General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Leys Pharmacy Rosehill, 6A Courtland Road, OXFORD, Oxfordshire, OX4 4JA

Pharmacy reference: 1092286

Type of pharmacy: Community

Date of inspection: 12/07/2019

Pharmacy context

The pharmacy is located at the end of a parade of businesses in a residential area. 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 collection and delivery, minor ailments, NHS urgent medicines supply, substance misuse, needle exchange 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	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. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy manages risk and keeps people's information safe. The pharmacy's team members do not always record the mistakes they make while dispensing medicines. So they may be missing opportunities to learn and prevent the same things happening again. The pharmacy has written procedures which tell staff how to complete tasks effectively. But the team does not always follow them, for example, the way the team delivers prescriptions. This could introduce unnecessary risk into the service. 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

Some near misses were recorded, reviewed and actions taken to prevent a repeat near miss were completed for each incident. Patient safety reviews (PSR) were not completed. Different strengths of quinine tablets had been separated and prednisolone tablets were stored on their own to minimise picking errors. 'Lookalike, soundalike' (LASA) medicines trazodone and tramadol had been highlighted with 'Select with care' stickers on the dispensary shelves.

Workflow: the pharmacist explained that stock was checked against the prescription. Baskets were in use to separate prescriptions and medicines during the dispensing process. Labels were generated from reading the prescription. There were separate dispensing and checking areas. The pharmacist performed the 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 contacted to arrange an alternative if necessary. There was a note pad template to complete and detach a copy to send to the surgery with prescriptions to be amended.

Multi-compartment compliance packs (blister packs) were prepared for a large number of patients. Some blister packs were prepared daily to manage workload and limited available work space. During the visit, blister packs were being prepared in the consultation room and at another bench which had good natural light. The pharmacy managed prescription re-ordering on behalf of patients. Prescriptions were checked against the patient medication record (PMR) and any changes were queried with the prescriber.

High-risk medicines such as alendronate were supplied separately from the blister pack. Controlled drugs (CDs) were added to the blister pack at the time of delivery and the dates of CD prescriptions were managed to ensure supply within 28-day validity of the prescription. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a blister pack. Each patient had their own polythene sleeve to contain a visual guide of the position of tablets/capsules in the blister pack and information relating to blister packs. Some visual guides had been corrected to reflect changes in medication. Ensuring visual guides were re-written

following changes to medication was discussed. Labelling included a description to identify individual medicines and patient information leaflets were supplied with each set of blister packs. The start date was marked on each blister pack. Backing sheets were not always fixed to the lid of the blister pack and may become detached.

The complaints procedure was displayed. The annual patient questionnaires were on display to ask members of the public for feedback. The standard operating procedures (SOPs) included safeguarding, whistleblowing, complaints and responsible pharmacist (RP) procedures which were due to be reviewed. The delivery procedure was not followed as described in the SOP. Staff explained that they would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. Chloramphenicol eye drops would not be sold to treat conjunctivitis in an infant of one year old. Training records for SOPs were available.

To protect patients receiving services, there was professional indemnity insurance in place provided by BGP Ltd expiring 3 April 2020. 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 patient group direction (PGD) to supply trimethoprim to treat a simple urinary tract infection was signed and in date. Medicines to treat minor ailments such as vomiting or elevated temperature were selected from a set list.

The CD registers were generally complete, and the balance of CDs was audited monthly in line with the SOP. A random check of actual stock of three strengths of MST reconciled with the recorded balance in the CD registers. Loose leaves in the CD register were at risk of becoming detached from the register and lost. Footnotes to correct entries were not always signed and dated. Invoice number and name but not the address of supplier was recorded for receipt of CDs. Patient returned CDs were recorded in the destruction register for patient returned CDs.

Methadone registers were electronic and linked to the Methasoft apparatus. There was a large discrepancy in the methadone register which the pharmacist had identified. Following the visit, the pharmacist confirmed that the discrepancy had been investigated and resolved. A random sample of FP10MDA entries complied and the prescription was endorsed at the time of dispensing. Increasing the frequency of balance checks of methadone was discussed to identify and investigate discrepancy.

Staff had signed confidentiality agreements and were aware of procedures regarding General Data Protection Regulation (GDPR). The Data Security and Protection toolkit had been completed at head office. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff generally used their own NHS cards. A poster about ‘How we safeguard information about you’ was displayed. Staff had undertaken safeguarding and dementia friends training and the pharmacist was accredited at level 2 in safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy and it 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 regular pharmacist, one part-time pharmacy technician, one full-time trainee pharmacy technician, one part-time dispenser, three part-time NVQ2 dispensers (one who covered Saturdays) and one part-time delivery driver. One part-time dispenser was an overseas qualified pharmacist who had not completed accredited training in line with published GPhC guidance. The superintendent pharmacist said the staff member would be enrolled.

Staff said they had some protected learning time to study when in training and had completed children's oral health and risk management. The pharmacy technician described study topics undertaken to submit for re-validation. Staff said they were able to provide feedback at regular monthly meetings with the superintendent pharmacist. Suggestions included planning cover of staff shortage due to prolonged leave from the pharmacy and planning ahead to ensure blister packs were prepared in a timely manner. There was a whistleblowing policy. Targets and incentives were set but staff did not believe patient safety and wellbeing was adversely affected.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally clean, secure and suitable for the provision of its services.

Inspector's evidence

The pharmacy was generally clean despite older fixtures and fittings. Flooring was slightly damaged in the dispensary and there was some unsecured wiring which may become a trip hazard. The layout of the pharmacy was unusual because of being a corner site. There was limited dispensary bench space. There was a large store area which would provide more working space if clutter was removed. The decorative order of the lavatory cubicle could be improved but the facility was clean and handwashing equipment was provided.

The consultation room was located to the rear of the public area of the pharmacy. The door was open as a member of staff was preparing blister packs at the bench. There was a small number of dirty dishes on the surface at the rear of the consultation room which required removal to present a more professional image. Health related leaflets were displayed. There was sufficient lighting including natural light and ventilation provided by fans.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective, and it gets its medicines from reputable sources. The pharmacy team takes the right action if any medicines or devices need to be returned to the suppliers. Medicines are not always stored in appropriately labelled containers. This could mean the pharmacy is not able to identify all stock affected by drug recalls or alerts. 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 and staff said they went to the door if necessary. Large font labels could be printed to assist visually impaired patients. Staff could converse in Cantonese, Mandarin, Arabic, Punjabi and Urdu to assist patients whose first language was not English. Patients were signposted to other local services including the doctor's surgery.

The pharmacist was aware of the procedure for supply of sodium valproate to people in the at-risk group and the intervention would be recorded on the PMR. There was information on the pregnancy prevention programme (PPP) and two sodium valproate information posters were displayed in the dispensary for staff reference. The pharmacist explained the procedure for supply of isotretinoin to people in the at-risk group and recording of the intervention. The prescriber would be contacted regarding prescriptions for more than 30 days' supply of CD. When supplying warfarin people were asked about blood test dates and for their record of INR. The dose of the warfarin and the colour of tablets in relation to strength of warfarin was explained. Advice was given about side effects of bruising and bleeding. Advice was given about over-the-counter and diet containing green vegetables which could affect INR. Patients taking methotrexate were reminded of the weekly dose and taking folic acid on a different day. Advice was given to visit the doctor if sore throat or fever developed.

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). There was a planned audit regarding making sure steroid warning cards were given to people prescribed prednisolone. Health campaigns included increasing public awareness of stroke, sepsis and referring diabetic people for flu vaccinations.

Medicines and medical devices were delivered outside the pharmacy by a delivery person. The SOP referred to a delivery record book and patient signatures being recorded for a successful delivery. A delivery drop sheet was compiled and patient signatures were not always recorded. The pharmacist later confirmed that the delivery procedure was in the process of being reviewed to include a delivery sheet and recording of patient signatures if possible. A duplicate delivery sheet would be retained at the pharmacy during the delivery as a record of what was being delivered.

Medicines and medical devices were obtained from Alliance, AAH, Phoenix and Doncaster. Floor areas were clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and recorded. No date expired medicines were found in a random check. Liquid medicines were marked

with the date of opening. Medicines were generally stored in original manufacturer's packaging on the dispensary shelves. There were de-blistered morphine tablets in a container in the CD cabinet. The label did not include information such as batch number and expiry date. Cold chain items were stored in the medical fridge. Waste medicines were stored separately.Falsified medicines directive (FMD) hardware and software were not operational at the time of the visit.

Supplies of medicines via NHS Urgent Medicine Supply Advanced Service (NUMSAS), PGD, minor ailments and supervised consumption were reported on PharmOutcomes. Needle exchange was reported on PharmOutcomes. Drug alerts were actioned on receipt, annotated and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

Current reference sources included BNF and Drug Tariff. Minimum and maximum fridge temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinets were fixed with bolts. The Methasoft equipment was cleaned and re-calibrated daily. The dispensary sink required treatment to remove lime scale. The needle exchange sharps bin was located in the consultation room but lifted outside the door during the visit, when blister packs were being prepared. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff generally used their own NHS cards.

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.