General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: North Abingdon Pharmacy, 45 Loyd Close, Abingdon, Oxfordshire, OX14 1XR

Pharmacy reference: 9010292

Type of pharmacy: Community

Date of inspection: 21/05/2019

Pharmacy context

The pharmacy is located within the same building as 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 (MDS blister packs) for people who have difficulty managing their medicines. Services include prescription collection and delivery, substance misuse and seasonal flu vaccination.

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 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 well and keeps people's information safely. The pharmacy asks its customers for their views. The pharmacy has written procedures which tell staff how to complete tasks safely. 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 at a low rate. 'Lookalike, soundalike' (LASA) medicines had been separated on the dispensary shelves to reduce picking errors. Amitriptyline and amlodipine had been separated. Pregabalin and gabapentin were separated to avoid picking errors including mixing up different strengths. Prednisolone tablets were stored separately in line with NHS Oxfordshire policy, in a drawer away from other stock.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. The processes of picking medicines and generating labels were shared between both dispensers. Labels were generated, and medicines were picked from reading the prescription. There were separate dispensing and checking areas. The dispensing audit trail was completed to identify who dispensed and checked medicines. The pharmacist performed the final check of all prescriptions prior to transfer to the patient.

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.

Multi-compartment compliance packs (MDS blister packs) were prepared for a number of patients according to a matrix and one week in advance of when supply was due. The pharmacy managed repeat dispensing prescription re-ordering on behalf of patients. Weekly prescriptions were issued for supply of controlled drugs (CDs) to manage 28-day validity period. Alendronate was supplied separately or positioned on its own in the blister pack if necessary. The dose for levothyroxine stated it should be taken 30 minutes before food. There were currently no patients taking sodium valproate and who were supplied medicines in a blister pack.

The pharmacy liaised with the prescriber and a relative if appropriate when a new patient was identified who would manage taking their medicines more effectively via a blister pack. The time of day when each medicine was to be taken was agreed.

Each patient had their own patient record sheet which was retained in a folder along with their discharge summaries and notes in a polythene sleeve. The double-sided record sheet included patient details, contact details, collection or delivery information, monthly/weekly supply, extra medicines not included in the blister pack, a visual grid for position and medication administration details in the blister pack. Any changes to medication were also to be listed. Labelling included a description to identify

individual medicines and package information leaflets were supplied with each set of blister packs.

Standard operating procedures (SOPs) were updated regularly by head office and included responsible pharmacist and complaints procedures. The date of the next expected review was July 2020. The dispenser who also served at the medicines counter said she 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. The WWHAM questions when selling ibuprofen were explained and diabetics were generally referred to the pharmacist or doctor when they requested a remedy for a foot condition.

The practice leaflet was due to be reprinted. The annual patient questionnaire had been conducted and results were on display and included comments on the consultation room which was located near the entrance.

To protect patients receiving services, there was professional indemnity insurance in place provided by Numark expiring 31/12/2019.The responsible pharmacist (RP) notice was on display and the responsible pharmacist log was completed although the RP had not always signed off at the end of a session. Records for private prescriptions and special supplies were generally complete.

Following recent changes in classification of gabapentin and pregabalin, there was a private prescription for supply of gabapentin (a schedule 3 CD) which was not written on a standardised form. Later the pharmacist confirmed that the surgery where the prescription was issued had been contacted and the prescription re-issued on a FP10PCD. The private prescription was for more than one month's supply of a CD for which an intervention had been recorded on the patient medication record (PMR) as good practice. The pharmacist said the accountable officer had been informed and sharing the learning with other branches of the pharmacy was discussed.

The CD and methadone registers were generally complete and the balance of CDs was audited regularly although not weekly in line with the SOP. A random check of actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. There was a discussion about increasing the frequency of audit of methadone, so the overage would reduce. A random check of FP10MDA entries complied and the prescription was endorsed at the time of supply. A small number of headers were not completed. Footnotes correcting entries were not always signed and dated. Invoice details for receipt of CDs were not always complete.

Patient returned CDs were recorded in the destruction register for patient returned CDs but witness signatures to destruction were not always recorded. Patient group direction (PGD) was in date and valid. Supplies were reported on PharmOutcomes.

Staff had signed confidentiality agreements and were aware of procedures regarding General Data Protection Regulation (GDPR) following training provided by head office. The pharmacist said the Data Security and Protection toolkit had been completed at head office. Confidential waste paper was collected for safe disposal and a there was a cordless phone to enable a private conversation. Staff were using their own NHS cards. The leaflet 'Your data matters to the NHS' 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: one regular pharmacist, one part-time pharmacist on Saturdays, two dispensers both accredited as medicines counter assistants and one training to be a pharmacy technician and a delivery driver. There was a vacancy for a part-time medicines counter assistant.

Staff were provided Numark training materials on a monthly basis. Counter Excellence topics had included dementia and engaging with patients. There was a quiz to complete at the end of the topic. The trainee pharmacy technician was allocated 8 hours study time per week if the pharmacy was not busy. The pharmacist was undertaking a clinical diploma sponsored by head office. There was no protected learning time. Training had been provided by head office in wholesale distribution for a recent MHRA inspection.

The pharmacist said staff were due to have an appraisal. Staff said they were able to provide feedback and had suggested trialling the reminder card for repeat prescriptions to reduce the calls to patients regarding prescriptions due for collection. Staff said targets were set for MURs but patient safety and wellbeing were not affected.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean, secure and suitable to provide services and healthcare.

Inspector's evidence

The premises were generally clean and tidy. The public area presented a professional image. There were chairs in the waiting area. The sink used for medicines preparation required treatment to remove lime scale and staining. The lavatory was clean and handwashing equipment was provided.

The consultation room was not locked when not in use. The cabinets were not locked although they were used to store documentation. Waste medicines and wholesale stock was stored in the consultation room. Patient privacy was protected. There was sufficient lighting and air conditioning.

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. The pharmacy team does not always follow the written procedures for delivery and this may make it difficult to investigate when people query a failed delivery of their medicines. 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 wide automatic doors at the entrance. Large font labels could be printed to assist visually impaired patients. Staff could converse in Mandarin and Cantonese to assist patients whose first language was not English.

Patients were signposted to the surgery, A&E and NHS 111. There was a book to record interventions and the pharmacist had recorded the intervention regarding a schedule 3 CD prescribed for more than one month. The pharmacy had level 1 healthy living status. Staff had completed training in Children's Oral Health and Risk Management. The safety of the premises had been risk-assessed regarding hazards, environment and cleaning.

Audits had been conducted. No patient was identified for referral for prescription of proton pump inhibitor for gastric protection during the non-steroidal anti-inflammatory drug (NSAID) audit. The audit regarding use of inhalers in the treatment of asthma resulted in no referrals to the doctor. There were no female patients prescribed sodium valproate. There was information to distribute to female patients of child bearing potential regarding sodium valproate and the pregnancy prevention programme. The pharmacist conducted an audit and only male patients were supplied sodium valproate at the time of the visit. The pharmacist was signposted to information regarding both phases of the audit of sodium valproate.

There were toothbrushing charts and information on 'protect your child's smile'. Other previous health campaigns had included Stoptober, mental health awareness, smear awareness and oral health. The NHS.UK entry and email were current.

Patients taking warfarin were asked for their record of INR which was sometimes recorded on the PMR. If the patient had no yellow book they were given a yellow book. The dose of warfarin was checked. Advice was given about side effects of bruising and bleeding. Advice was given about over-the-counter medicines and diet 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 rash developed. Blood test dates were checked.

All CD prescriptions were highlighted to prompt recording a signature on the reverse of the prescription and check date before handing out the CD to the patient. CD stickers were in use. Medicines and medical devices were delivered outside the pharmacy. The delivery driver had not signed the SOP for

delivery. A drop sheet was prepared with bag labels and CD/fridge stickers were attached if appropriate. There was a failed delivery slip to put though the letterbox if the patient was not at home. A patient signature was not recorded in line with the delivery SOPs.

Falsified medicines directive equipment was not yet operational although the pharmacy computer system had been updated and staff had completed training. The SOP and scanner were not yet in place. Medicines and medical devices were obtained from AAH, Alliance and Phoenix. Floor areas were clear. Stock was date checked and recorded. No date-expired medicines were found. Liquid medicines were marked with the date of opening. Medicines were generally stored in original manufacturer's packaging although there were a small number of tablets not in original packaging. The risk of missing affected batches on receipt of a drug alert was discussed. Cold chain items were stored in the medical fridge. Waste medicines were stored in the consultation room. Although there was not much storage space generally, security of waste medicines and risk of diversion was discussed.

Uptake of services: one supply of trimethoprim was made via PGD and recorded on Pharma Outcomes per week. Drug alerts were actioned on receipt, annotated and filed. A matrix was completed.

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. Measures required treatment to remove lime scale.

The medical fridge was in good working order. Minimum and maximum temperatures were monitored daily and found to be within range 2□-8□. The CD cabinet was fixed with bolts.

Staff had signed confidentiality agreements and were aware of procedures regarding General Data Protection Regulation (GDPR) following training provided by head office. The pharmacist said the Data Security and Protection toolkit had been completed at head office. Confidential waste paper was collected for safe disposal and a there was a cordless phone to enable a private conversation. Staff were using their own NHS cards. The leaflet 'Your data matters to the NHS' 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.