

Registered pharmacy inspection report

Pharmacy Name: Springfield Pharmacy, 19 High Street, HARPENDEN,
Hertfordshire, AL5 2RU

Pharmacy reference: 1032183

Type of pharmacy: Community

Date of inspection: 02/08/2022

Pharmacy context

The pharmacy is located on a busy high street. 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 delivery, new medicines service, community pharmacy consultation service (CPCS), hypertension case-finding service, emergency hormonal contraception free for people under 25 years old, travel and seasonal flu vaccinations. The pharmacy is a COVID-19 vaccination centre.

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 mostly safe and effective. It has satisfactory written instructions for the pharmacy's team members to follow so they work safely. Members of the pharmacy team understand their roles and responsibilities. And they generally keep the records they need up to date so they can show the pharmacy is supplying its services safely. They protect people's private information, and they are trained in how to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team discussed the mistakes they made as soon as they were identified, to learn from them and reduce the chances of them happening again. The regular pharmacist reviewed mistakes they made to spot patterns or trends and take action such as separating medicines involved in incidents or were similar in some way from each other in the dispensary. The dispensing assistant (DA) explained that medicines involved in incidents, with similar packs or names, such as codeine tablets in packs of 30 and 100 tablets, gabapentin and pregabalin packs, and eye drops which came in two strengths were highlighted by being placed on a designated shelf in the dispensary. The pharmacy had a complaints procedure which was accessed via email to the superintendent pharmacist.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these have been updated since the last inspection. One of the more recent SOPs related to the blood pressure monitoring service. 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. Pharmacy team members 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 clinically, and accuracy checked by the responsible pharmacist (RP). Team members showed interactions between medicines prescribed for the same person to the pharmacist. And interventions were recorded on the patient medication record (PMR). The pharmacy team members highlighted prescriptions awaiting collection which contained high-risk medicines or needed additional counselling. A member of the team explained the procedure for handing out prescription medicines to people and circling each fact asked to identify the person such as name, address or date of birth.

The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. Members of the pharmacy team were self-testing for COVID-19 regularly. They had access to personal protective equipment to help reduce the risks associated with the virus. And they washed their hands regularly and used hand sanitising gel when they needed to. The regular pharmacist completed risk assessments for people who needed travel vaccinations to protect them against illnesses in certain countries on holiday. These were filed together with the vaccination record. The pharmacy completed audits in line with the pharmacy quality scheme (PQS) to monitor risk to people taking anti-coagulants or safe and effective use of antibiotics.

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. Members of the pharmacy team knew what they could and could not do, what they were responsible for and when they might seek help. A team member explained that they would not hand out prescriptions or sell medicines when the pharmacist was not 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 it had received positive feedback from people online. The pharmacy asked people for their views and displayed their suggestions on how it could do things better.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. 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 weekly. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. The pharmacy team members recorded the emergency supplies and the private prescriptions which were supplied. And these generally were in order. But the name and address of the prescriber were sometimes incorrectly recorded. Records for vaccination services such as patient group directions (PGDs) were not all available on the day of the visit as the regular pharmacist who was trained and provided these services was not present.

The pharmacy's SOP folder included data protection training materials in which the team members had trained. The pharmacy was registered with the Information Commissioner's Office although the certificate required updating. A member of the pharmacy team explained how the pharmacy protected people's private information. The team tried to make sure people's personal information could not be seen by other people and was disposed of securely. The pharmacy had a safeguarding SOP. And the RP had completed a safeguarding training course as required to supply emergency hormonal contraception. 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 effectively together to manage the workload and deliver services safely. They are supported in completing training appropriate to their roles. Team members provide feedback about the pharmacy which improves its services.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist, one full-time pre-registration pharmacy technician, a full-time dispensing assistant (DA), a full-time medicines counter assistant (MCA), a part-time MCA and a part-time delivery driver. Members of the pharmacy team were enrolled on accredited training relevant to their roles. The pharmacist had undertaken training to provide services such as travel and flu vaccinations. Training certificates were filed. And the NaTHNaC yellow fever certificate was displayed. A new member of the pharmacy team was undertaking induction and becoming familiar with the systems in the pharmacy before enrolment onto accredited training. Pharmacy team members were allocated protected learning time.

They worked well together. So, people were served quickly, and their prescriptions were processed safely. On the day of the visit, a locum pharmacist was the RP, supervising and overseeing the supply of medicines and advice given by the pharmacy team. The pharmacy had an over-the-counter (OTC) sales and self-care SOP which its team needed to follow. A member of the team described the questions they needed to ask people when making OTC recommendations. And when they should refer requests to a pharmacist. There were regular appraisals to monitor progress in training. The pharmacy's team members were comfortable about making suggestions on how to improve the pharmacy and its services. The DA had suggested using compliance aids with different numbers of compartments depending on the time of day people took their medicines. Team members communicated via a WhatsApp group and team meetings. They knew who they should raise a concern with if they had one. And there was a whistleblowing SOP if needed.

Principle 3 - Premises ✓ Standards met

Summary findings

Overall, the pharmacy's premises are clean, bright and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe and people's information is protected.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. And steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a retail area, a counter, and a dispensary which was at a slightly higher level than the public area. The pharmacy's consultation room was signposted. So, people could have a private conversation with a team member. The pharmacy displayed its chaperone policy. To protect against COVID-19 infection, screens were fitted at the medicines counter and there were floor markings, so people did not stand too close to each other. The dispensary had limited workspace and storage available. So, items were sometimes stored on the floor. And the main worksurface in the dispensary could become cluttered when the pharmacy was busy. Multi-compartment compliance aids were prepared at a small work bench which was separate from other dispensing activities. The compliance aids were prepared weekly or monthly according to a matrix. Members of the pharmacy team were responsible for keeping the pharmacy's premises clean and tidy.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers a range of services which people with different needs can access easily. Its working practices are generally safe and effective. The pharmacy obtains its medicines stock from reputable suppliers and stores it appropriately so the medicines it supplies are safe to use. Team members know what to do in response to alerts and product recalls and they keep records of any medicines or devices returned to the suppliers. They make sure people have the information they need to use their medicines safely.

Inspector's evidence

The pharmacy had double doors at the entrance. The pharmacy displayed pharmacy information at the entrance and a notice warned people that the door was stiff. A member of the team went to the door to help people if needed. The pharmacy's 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. The pharmacy had seating for people to use if they wanted to wait. Members of the pharmacy team were helpful. And they signposted people to another provider if a service was not available at the pharmacy. The pharmacy team tried to make sure people could use the pharmacy services. They could speak or understand several languages to assist people whose first language was not English. The pharmacy had a business continuity plan to deal with system failures. There were torches to use in the event of a power-cut and the local surgeries would be contacted.

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 supplied medicines in multi-compartment compliance aids to help people who had difficulty managing their medicines. The pharmacy team members re-ordered prescriptions for these people and checked them for changes from the last time. The pharmacy checked whether the medicines were suitable to be re-packaged. They provided a brief description of each medicine contained within the compliance aids and patient information leaflets (PILs). So, people had the information they needed to make sure they took their medicines safely. Members of the pharmacy team knew which of them prepared a prescription. And they marked some prescriptions 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. 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. And warning cards to give people who were prescribed high-risk medicines such as warfarin.

The pharmacy received referrals for the community pharmacist consultation service (CPCS) via PharmOutcomes. People who fitted the criteria for the hypertension case-finding service were referred to their doctor for possible treatment for elevated blood pressure. The pharmacy provided the new medicines service (NMS) to help people benefit from taking their medicines correctly. The pharmacist contacted people by phone to have a follow up consultation. Although the pharmacy offered the COVID-19 vaccination service, it was not available at the time of the visit. The pharmacy had been

unable to obtain vaccine stock. Team members explained that the MCA allocated appointments which were 15 minutes apart to people in advance of attending the pharmacy. This allowed the pharmacy team time to provide its regular services. The MCA booked the number of appointments to match the number of vaccine doses in a vial to minimise wastage. On the day of the vaccination, the people were checked in at the medicines counter confirming name, contact details and NHS number. The pharmacist completed the clinical assessment including previous vaccinations. The vaccination was prepared in the consultation room and drawn up when it was needed. The pharmacist provided post-vaccination counselling and recorded each vaccination on PharmOutcomes which informed the person's usual doctor's surgery. When providing travel clinic vaccines the pharmacist checked what vaccinations were appropriate to the destination. The pharmacist could sell anti-malarial tablets to adults but there was a PGD to supply anti-malarial tablets to children.

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 pharmacy team checked the expiry dates of medicines and had regular stock takes when short-dated medicines were removed from the shelves. And it recorded when it had done a date-check. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs, which were not 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 generally 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 had hand sanitisers for people to use if they wanted to. And it had the personal protective equipment its team members needed. The pharmacy had clean glass measures for use with liquids, and some were marked for use only with certain liquids. The pharmacy team had access to up-to-date reference sources for information and guidance. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. A data logger checked and monitored maximum and minimum temperatures of the refrigerator. The CD cabinet was fixed with bolts. The pharmacy team collected confidential wastepaper to be disposed of appropriately. 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 made sure they used their own NHS smartcards. An up-to-date blood pressure monitor was in use to ensure accurate blood pressure readings. The pharmacy had a sharps bin for safe disposal of vaccination sharps. The pharmacist had prepared an emergency kit which included adrenaline ampoules to treat anaphylaxis and Glucogel and dextrose sweets to deal with hypoglycaemia.

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.