General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hanborough Pharmacy, Willis Court, Long Hanborough, Witney, Oxfordshire, OX29 8FQ

Pharmacy reference: 9011558

Type of pharmacy: Community

Date of inspection: 01/02/2022

Pharmacy context

The registered pharmacy is co-located in the dispensary of a dispensing doctor's surgery in a rural village. It dispenses NHS prescriptions on behalf of the dispensing doctor's practice as well as those for people using the pharmacy itself. It also dispenses 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 delivery, vaccinations for chicken pox and seasonal flu. The pharmacy and dispensing doctor's surgery re-located to a new site within the same village. The pharmacy opened during March 2021. The inspection took place during the COVID-19 pandemic. All aspects of the pharmacy were not inspected.

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. It has adequate written procedures which tell team members how to manage risks and work safely. Pharmacy team members learn from mistakes they make to help prevent similar mistakes in future. They have introduced new ways of working to help protect people against COVID-19 infection. The pharmacy mostly keeps satisfactory records it needs to by law so it can show it is providing safe services. And it enables people to give their views on how it can improve its services. Members of the pharmacy team understand their role in protecting vulnerable people. And they keep people's private information safe.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The responsible pharmacist (RP) organised regular team meetings and the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. Mistakes involving the surgery were discussed with the surgery team to help reduce the risk of them happening again too. The RP reported errors through NHS 'learning from patient safety events' (LFPSE) service. The RP explained that if medicines stock in the robot was loaded correctly, it reduced the chances of picking errors. Medicines with more than one strength were separated by loading one strength into the robot and storing the other strength elsewhere in the dispensary. There may be more quantity errors due to full packs of medicine being dispensed by the robot. Most packs contained a multiple of 28 tablets or capsules which was the usual quantity prescribed. But some medicine packs contained 30 tablets or capsules meaning the quantity had to be adjusted if only 28 were prescribed.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided, and some were being reviewed. There were new SOPs reflecting different ways of working in the new pharmacy's premises. 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 RP had risk assessed the impact of COVID-19 upon the pharmacy's services and the people who used it. A written occupational COVID-19 risk assessment for each team member had been completed. The RP knew that any work-related infections needed to be reported to the appropriate authority. Team members were self-testing for COVID-19 twice weekly. They wore personal protective equipment (PPE) to help reduce the risks of infection. And they washed their hands regularly and used hand sanitising gel when they needed to. The RP had risk assessed the pharmacy's kick-steps and other ways the pharmacy team members could reach medicines stock stored on high shelves to avoid storage on the floor.

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 products. There were separate computer terminals in use for processing pharmacy or dispensary prescriptions and selecting medicines stock from the robot. The RP checked all assembled prescriptions before they were handed out. Prescriptions dispensed on behalf of the dispensing doctors were identified so they were to be dispensed separately. Team members initialled the dispensing labels to show who dispensed and checked medicines. Interactions between

medicines for the same person were highlighted to the RP.

Pharmacy team members understood their roles and responsibilities, what they could and couldn't do and when they should seek help. They wouldn't hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for medicines which may be abused, misused or overused to a pharmacist. The pharmacy had a complaints procedure and completed an annual review of complaints. Feedback was mostly verbal and generally positive. People liked the new pharmacy premises and improved facilities such as the medicines counter and consultation room.

The pharmacy had appropriate insurance including professional indemnity to cover the services it provided. It displayed a notice which told people who the RP was and kept a record to show which pharmacist was the RP and when. The pharmacy maintained a controlled drug (CD) register. And the stock levels recorded in the CD register were checked regularly. A random check of the actual stock of a CD matched the amount recorded in the CD register. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. The pharmacy recorded the private prescriptions it supplied. And records were generally in order. There were very few emergency supplies of medicines because the surgery was next door. The pharmacy recorded interventions on the patient medication record (PMR) and on Egton medical information system (EMIS) so the surgery was aware of the intervention too.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Members of the team tried to make sure people's personal information couldn't be seen by other people and was disposed of securely. The pharmacy had a safeguarding SOP. And the RP had completed a level 2 safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person. They could refer to the poster showing who to contact to raise their concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to deliver its services safely. They work well together to manage the workload. And they are supported in keeping their knowledge and skills up to date. Team members can make suggestions to improve services.

Inspector's evidence

The pharmacy team consisted of: the superintendent pharmacist who was also the regular RP and was full-time, regular part-time pharmacists who covered one day per week, three full-time dispensing assistants and a full-time medicines counter assistant. The pharmacy relied upon its team to cover absences.

Members of the pharmacy team had undertaken accredited training relevant to their roles and two were healthy living champions. They worked well together serving people and processing prescriptions safely. The RP was responsible for managing the pharmacy and its team, supervising the supply of medicines and advice given by the pharmacy team members. They had protected learning time when possible and training had been completed in a range of topics in line with the pharmacy quality scheme (PQS). These included risk assessments, dealing with 'look-alike, sound-alike' (LASA) medicines, inhaler technique, infection control and antimicrobial stewardship.

The RP organised daily, weekly and monthly meetings to brief the team on COVID and other updates, discuss near misses and share learnings and for the team to undertake some continuing professional development (CPD). Team members were encouraged to contribute to the agendas for meetings on the white board in the dispensary. There was a section on the whiteboard for deliveries, the robot, agenda, daily meeting and other events. Notes and reminders had been recorded for discussion.
The RP described an open policy to encourage team members to provide feedback at meetings. The RP prepared briefing sheets to share with the surgery team members so they understood how the pharmacy operated. For instance, a briefing sheet for methotrexate included checking blood test results before issuing the next prescription.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's new premises are clean, secure and suitable for the provision of healthcare. It protects the privacy of people receiving services and prevents unauthorised access to its premises when it is closed so that it keeps its medicines and people's information safe. The pharmacy's team members have introduced new ways to help protect people from COVID-19 infection.

Inspector's evidence

The registered pharmacy was in new purpose-built premises. It was clean, bright and secure. And steps were taken to make sure the pharmacy and its team didn’t get too hot. The pharmacy had a large retail area, a medicines counter and a spacious dispensary. There was underfloor heating, so the team tried to avoid leaving items on the floor. The pharmacy had a consulting room where people could have a private conversation with a team member. The chaperone policy was displayed. The screens at the medicines counter offered people some privacy as well as helping to protect against infection. The floor was marked so people knew where to stand and chairs were well separated in the waiting area. Members of the pharmacy team cleaned the pharmacy’s surfaces regularly throughout the day. And a cleaner cleaned the pharmacy daily.

Principle 4 - Services ✔ Standards met

Summary findings

People with different needs can easily access the pharmacy's services. The pharmacy's working practices are generally safe and effective. It sources, stores and manages its medicines to make sure they are fit for purpose. Members of the pharmacy team know what to do if any medicines or devices need to be returned to the suppliers. And they make sure people have all the information they need to use their medicines safely.

Inspector's evidence

The pharmacy had an automated wide door, and its entrance was level with the outside pavement. This made it easier entering the building for people who found it difficult to climb stairs such as someone using a wheelchair or who had small children. The pharmacy team could use the interpreter line for people whose first language was not English. And print large font labels so visually impaired people could read how to use their medicine. The pharmacy shared information about its services via a visual display unit and had a notice that told people when it was open. It had a seating area with well separated chairs for people who wanted to wait. Members of the pharmacy team were helpful, and they signposted people to another provider, such as the local walk-in centre or reception at the surgery, if a service wasn’t available at the pharmacy.

The pharmacy offered a repeat prescription collection service and people could have their medicines delivered to their homes by a delivery driver on behalf of the surgery. There was patient consent to send the prescription to the pharmacy, then to the surgery to deliver. There was an audit trail to check if deliveries were successful. The vehicle had a fridge to transport medicines requiring refrigeration. The pharmacy supplied medicines in multi-compartment compliance aids to people who had difficulty managing their medicines. The pharmacy team checked whether a medicine was suitable to be re-packaged. They provided a brief description of each medicine contained within the compliance aids and always provided patient information leaflets. So, people had the information they needed to make sure they took their medicines safely. The pharmacy team were ready to deal with referrals through the Discharge Medicines Service (DMS) but had not received many from the local hospital.

Members of the pharmacy team initialled the dispensing labels, to show who had prepared a prescription. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about a medicine they were collecting or if other items needed to be added. The RP described the valproate pregnancy prevention programme and counselling people in the at-risk group who were prescribed valproate on its contraindications. The pharmacy had the valproate educational materials to give to patients and the intervention was recorded on EMIS. The pharmacy team had warning cards to give people regarding high-risk medicines such as oral steroids, methotrexate and medicines to treat diabetes. They could add an alert to the PMR.

In line with the PQS, people taking a medicine for the first time could be counselled during new medicine service (NMS) consultations. The RP followed up initial consultations by phone to encourage people to use their medicines in the best way. The pharmacy was ready to start the hypertension case-

finding service by identifying suitable people and offering to check their blood pressure. There had been good uptake of the flu vaccination service this winter and the pharmacy had provided NHS, private and paediatric flu vaccinations via patient group directions (PGDs). Posters were displayed asking people to return their old inhalers to the pharmacy. And the RP was planning to conduct the anti-coagulant audit. And commence the weight management service. The pharmacy had completed the preparation and training required to offer the community pharmacist consultation scheme (CPCS) but had not received many referrals at the time of the visit.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices in their original manufacturer's packaging. Full packs of medicines were loaded into the robot and split packs of medicines were on the shelves. The robot was linked to the pharmacy and dispensary computers and when fully operational it produced a report of stock that had been dispensed on which to base an order. The pharmacy team regularly checked the expiry dates of medicines. And no expired medicines were found in the stock on the shelves in a random check. 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. Waste medicines were kept separate from stock in pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the RP described the actions they took and what records they kept when the pharmacy received a concern about a product via NHS email.

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

Members of the pharmacy team had access to current reference sources. The pharmacy had stamped glass measures to measure liquids. It had fridges to store pharmaceutical stock requiring refrigeration. And the maximum and minimum temperatures of the fridges were monitored and recorded. The pharmacy team collected and disposed of confidential waste appropriately. The pharmacy computers and PMR system were password protected. Computer screens could only be seen by members of the pharmacy team who used their own NHS smartcards when they were working. The robot had a manufacturer's manual and maintenance contract for servicing and dealing with breakdowns. The pharmacy team checked the expiry dates of stock before scanning the barcodes of packs and manually loading them into the robot. The blood pressure monitor was calibrated and there was a SOP to follow when measuring blood pressure and recording the results. Equipment for use during the weight management service had been received by the pharmacy.

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.