General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Apollo Pharmacy, 7 Lostock Place, Didcot, Oxfordshire, OX11 7XT

Pharmacy reference: 9011958

Type of pharmacy: Community

Date of inspection: 12/09/2023

Pharmacy context

The pharmacy is in small shopping precinct in a residential area in Didcot, Oxfordshire. The pharmacy dispenses NHS and private prescriptions. It sells over-the-counter medicines and provides health advice. It supplies medicines in multi-compartment compliance packs for people who have difficulty managing their medicines. Services include delivery and managed repeat prescription service. This was a routine inspection following approval to register as new pharmacy premises. The pharmacy opened early July 2023.

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 generally safe and effective. It provides members of the team with suitable written instructions they can follow to help them manage the risks associated with providing services and working safely. The pharmacy's team members discuss the mistakes they make to learn from them and take appropriate action to stop the same mistakes happening again. The pharmacy keeps the records it needs to show that medicines are supplied safely and legally. The pharmacy team members safeguard people’s private information. And they are trained in how they can help protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. The superintendent pharmacist (SI) discussed the mistakes recorded online by members of the pharmacy team during a weekly meeting. This helped them to learn from mistakes, sometimes spotting patterns or trends with the mistakes they made, and so reducing the chances of them happening again. A member of the team explained that medicines involved in incidents, or were similar in some way, such as pregabalin and gabapentin, were generally separated from each other in the dispensary. The pharmacy team members responsible for making up people’s prescriptions used different coloured baskets to separate each person’s medication and to help prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were checked by a pharmacist. The pharmacy team reported incidents and complaints to the SI in line with the complaints procedure. And incidents were reported to the NHS learning from patient safety events (LFPSE) service.

The pharmacy had standard operating procedures (SOPs) for responsible pharmacist (RP) and most of the services it provided. And these had been endorsed with details of their author, dates from which they were effective and when they would be reviewed. Members of the pharmacy team had job descriptions and understood their roles and responsibilities. They were required to read and sign the SOPs relevant to those roles to show they understood them and would follow them. The team members, who were doing combined training as dispensing and medicines counter assistants, described the over-the-counter (OTC) sales protocol with reference to a medicine which was liable to misuse. The pharmacy asked people for their views and suggestions on how it could do things better. The pharmacy had received positive feedback from people online.

The SI had risk-assessed the pharmacy’s premises as part of preparing to open and had identified issues to address such as wiring to be secured by an electrician. And the SI’s risk assessments (RA) had contributed to a decision to postpone introducing some planned services such as the flu vaccination service. The SI had risk-assessed recruitment of new team members and as a result had changed the procedure. The SI updated RAs annually and described audits to be completed as part of monitoring the pharmacy’s services. The pharmacy team would complete the sodium valproate audit and the audits required by the pharmacy quality scheme (PQS).

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 an electronic

controlled drug (CD) register. The SI and pharmacy team made sure the CD register was kept up to date. The stock levels recorded in the CD register were checked monthly according to the SOP. A pharmacy team member described the electronic records required for the supply of the unlicensed medicinal products and the private prescriptions it supplied. But the pharmacy had not made either supply yet at the time of the visit. The pharmacy recorded a few supplies of medicines via the community pharmacist consultation service (CPCS).

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. The pharmacy team tried to make sure people's personal information could not be seen by other people and was disposed of securely. The pharmacy team contracts of employment included information governance (IG) and Smartcard management procedures. The pharmacy had a safeguarding SOP. And the SI had completed a level 3 safeguarding training course. Members of the pharmacy team knew what to do and who they would make aware if they had concerns about the safety of a child or a vulnerable person. The SI was aware of 'ANI' safe space codeword scheme to help victims of domestic abuse. The SI was signposted to the NHS safeguarding Ap.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together to manage the workload. They are supported in keeping their knowledge up-to-date and developing their skills. Team members are comfortable about providing feedback to improve services and they can raise concerns if they need to.

Inspector's evidence

The pharmacy team consisted of the SI (also the RP), a full-time dispensing assistant, and a part-time dispensing assistant. The dispensing assistants were both enrolled on an accredited combined training course for medicines counter and dispensing assistants. Both team members also acted as delivery person if needed. The SI had a business continuity plan and was part of a network of local pharmacy owners who could share resources and re-direct phone calls to another pharmacy during an adverse event to help maintain provision of healthcare. The SI said it was difficult recruiting a pharmacist on a permanent basis.

Members of the pharmacy team needed to complete accredited training relevant to their roles. The SI explained that each team member had a human resources folder containing a contract of employment, annual appraisal records and their development plan. Pharmacy team members were allocated protected learning time and could access NHS elearning for healthcare. The SI communicated daily with the team via WhatsApp. Members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. There was a designated person for the team to contact with feedback or to raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are bright and suitable for the provision of healthcare. The pharmacy is secured when it closes so it protects people’s private information and it keeps the pharmacy’s medicines stock safe.

Inspector's evidence

The registered pharmacy premises were bright, clean and suitable for the provision of healthcare. And steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a retail area with seating for people who wanted to wait, a medicines counter, a spacious dispensary and storage area. The pharmacy had a consultation room where people could have a private conversation with a team member. The pharmacy’s chaperone policy and privacy notice were displayed. There were lockable cabinets to secure equipment.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team members try to make sure people with different needs can easily access pharmacy services. Their working practices are generally safe and effective. They mark prescriptions that contain medicines which require more information and support so people use them properly. The pharmacy obtains its medicines from reputable sources so they are fit for purpose and safe to use. They store medicines securely and the team knows what to do if any medicines or devices need to be returned to the suppliers.

Inspector's evidence

The pharmacy had a manual door and the entrance was not level with the outside pavement. This made it harder for someone who used a wheelchair, to enter the premises but a member of the team could go to the door to give assistance and make sure people could use the pharmacy services. The pharmacy displayed a notice that told people when it was open. It 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 offered a repeat prescription service. And people could order their prescriptions through the pharmacy. 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 plan was to introduce more services.

The pharmacy used a disposable pack for people who received their medicines in compliance packs and ordered their repeat prescriptions. The pharmacy team members checked prescriptions for changes in medication and printed a new backing sheet if needed. For instance, following a stay in hospital. They made sure medicines were suitable to be re-packaged and provided a brief description of each medicine contained within the compliance packs. But they did not always provide patient information leaflets (PILs) so people did not always have the information they needed to make sure they took their medicines safely. The SI gave assurances that moving forward PILs would be supplied with each set of compliance packs.

The pharmacist performed the clinical and final check of prescriptions. Members of the pharmacy team alerted the pharmacist to check interactions between medicines prescribed for the same person. Making sure interventions were recorded on the patient medication record (PMR) was discussed. Member of the team generally initialled dispensing labels to show which of them prepared a prescription. They marked some prescriptions with stickers to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added. A member of the team explained what information they would ask for to identify the patient or their representative before handing over a prescription. The SI was aware of the valproate pregnancy prevention programme. And knew that girls or women in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed. It also had information cards to give out for other high-risk medicines such as prednisolone.

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. Stock on the dispensary was generally tidy. The pharmacy team checked the expiry dates of medicines and highlighted short-dated items. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. It mostly stored its CDs securely in line with safe custody requirements. The pharmacy stored unwanted medicines and obsolete medicines separate from stock in a pharmaceutical waste bin. The pharmacy printed alerts and recalls about medicines and medical devices. The SI described the actions taken, such as checking stock for effected batches, when the pharmacy received a concern about a product. Keeping a record of these actions was discussed. The pharmacy team members explained how they managed shortages in certain medicines by liaising with other local community pharmacists and practise pharmacists. And they communicated a solution with the prescriber. For instance, when one strength of a medicine was unavailable but the same medicine in a different strength was readily available, the dose could be adjusted on a temporary basis to ensure people could continue with their treatment.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. The pharmacy uses its equipment appropriately to keep people's private information safe.

Inspector's evidence

The SI regularly arranged for electrical equipment to be PAT tested to make sure it was safe to use. The pharmacy had glass measures for use with liquids. It had a shredder to dispose of confidential wastepaper. The pharmacy computer was password protected and backed up regularly. Members of the pharmacy team had training in Smartcard management.

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.