

# Registered pharmacy inspection report

**Pharmacy Name:** Kidlington Pharmacy, The Health Centre, Exeter Close, Oxford Road, KIDLINGTON, Oxfordshire, OX5 1AP

**Pharmacy reference:** 1110429

**Type of pharmacy:** Community

**Date of inspection:** 03/07/2019

## Pharmacy context

The pharmacy is located in a health centre 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 substance misuse and NHS urgent medicines supply.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy's working practices are 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 asks people for their views. The pharmacy has written procedures which tell staff how to complete tasks effectively. 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

Near misses were recorded and reviewed but the pharmacist said near misses were greatly reduced by installation of the robot. Stock was loaded into the robot which read the barcode on the pack and chose a location. When generating labels as part of the dispensing process, the robot selected the required medicine. Errors involving 'lookalike, soundalike' (LASA) medicines were confined to medicines not stored in the robot. Stock stored on the shelves was greatly reduced in quantity, but the pharmacist explained that Fine Point needles 31G and 32G packs had been separated to minimise picking errors due to similar packaging. An annual patient safety report was completed. Learning points included elimination of LASA errors after installation of the robot. Reference was made to reduction in errors programming items into the robot. Patient safety improvements included use of clear plastic bags when supplying insulin to allow an additional check prior to transfer to the patient.

Workflow: the pharmacist explained that baskets were in use to separate prescriptions and medicines during the dispensing process. Red baskets were used for waiting prescriptions. Labels were generally generated by scanning the bar code on the prescription. Medicines were picked and delivered by the robot. There were separate dispensing and checking areas. The pharmacist performed the final check of all prescriptions prior to completing the dispensing audit trail. The label was endorsed [R] to show when the robot dispensed. Interactions between medicines were highlighted to the pharmacist. 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 doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance packs (blister packs) were prepared on a weekly rolling basis for a number of patients according to a matrix. Blister packs were prepared on a Sunday when it was quiet in the pharmacy. The pharmacy managed prescription re-ordering on behalf of patients. New patients were assessed for suitability for the service by the pharmacist. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a blister pack. Any patient's notes such as discharge summaries were recorded on the patient medication record (PMR). Labelling included a description to identify individual medicines and patient information leaflets were supplied with each set of blister packs.

High-risk medicines such as alendronate and controlled drugs (CDs) were supplied separately from the blister pack. The dates of CD prescriptions were managed to ensure supply within 28-day validity of the prescription. Levothyroxine and lansoprazole were supplied in the blister pack but patients/carers were counselled to ensure it was taken before other medication or food. The pharmacist said there were currently no patients taking sodium valproate supplied in a blister pack.

The practice leaflet was on display and included details of how to comment or complain. The annual patient questionnaire had been conducted and had resulted in positive feedback. People had commented that the pharmacy required more space. The standard operating procedures (SOPs) included a complaints procedure, responsible pharmacist (RP) procedures, an SOP regarding checking medicines were compliant with falsified medicines directive and dealing with uncollected prescriptions and returning the medicines to stock. There was a pharmacist locum guide. The pre-registration pharmacist said he would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. Hydrocortisone cream would not be sold for use on the face. Diabetic patients were generally referred to the pharmacist or doctor when they requested a remedy for a foot condition.

To protect patients receiving services, there was professional indemnity insurance in place provided by Numark expiring 15 Jan 2020. The majority of paperwork was available on the pharmacy computer system to maximise space in the pharmacy. The responsible pharmacist notice was on display and the responsible pharmacist log was completed. There was a notice on the pharmacy computer reminding pharmacists to complete the RP log. There were a small number of gaps in the record.

The CD register was electronic and provided through Proscript. The CD registers were complete and the balance of CDs was audited weekly. A random check of actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. Patient returned CDs were recorded manually in the destruction register for patient returned CDs. A random sample of FP10MDA entries complied and the prescription was endorsed at the time of supply. Specials records were complete. Private prescription records did not always include full prescriber details.

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. Confidential waste paper was collected for safe disposal and there was a cordless phone to enable a private conversation. Staff used their own NHS cards. A privacy notice 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 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: three regular full-time pharmacists, four regular locum pharmacists, one full-time pre-registration pharmacist, one full-time trainee pharmacy technician, one full-time dispenser, and one newly recruited part-time staff member to cover Saturdays.

The pharmacist was the pre-registration tutor. The pre-registration pharmacist was enrolled on ProPharmace pre-registration training and attended regular training days. Regular weekly protected learning time was set aside for study. Study topics had included chapters of the British National Formulary (BNF), calculation, legislation and over-the-counter medicines. The pre-registration pharmacist regularly joined the practice pharmacist's clinic in the health centre to increase his clinical knowledge. Staff were provided industry publications including Counter Intelligence which included new product information and treating minor ailments with medicines purchased over-the-counter. Staff had also completed Children's Oral Health and Risk Management. All staff were trained to re-load the robot with stock.

There were staff appraisals including the pre-registration 13 weekly appraisals which were documented. Staff were able to provide feedback anonymously if they wished. There was a whistleblowing policy. Staff had suggested changing the location of CD prescriptions awaiting collection from the bottom shelf of the CD cabinet to the top shelf for easier removal. Targets and incentives were not set.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The premises are clean, secure and suitable for the provision of its services.

### Inspector's evidence

The pharmacy premises were located at the entrance to the health centre and restricted in size so the arrangement of equipment, stock and documentation was well organised. The pharmacy was clean including the dispensary benches and sink.

Lavatory facilities were located separate to the pharmacy in the health centre. The consultation room was located beside the medicines counter and protected patient privacy. The door to the consultation room was lockable. The chaperone policy was displayed. There was sufficient lighting and ventilation provided by fans.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's working practices are 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. 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 and large font labels could be printed to assist visually impaired patients. There was access to a hearing loop in the health centre if necessary. Staff could converse in Hindi, Polish, French and Vietnamese to assist patients whose first language was not English. Patients were signposted to other local services including dentist, minor ailments unit, optician and podiatrist.

Prescriptions for more than one month's supply of a CD were queried with the prescriber although the intervention had not always been recorded. Prescriptions for CDs were highlighted to collect patient signatures for schedule 2 and 3 CDs. Filed prescriptions awaiting collection were checked to ensure CDs were not supplied outside the 28-day validity of the prescription. Stickers were attached to prescriptions to highlight any high-risk medicines being supplied such as warfarin and methotrexate. The pharmacist would then counsel the patient on how best to take their medication. Patients taking warfarin had their blood tests at the health centre. During a medicine use review, 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 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.

The pre-registration pharmacist said he would ask patients taking lithium if they had had a recent blood test and to seek medical assistance if they developed blurred vision. The pre-registration pharmacist explained the procedure for supplying isotretinoin to patients including giving advice on the pregnancy prevention programme and what interventions would be recorded. During the visit, the pharmacist explained using a blister pack to a new patient. The pharmacist said that following the visit, a record of interventions such as therapeutic monitoring checks was being kept showing that appropriate counselling was provided to protect patient safety.

The pharmacy did not have healthy living status due to space restrictions although staff had completed training. NHS England health campaigns were conducted and the most recent had been children's oral health. Audits were conducted and included referral for prescription of proton pump inhibitor for gastric protection while taking non-steroidal anti-inflammatory drug (NSAID) and the use of inhalers to best control asthma. There was information on the risk of taking sodium valproate while pregnant to give patients in the at-risk group regarding the pregnancy prevention programme.

Medicines and medical devices were obtained from Alliance, AAH and Phoenix. Falsified medicines directive (FMD) hardware and software had were operational at the time of the visit. Floor areas were clear, and stock not suitable for the robot was neatly stored on the dispensary shelves. Liquid medicines were marked with the date of opening. Non-robot stock was date checked every three months and

short dated stock was highlighted. Medicines were stored in original manufacturer's packaging. Medicines were stored in the robot. The robot read the bar code and located medicines in a specific shelf. A date of expiry was entered manually when loading the robot so the robot could alert the pharmacy team to short dated items. The seal on each pack was checked visually. Part packs were also stored in the robot. Excess stock was stored in cabinets in the consultation room. Cold chain items were stored in two medical fridges.

There was limited stock of over-the-counter medicines to purchase. The pharmacy said supplies of medicines via NHS Urgent Medicine Supply Advanced Service (NUMSAS) was popular due to the opening hours of the pharmacy. Substance misuse services were accessed by a number of patients. Drug alerts were actioned and a record of action taken was maintained in a matrix.



## 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. There was a range of British standard glass measures to measure liquids including separate marked measures for methadone. The use of a plastic syringe to measure methadone regarding weights and measures requirements was discussed.

The SOP to operate the robot was displayed. There was an annual maintenance and service and 24 hour call out in the event of breakdown. The robot had an emergency mode so the pharmacy could remain operational. The medical fridges were in good working order. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinet was fixed with bolts.

Confidential waste paper was collected for safe disposal and there was a cordless phone to enable a private conversation. Staff used their own NHS cards. A privacy notice was displayed.

### 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.