General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lloydspharmacy, Windrush Health Centre, Welch Way, WITNEY, Oxfordshire, OX28 6JS

Pharmacy reference: 1111414

Type of pharmacy: Community

Date of inspection: 20/04/2023

Pharmacy context

The pharmacy is next door to a health centre surgery near the centre of Witney in Oxfordshire. It dispenses NHS and private prescriptions and provides health advice. Services provided by the pharmacy include Community Pharmacist Consultation Service (CPCS), delivery, new medicines service (NMS), blood pressure case-finding, supervised consumption, 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

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
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 provides the pharmacy team members with clearly written instructions to make sure they work safely. They discuss the mistakes they make while dispensing medicines 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 explained that when a near miss was identified, it was shown to the team members and discussed before completing the near miss record. So, they learned from their mistakes and reduced the chances of them happening again. The dispensing assistant showed how medicines involved in incidents, or were similar in some way, such as clobetasol and clobetasone preparations, were generally separated from each other in the dispensary. The pharmacy's safety information was included in regular patient safety reviews (PSRs). As a result of an incident, the dispensing assistants had introduced an additional check when they were dispensing certain medicines. 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 medicines. And assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP).

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these had been reviewed since the last inspection. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. The pharmacy maintained individual training records for each member of the team. The team members were able to describe the latest SOP they had read and how they would follow the sales protocol when selling over-the-counter (OTC) medicines. They would refer repeated requests for medicines liable to abuse to a pharmacist. Members of the pharmacy team discussed what they could and could not do if a pharmacist was not present and what they were responsible for. Their roles and responsibilities were described in the SOPs. The pharmacy had a complaints procedure and members of the public could leave feedback about the pharmacy and suggestions on how it could do things better via online reviews.

The pharmacy had risk-assessed the impact of COVID-19 on its services and the people who used it. It had screens at the medicines counter, hand sanitiser for people to apply and team members followed a protocol of wearing fluid resistant face masks to help contain respiratory tract infections. The pharmacy team regularly completed a professional standards audit to monitor how it provided its services. Team members also participated in pharmacy quality scheme (PQS) audits to monitor how effectively people were using medicines they took such as valproates, anti-coagulants, asthma and antibiotics.

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. The pharmacy had a controlled drug (CD) register. And its team made sure the CD register was kept up to date and the stock levels recorded in the CD register were checked regularly. So, the pharmacy team could spot mistakes quickly. A random check of the actual stock of a CD matched the recorded amount. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. The pharmacy team members recorded the private prescriptions it supplied in the private prescription register but they had fallen behind completing some of the entries. During the visit the pharmacy team gave an assurance that the private prescriptions would be entered up to date.

The pharmacy displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy. Its team tried to make sure people's personal information could not be seen by other people and was disposed of securely. The locum pharmacist and a member of the team were using their own NHS Smartcards. The pharmacy's team had trained in the safeguarding SOP so they 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 RP had completed a level 3 safeguarding training course. The pharmacy team were signposted to the NHS safeguarding Ap.

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 its team members with enough support for them to keep their skills up to date although it does not always give them any protected learning time. They are able to provide feedback about services to the pharmacist and they know how to raise concerns.

Inspector's evidence

The pharmacy team consisted of a locum pharmacist who was the RP, three full-time pharmacy assistants (who had completed accredited training as dispensing and medicines counter assistants) and a delivery person who was shared with another branch of the pharmacy. The pharmacy was trying to recruit two additional members of the team. It provided ongoing training for support staff via a training platform. But team members were not allocated protected learning time at the time of the visit because the team was short-staffed.

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 by the pharmacy team. One member of the team generally organised the preparation of compliance aids. The pharmacy had an OTC sales protocol on display for the team to refer to and it described the questions the team member needed to ask people when making OTC recommendations.

Team members were comfortable about making suggestions on how to improve the pharmacy and its services. And they had suggested an improved way of locating bagged prescriptions when people visited the pharmacy to collect them. They knew who they should raise a concern with if they had one. The pharmacy was in the process of changing ownership and it was trying to recruit new team members so some processes such as their appraisals had been postponed until the new ownership was finalised. The pharmacy had been running with no permanent RP so the team members had been completing much of the routine administrative tasks.

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. clean and presented a professional image. Steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a retail area, a counter, a small dispensary and a separate area where compliance aids were prepared. Its fixtures and fittings generally appeared to be well maintained. Pharmacy medicines were behind Perspex screens with ‘ask for assistance’ labels. The pharmacy team cleaned the pharmacy. The pharmacy had signposted its consultation room which was tidy. So, people could have a private conversation with a team member. The dispensary had limited storage available and designated work bench space could become cluttered when the pharmacy was busy. The pharmacy had a sink which required treatment to prevent a build-up of limescale.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people with different 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 had a wide entrance which was level with the outside pavement. This made it easier for people who used a wheelchair to enter the building. The pharmacy team tried to make sure people with different needs could use the pharmacy services. The pharmacy displayed notices that told people when it was open and about some of the services the pharmacy offered. The pharmacy had seating for people to use if they wanted to wait. Members of the pharmacy team were helpful and signposted people to another provider if a service was not available at the pharmacy. The pharmacy team members could speak or understand Spanish and Romanian which was helpful to some people whose first language was not English. There was a hearing loop and large font labels could be printed so they were easier to read.

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 used a disposable pack for people who received their medicines in compliance aids. The pharmacy team managed re-ordering of prescriptions and checked whether a medicine was suitable to be re-packaged. It provided a brief description of each medicine contained within the compliance aids and it provided patient information leaflets. So, people had the information they needed to make sure they took their medicines safely. Members of the pharmacy team initialled dispensing labels to show which of them prepared a prescription. And they marked prescriptions to highlight interactions between medicines prescribed for the same person and to show when a pharmacist needed to speak to the person about the medication they were collecting. Interventions were recorded on the patient medication record (PMR) or in an intervention book.

The RP was 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 RP explained counselling points to discuss with people when they were collecting some medicines such as warfarin which required monitoring to make sure it was taken safely. The pharmacy provided the weight management service via the pharmacy's online prescribing service. People's weight loss was monitored by a regular locum pharmacist and if there was any deviation from the service procedure, no more prescriptions were issued. The locum pharmacist also monitored delivery of the new medicines service which helped people get the most from newly prescribed medicines Community Pharmacist

Consultation Service (CPCS) referrals were received via PharmOutcomes.

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. And it generally recorded when it had done a date-check. No expired medicines were found on the shelves amongst in-date stock. 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 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 the pharmacy had 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 certain liquids. Members of the pharmacy team made sure they cleaned the equipment they used to measure out, or count, medicines before they used it. The pharmacy team had access to up-to-date reference sources.

The pharmacy team members monitored the maximum and minimum fridge temperatures for pharmaceutical stock requiring refrigeration. The pharmacy team disposed of confidential waste appropriately. 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.