General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gilbert's Chemist, 87-89 Shenley Road, BOREHAMWOOD, Hertfordshire, WD6 1AG

Pharmacy reference: 1032171

Type of pharmacy: Community

Date of inspection: 07/04/2022

Pharmacy context

The pharmacy is on the high street near a residential area in Borehamwood. The pharmacy dispenses NHS and private prescriptions and provides health advice. It supplies medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Its services include prescription delivery, seasonal flu vaccination and supervised consumption. 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 satisfactory written instructions which tell team members how to complete tasks and work safely. Pharmacy team members record their mistakes so they can learn from them and help prevent similar mistakes happening again. The pharmacy keeps the records it needs to by law to show it is providing safe services. And it asks people for feedback on how it can improve its services. Members of the pharmacy team keep people's private information safe. And they understand their role in safeguarding vulnerable people. They have ways of working to help protect people against COVID-19 infection.

Inspector's evidence

The pharmacy was undergoing a re-fit at the time of the visit. The dispensary had been temporarily set up in the interim until the work was completed. The pharmacy had systems to review dispensing errors and near misses. The responsible pharmacist (RP) worked with the dispensing assistant. If the RP identified a mistake when checking a prescription, she set the basket to one side and discussed it later with the dispensing assistant to learn from it and reduce the chances of the same mistake happening again. The pharmacy team recorded near misses on the pharmacy computer. The RP explained that medicines involved in incidents, or were similar in some way, such as atenolol and allopurinol, were being separated from each other in the new layout of the dispensary.

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. And assembled prescriptions were not handed out until they were checked by the RP. The pharmacy team completed an incident report and reported incidents to the NHS 'learning from patient safety events' service. The reports were filed along with any evidence such as the packaging of a medicine supplied in error.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. These have been reviewed since the last inspection and 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. Some SOPs were updated for COVID-19. So, the pharmacy had reviewed the delivery SOP to minimise the risks of the infection and the delivery person had re-trained in the modified procedure. The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. And a written occupational COVID-19 risk assessment for each team member had been completed. Members of the pharmacy team knew that any work-related infections needed to be reported to the appropriate authority. They wore fluid resistant face masks to help reduce the risks associated with the virus. And they used hand sanitising gel when they needed to.

Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. A team member explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as

medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy had a complaints procedure and displayed the practice leaflet with details for leaving feedback. The annual community pharmacy patient questionnaire (CPPQ) was re-commencing after it had been stopped due to the pandemic. It asked people for their views and suggestions on how it could do things better.

The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy displayed a notice that told people who the RP was and kept a record to show which pharmacist was the RP and when. 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. 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. And it recorded the emergency supplies it made and the private prescriptions it supplied. These generally were in order.

The pharmacy had an information governance folder which included a business continuity plan. And it displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Team members 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.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work well together to manage the workload. And the pharmacy supports them in keeping their skills and knowledge up to date. Team members feel able to provide feedback to improve services.

Inspector's evidence

The pharmacy team consisted of the full-time regular responsible pharmacist (the RP), two regular locum pharmacists who covered two days per week, a full-time dispensing assistant, a full-time and a part-time medicines counter assistant (MCA) and a part-time delivery driver. The pharmacy relied upon its team to cover absences.

Members of the pharmacy team had completed accredited training relevant to their roles. They worked well together. So, people were served quickly, and their prescriptions were processed safely. The RP was responsible for managing the pharmacy team. And supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an SOP for the team members to refer to when selling over-the-counter medicines and an MCA explained the questions she would ask people wanting to purchase painkiller tablets. The pharmacy team knew when they should refer requests to a pharmacist. Members of the team could study continuing professional development modules and articles in industry publications when it was quiet in the pharmacy. They did not have formal appraisals, but the RP was available most days to discuss any issues and there were regular staff meetings. The RP discussed the workload and monitored owing medication with the dispensing assistant. Members of the pharmacy team were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally clean, secure and suitable for the provision of healthcare. It protects the privacy of people who use its services and prevents unauthorised access to its premises when it is closed. It keeps its stock and people's information safe. The pharmacy keeps measures in place to help protect people from COVID-19 infection.

Inspector's evidence

The pharmacy was undergoing a re-fit at the time of the visit.
The registered pharmacy premises were bright and secure. It had air conditioning so its team didn’t get too hot. The pharmacy had a large retail area, a counter and the dispensary which had been temporarily set up while the pharmacy was re-fitted. To help protect people from infection, the pharmacy had fitted screens at the medicines counter, marked the floor so people knew where to stand and there was hand sanitiser for people to apply. The pharmacy had a consulting room and the chaperone policy was displayed. So, people could have a private conversation with a team member. The dispensary temporarily had limited workspace and storage available. But the floor area and work surfaces were kept clear. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy.

The pharmacy’s website displayed information about its services and medicines and health information. The pharmacy’s website offered General Sales List (GSL) and Pharmacy (P) medicines for sale. This service was provided by a third-party pharmacy registered with the GPhC. The pharmacy did not advertise details of this third-party provider prominently on its website. But information was available upon check-out of baskets when people purchased medicines.

Principle 4 - Services ✔ Standards met

Summary findings

People with different needs can easily access the pharmacy's services. The pharmacy's working practices are mostly safe and effective. It obtains its medicines from reputable sources. And it makes sure it stores them securely at the right temperature so they are fit for purpose and safe to supply. Members of the pharmacy team make sure people have all the information they need to use their medicines in the right way. They know what to do if any medicines or devices need to be returned to suppliers.

Inspector's evidence

The pharmacy had automated double doors. And its entrance was level with the outside pavement. This made it easier for people who found it difficult to climb stairs, such as someone who used a wheelchair, to enter the building. But the pharmacy team tried to make sure these people could use the pharmacy services. The pharmacy had a notice that told people when it was open. And other notices in the pharmacy and on the website told people about some of the other services the pharmacy offered. Members of the pharmacy team were helpful and some could speak Gujarati to assist some people whose first language was not English. They signposted people to another provider if a service wasn't available at the pharmacy. The pharmacy had been involved with the pilot version of the community pharmacist consultation service (CPCS). They dealt with referrals for minor ailments via PharmOutcomes. The pharmacy had completed an audit of anti-coagulant medicines supplied to people. The findings identified that the pharmacy needed more warfarin alert cards to give to people explaining their treatment. Flu vaccinations were administered to people via patient group direction (PGD) and recorded on PharmOutcomes so the doctor's surgery was informed.

The pharmacy provided a delivery service to people who couldn't 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 disposable multi-compartment compliance packs for people who received their medicines in compliance packs. The pharmacy team checked whether a medicine was suitable to be re-packaged. It provided a brief description of each medicine contained within the compliance packs and 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 the dispensing labels to show which of them prepared a prescription too. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting such as warfarin. The RP counselled people and noted monitoring information on the patient medication record (PMR) in line with SOPs for handing out medicines. They were 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 pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. The dispensary was tidy. The pharmacy team checked the expiry dates of medicines and marked short-dated items. The

pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs, which weren’t exempt from safe custody requirements, securely. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these 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 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 to keep people's private information safe.

Inspector's evidence

The pharmacy team had access to up-to-date reference sources. The pharmacy had a plastic screen on its counter and hand sanitisers for people to use if they wanted to. And it had personal protective equipment if its team members needed it. The pharmacy had glass measures for use with liquids, and some were used only with certain liquids. It had a refrigerator to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the refrigerator and recorded these values. The pharmacy collected confidential waste for safe disposal. 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. And its team members used their own NHS smartcards.

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.