

Registered pharmacy inspection report

Pharmacy Name: Ahmeys Pharmacy, 150 Oxford Road, Cowley,
OXFORD, OX4 2EA

Pharmacy reference: 1115951

Type of pharmacy: Community

Date of inspection: 21/10/2020

Pharmacy context

The pharmacy is on a busy road in a mixed commercial and residential area of Oxford. 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 collection and delivery and substance misuse service. The pharmacy has healthy living status. All aspects of the pharmacy were not inspected on this occasion. The inspection took place during the COVID-19 pandemic.

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

The pharmacy's working practices are safe overall. It has written procedures to identify and manage risks and they tell staff how to work safely. The pharmacy team members have introduced new ways of working to protect people against COVID-19 infection. The pharmacy generally keeps the records it needs to so it can show it supplies its medicines safely and legally. Its team members understand their role in protecting vulnerable people. And they keep people's private information safe. But they do not always record their mistakes, so they may miss opportunities to learn and prevent the same errors happening again.

Inspector's evidence

The pharmacy team recorded some near misses although all the fields were not completed in the record that was seen. So, the pharmacy team may be missing opportunities to learn from their mistakes. Staff had re-arranged medicines stock A-Z on the dispensary shelves with some 'lookalike-soundalike' (LASA) medicines being separated to minimise picking errors. For example, amlodipine and amitriptyline were on different shelves. Analgesics were together in one place and antibiotics were all stored together in another location. On some packs the name of the medication had been printed in a way that prompted checking a LASA medicine had not been picked in error. For instance, cefalexin was printed as 'cefALEXin'. Prednisolone was in a separate place to reduce risk of picking errors in line with NHS Oxfordshire policy.

The pharmacy had completed risk assessments for the premises and staff including Black, Asian and Minority Ethnic (BAME) employees, most of whom also had vulnerable relatives at home. Staff had personal protective equipment (PPE) which was changed regularly during the day. The pharmacy displayed posters explaining social distancing and reminding people to wear face coverings when entering the pharmacy. The entrance was wide and opened automatically when entering or leaving the pharmacy avoiding anyone having to touch and contaminate a door handle. A one-way route around the public area had been marked out with floor stickers so people knew where to stand. Two members of the public could be in the pharmacy at a time. Hand sanitiser was available for people to use and a large screen had been fitted at the medicines counter. Staff cleaned the surfaces in the pharmacy during the day and a company cleaned the pharmacy weekly. Most payments were by contactless card transactions. The pharmacy had assorted masks and hand sanitiser products for sale.

The pharmacist said there was a business continuity plan which included liaising with two other local community pharmacies so that if the pharmacy had to close due to the 'test and trace' scheme, patients would still receive their medicines. Available resources were discussed such as checklist for closing and advice for community pharmacies via the Pharmaceutical Services Negotiating Committee (PSNC). The pharmacist was aware of the need to report COVID-19 cases contracted in the workplace to the relevant authorities under Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The pharmacy's standard operating procedures (SOPs) were available to view on the pharmacy

computer. The author's name and review dates were recorded, and SOPs included responsible pharmacist (RP), complaints, dealing with controlled drugs (CDs), delivery of medicines and supplying high-risk medicines. There were training records, but these were due to be updated. The staff member at the medicines counter said he would not sell co-codamol tablets or give out a prescription if the pharmacist were not on the pharmacy's premises.

The pharmacy had professional indemnity insurance in place to protect patients receiving services, provided by NPA and renewed in July each year. The RP log was completed but the RP did not always sign out at the end of the session. The RP notice was printed to show the RP was provisionally registered. The CD registers were mostly complete, and the balance of CDs was audited regularly. The pharmacist said the pharmacy planned to move to electronic CD registers and staff members would have their own PIN code to access the register. The pharmacy team recorded supplies via private prescription electronically although some of the required information was missing on the records viewed. Records for patient group direction, emergency and 'specials' supplies were not seen during the visit.

Staff had signed confidentiality agreements. The pharmacy's privacy notice as required under General Data Protection Regulation (GDPR) was not seen but the RP said he would re-print and display it. Confidential wastepaper was shredded. There was a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly. The pharmacist said the data security and protection (DSP) toolkit had been submitted. The pharmacists were accredited at level 2 in safeguarding training and new support staff were due to undertake safeguarding training.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough suitably qualified staff on duty to safely provide its services. The pharmacy's team members work well together, and they are supported with ongoing training. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: three full-time pharmacists, one part-time pharmacist, one full-time pharmacy technician and four full-time dispensers of whom one was also an accredited medicines counter assistant. There were two delivery drivers and one member of staff who managed stock ordering for the pharmacy and its branch in another town.

One full-time pre-registration pharmacist was due to commence employment and a pre-registration tutor had not been appointed at the time of the visit. The provisionally registered pharmacist was RP at the time of the visit. A risk assessment had been completed and would be updated monthly. There was a senior pharmacist to refer to and study time had not yet been formally agreed.

Staff were provided in-house training on topics such as digital and consultation skills to be able to take a clinical history when a patient visited the pharmacy regarding treatment for a minor illness. Staff could then refer the person to one of the pharmacists who was a pharmacist independent prescriber (PIP). The pharmacy team were planning to undertake the required training for the pharmacy quality scheme (PQS) part 2. The pharmacist was signposted to recent GPhC guidance for training of support staff.

Staff performance was monitored via regular appraisals. There were coffee meetings and team members felt able to make suggestions including purchasing an extra dispensary fridge and installing scanning equipment which would encompass falsified medicines directive and add barcodes to prescription labels to provide an audit trail identifying the patient, prescription and the medicines prescribed. So, during the dispensing process if an incorrect item was picked and then scanned the system would alert the pharmacy team to the error. Daily activities and responsibility for the activity was agreed at the team meetings. The pharmacy had a whistleblowing policy.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are safe and clean and suitable for the provision of services. The pharmacy team has introduced additional cleaning measures and equipment to help protect people from COVID-19 infection. The pharmacy prevents people accessing its premises when it is closed so that it keeps its medicines and people's information safe.

Inspector's evidence

The pharmacy reduced the risk of COVID-19 infection with daily cleaning routines by staff and a weekly clean provided by a company who used a product that they claimed provided 30 day's cover against infection. Two people could enter the pharmacy at a time and follow marks on the floor in a one-way system to maintain a social distance. As it was a very wet day there were signs to warn members of the public about slipping on the wet floor. The pharmacy had installed a screen which provided protection at the medicines counter and hand sanitiser was available for people to use. Payments for goods were generally by contactless card transactions. The pharmacy displayed posters reminding people about the need to keep a safe distance and cover their face when entering the pharmacy. There was hand sanitiser for people to apply and the pharmacy sold masks and hand sanitiser.

The pharmacy's premises were generally clean and the public facing retail area was tidy. The dispensary was spacious meaning staff could work at a safe distance from each other. It was located on the same level behind the retail area and there was access to the consultation room and a separate room where compliance aids were prepared. The consultation room door to the public area was closed but it provided a large, private area if needed. The dispensary sink and lavatory facilities were generally clean and hand washing equipment was available if needed.

There was sufficient natural and artificial lighting and air conditioning.

Principle 4 - Services ✓ Standards met

Summary findings

People with different needs can easily access the pharmacy's services. The pharmacy gets its medicines from reputable sources to protect people from harm. They know what to do if any medicines or devices need to be returned to the suppliers. The pharmacy team members give advice to people about where they can get other support. The pharmacy does not always keep a record when checking that medicines are safe for people to take. So it may not be able to show it gives appropriate advice to help protect patient safety.

Inspector's evidence

The pharmacy provided wheelchair access via the automatically opening entrance doors. Large font labels could be printed to assist visually impaired patients. Staff could converse in Hindi, Urdu, Mandarin, Malay, Arabic and French to assist patients whose first language was not English. Google translate was also available.

The pharmacy team said people were signposted to other local services but mainly the pharmacy because the doctor's surgeries were generally closed. The pharmacy and the PIP received referrals via the community pharmacy consultation service (CPCS) and were aware of forthcoming health campaigns promoting the flu service and managing winter illnesses. Other health related promotion included mental health awareness and self-care week in November to encourage people to seek medical advice for health conditions now that lockdown was over. The pharmacy had not yet started offering the flu vaccination service at the time of the visit. The pharmacists were signposted to information on the GPhC website such as the 'Knowledge Hub'.

Workflow: the pharmacy team generated labels and picked medicines from reading the prescription. The pharmacy computer system flagged up any changes to medication from the previous prescription. Patients re-ordered their own prescriptions via an App. The pharmacy team re-ordered prescriptions on behalf of vulnerable patients via email to the surgery using the NHS account. The pharmacist performed the clinical and final check of all prescriptions and there were separate dispensing and checking areas. The dispensing audit trail to identify who dispensed and checked medicines was seen to be completed during the visit. Interactions between two medicines for the same person were checked although interventions were not always recorded on the patient medication record (PMR). The pharmacy had 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 pharmacy team asked the patient how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Medicines were delivered outside the pharmacy by the delivery persons who had PPE. Deliveries were contactless and according to a daily drop sheet. The delivery persons signed on behalf of the patient for receipt of the medicines. Items which were not successfully delivered were returned to the pharmacy and stored on separate labelled shelving until transferred to the patient.

The pharmacy team prepared multi-compartment compliance aids for a number of patients who lived in the community or in one of two care homes. They managed prescription re-ordering on behalf of patients. Care home staff submitted a list of items to be ordered and the pharmacy staff ordered the

prescriptions on behalf of the care home patients. Communication between the care homes and the pharmacy was via a dedicated email account. Information relating to the compliance aids was recorded on the patient medication record (PMR). The pharmacy computer flagged up any changes in the current prescription compared to the previous prescription. Compliance aids were dispensed in a separate room off the dispensary. The pharmacist had a daily list of due compliance aids and checked one set of compliance aids at a time to avoid 'cross-over' errors by checking compliance aids for more than one person at a time. High-risk medicines were supplied separate to the compliance aid unless specifically requested for a patient. The RP checked the stability of sodium valproate preparations if they were to be included in a compliance aid. Medicines administration record (MAR) charts were supplied for care home patients and to record external medicines such as creams or inhalers. Labelling included a description of medicines and patient information leaflets were supplied with each set of compliance aids. The dates on CD prescriptions were managed to ensure supply was within the 28-day validity period of the prescription.

The pharmacist knew the procedure for supply of sodium valproate to people in the at-risk group and information on the pregnancy prevention programme (PPP) would be explained. There was information to give to people in the at-risk group. The pharmacist explained the procedure for supply of isotretinoin to people in the at-risk group. The prescriber would be contacted regarding prescriptions for more than 30 days' supply of a CD. Ensuring interventions were recorded was discussed. Warning stickers were attached to prescriptions for high-risk medicines such as fridge items or CDs.

When supplying warfarin, people were asked for their record of INR along with blood test due dates. The INR was not always recorded on the PMR. Advice was given about side effects of bruising and bleeding and about over-the-counter (OTC) medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were reminded about the weekly dose and when to take folic acid. The RP said that prescriptions for schedule 4 CDs were highlighted to ensure the supply was made within 28 days of the date the prescription was issued.

Medicines and medical devices were obtained from Alliance, AAH, Sigma and Colorama. Floor areas were mostly clear, and stock was stored neatly on the dispensary shelves. Dispensary stock was date-checked and recorded. No date-expired medicines were found in a random check. Liquid medicines were marked with a date of opening. Medicines were mostly stored in manufacturer's original packaging. Not storing medicines in original packaging may affect stability or mean that affected stock cannot be identified in response to a drug alert or recall. Cold chain items were stored in the medical fridge and the RP demonstrated taking minimum and maximum temperatures.

Uncollected prescriptions were cleared from retrieval every month after the patient had been contacted. Waste medicines were stored separate from other stock. The pharmacy was installing scanning equipment which was integrated with falsified medicines directive and added barcodes to prescription labels to provide an audit trail identifying the patient, prescription and the medicines prescribed. Drug alerts and recalls were actioned and but not always annotated and filed to show what actions had been taken.

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 dispensary sink was clean. The measures in use to measure liquid medicines including CDs and water to reconstitute antibiotic solutions were plastic. Ensuring they complied with weights and measures requirements was discussed. The laptop connected to the Methameasure recording supplies of methadone prompted daily cleaning and recalibration of the equipment.

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.