not easily enter the consultation room, the pharmacy had a screen which could be positioned in the retail area providing privacy.

The RP maintained Facebook and Instagram accounts with up-to-date information regarding the pharmacy and its services. And the RP was a Parish councillor which resulted in good links with the community. The pharmacy had a notice that told people when it was open. And other notices in its window told people about services the pharmacy offered. The pharmacy had seating areas for people to use if they wanted to wait. The team members could speak Italian, French, Urdu, Punjabi and Ethiopian to assist people whose first language was not English. And the pharmacy computer could generate large font dispensing labels to help vision-impaired people. Members of the pharmacy team were helpful and signposted people 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 received referrals from the community pharmacist consultation service (CPCS) which were for emergency supplies of medicines or to treat minor ailments. The RP was also trained in treating and prescribing for minor ailments. And was signed up to local prescribing and clinical knowledge guidelines. If people presented with a complaint outside the scope of a minor ailment, they were signposted to urgent care doctors, NHS 111 and the opticians for minor eye complaints. The pharmacy did not offer needle exchange at the time of the visit, but clients could return used needles for safe disposal. The pharmacy could offer people the blood pressure case-finding service with 24-hour monitoring subject to referrals from the local surgery. The pharmacy received a low rate of referrals via the discharge medicines service (DMS). New medicines service (NMS) initial appointments were followed up by phone to help people get the most from their newly prescribed medicines. The pharmacy supplied palliative care medicines under a service level agreement.

The pharmacy was registered to administer yellow fever vaccinations and offered a range of travel

vaccinations via PGD. The RP prescribed other medicines required for travel. People could have a COVID-19 and flu vaccination via PGD on a walk-in basis. The RP had completed up-to-date risk assessments, SOPs and business continuity plans for both services. The COVID-19 and flu vaccines were stored in designated sections of a large fridge which was monitored daily to make sure the temperature range was between two and eight Celsius. The RP gained consent and completed the clinical assessment prior to administration of the vaccine. A patient information leaflet (PIL) with information on the vaccine was given to people after their vaccination. Details of COVID-19 vaccinations were recorded on Outcomes4Health and flu vaccinations were recorded on PharmOutcomes. And this meant people's surgeries were informed about their vaccinations. The sharps and clinical waste items were disposed of in the appropriate waste bins. The adrenaline ampoules, needles and syringes were on the desk for ease of access in case of anaphylactic reaction to a vaccine.

The pharmacy used a disposable pack for people who received their medicines in multi-compartment compliance aids. The pharmacy team checked whether a medicine was suitable to be re-packaged and provided a brief description of each medicine contained within the compliance packs but did not always provide PILs. So, people did not always have the information they needed to make sure they took their medicines safely. The RP gave assurances that the PILs would be supplied with each cycle of compliance aids moving forward. The RP reviewed the service to make sure compliance aids were the best way for a people to be supplied their medicines.

The pharmacy supplied medicines in compliance aids to people in care or nursing homes according to a matrix to manage the service in a timely way. This allowed time to order prescriptions, deal with changes in medication, obtain stock, dispense the compliance aids and deliver them to the homes with medication administration record charts. The RP clinically and final checked medicines before they were supplied. And visited the homes to monitor the service and provide training to their staff.

Members of the pharmacy team initialled dispensing labels to identify 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 or if other items needed to be added. Uncollected prescriptions were cleared monthly. The pharmacy team members were aware of the valproate pregnancy prevention programme. And they knew 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 in their original manufacturer's packaging. And the dispensary was tidy and organised to accommodate the workflow. The pharmacy team checked the expiry dates of medicines on a rolling basis. And no expired medicines were found on the shelves. 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 in pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP 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 to keep people's private information safe.

Inspector's evidence

The pharmacy had a plastic screen on its counter. And hand sanitisers for people to use. And it had the personal protective equipment if needed. The pharmacy had a few 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 and referred to the green book regarding vaccination services. The pharmacy had refrigerators to store pharmaceutical items requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of the refrigerators. The pharmacy had maintenance records for its equipment and SOPs for using equipment to provide its services. The pharmacy team knew where the nearest defibrillator was located in case it was needed. The pharmacy collected confidential wastepaper for shredding and there were appropriate bins to dispose of waste items 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.

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.