General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Topkins Healthcare Limited, 6 Station Road, HARPENDEN, Hertfordshire, AL5 4SE

Pharmacy reference: 1032185

Type of pharmacy: Community

Date of inspection: 21/07/2022

Pharmacy context

The pharmacy is on a busy street just off the main road through Harpenden in Hertfordshire. It dispenses NHS and private prescriptions, sells medicines over the counter 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, new medicines service, supervised consumption, community pharmacist consultation service (CPCS), and clinics for a range of vaccinations against seasonal flu vaccination, COVID-19, chicken pox and for people who travel.

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

Overall, the pharmacy's working practices are safe and effective. It has satisfactory written procedures for the pharmacy's team members to follow so they work safely. The pharmacy enables people to give feedback so it can improve its services. Members of the pharmacy team understand their roles and responsibilities. And they mostly keep the records they need to 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 safeguard vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team recorded the mistakes they made to learn from them and reduce the chances of them happening again. The records were kept on PharmSmart on the pharmacy's computer system. The dispensing assistant explained that medicines involved in incidents, or were similar in some way, such as sumatriptan and sertraline, were generally separated from each other in the dispensary. The pharmacy's complaints procedure was accessed via the consultation room computer. And details of complaints procedure were in the pharmacy leaflet displayed in the retail area. 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 responsible pharmacist (RP).

The pharmacy had risk assessed the impact of COVID-19 upon its services and the people who used it. Members of the team were self-testing for COVID-19 regularly. There was hand sanitizing gel, and in the public area the floor was marked directing flow of people in a one-way direction. The pharmacy team members washed their hands regularly and used hand sanitising gel when they needed it. In relation to the travel medicines service, the RP completed malaria risk assessment forms for people travelling to areas where there was a risk of infection. So, the appropriate anti-malarial medication could be supplied.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these had been reviewed since the last inspection. Members of the pharmacy team were required to read the SOPs relevant to their roles. There were training records and team members were able to show they understood them and followed them. They described how they followed a sales SOP for over-the-counter (OTC) medicines and when they would refer to the RP for advice. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they should ask for help. Their roles and responsibilities were described in the SOPs. Team members explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for medicines liable to abuse, misuse or overuse, to a pharmacist. The pharmacy asked people for their views and suggestions on how it could do things better. The pharmacy conducted an annual survey which was online or on paper and it had received positive feedback from people. The team were able to show a hand-written note of positive feedback.

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 appropriate insurance arrangements in place, including professional indemnity, for the services it provided such as COVID-19 vaccination services. It kept a controlled drug (CD) register up to date on PharmSmart. The stock levels recorded in the CD registers were checked regularly. And a random check of the actual stock of a CD matched the recorded amount. The dispensing assistant described the records which were maintained for the supplies of the unlicensed medicinal products it made. The private prescriptions it supplied were recorded electronically. The RP administered COVID-19 vaccinations via patient group directions (PGDs). PGDs and records for supply of other medicines were on PharmOutcomes. Records generally were in order.

The pharmacy was registered with the Information Commissioner's Office. The RP displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Its 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 safeguarding training course and was able to refer to someone with level 3 safeguarding in line with providing the COVID-19 vaccination service. 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. Safeguarding team contact details were displayed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work effectively together to deliver its services safely and manage the workload. They are supported with ongoing training appropriate to their roles. Team members are able to provide feedback about the pharmacy and its services.

Inspector's evidence

The pharmacy team consisted of the superintendent pharmacist (the RP), two full-time dispensing assistants, two part-time medicines counter assistants (MCA) and a full-time MCA who worked on weekdays and Saturdays. The dispensing assistants also served at the medicines counter if needed. The pharmacy relied upon its team to cover absences.

The RP had trained to deliver COVID-19 vaccinations and had an NHS training and competency passport. Members of the pharmacy team had undertaken accredited training relevant to their roles. And they could access ongoing training topics on a portal. They worked well together. So, people were served quickly, and their prescriptions were processed safely. The RP supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an OTC sales SOP which its team needed to follow. This described the questions the team member needed to ask people when making OTC recommendations. And when they should refer requests to a pharmacist. The members of the team dealt with enquiries about the COVID-19 vaccination service. The RP ran a walk-in clinic two days a week. Adults attended in the morning and young people came in the afternoon. Upon arrival, people booked in at the medicines counter. The MCAs explained what they had to do and gave them a health questionnaire to be read and completed.

The pharmacy team was comfortable about making suggestions on how to improve the pharmacy and its services. So, the dispensing assistant had suggested a better way of organising the SOP folder. The RP did not undertake formal appraisals, but he was on the premises most of the time to monitor staff performance.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, bright and generally suitable for the provision of healthcare services. Its public facing areas are tidy. The pharmacy prevents people accessing its premises when it is closed so that it keeps its medicines safe and protects people's information.

Inspector's evidence

The registered pharmacy premises were bright and secure. And steps were taken to make sure the pharmacy and its team didn’t get too hot. The pharmacy had a retail area, a counter, a small dispensary which was at a higher level than the retail area and a storeroom. Some of its fixtures were dated. The pharmacy had a consultation room which was signposted and in constant use for the vaccination service during the visit. So, people could have a private conversation. The dispensary had limited workspace and storage available. So, items were sometimes stored on the floor in the dispensary until being put away. And worksurfaces in the dispensary could become cluttered when the pharmacy was busy. The dispensary had a sink. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy. They cleaned the premises surfaces with wipes and antibacterial spray throughout the day and at the end of the vaccination clinics.

Principle 4 - Services ✔ Standards met

Summary findings

People with different needs can easily access the pharmacy's services. The pharmacy's working practices are safe and effective and it obtains its stock from reputable suppliers. It stores its medicines securely at the right temperature. The pharmacy team members respond to alerts and product recalls and 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. And keep a record when checking that medicines are safe to take.

Inspector's evidence

The pharmacy didn't have an automated door. And there was a wall handle and a ramp from its entrance to the pavement to help people who found it difficult to climb stairs, such as someone who used a wheelchair. 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. It had a small seating area for people to use if they were waiting for a vaccination or prescription. And this area was set away from the counter to help people keep apart. Members of the pharmacy team were helpful, and they could advise and help people. And they signposted people to another provider if a service wasn't available at the pharmacy. People who could not be vaccinated during the current clinic were directed back to the NHS website for available vaccination slots elsewhere. The pharmacy received referrals for CPCS supply of medicines via PharmOutcomes.

The RP had undertaken training to deliver the COVID-19 vaccination service. COVID-19 vaccines were stored in a separate vaccines fridge which was monitored, and the maximum and minimum temperatures were uploaded to PharmSmart records daily. The RP maintained a folder of information on his laptop, and this included green book guidelines and a risk assessment for the service as it developed. The RP prepared vaccinations at a separate bench in the dispensary. And took care to only draw up a vaccine when it was needed. The vaccines available were Moderna, Pfizer and Pfizer paediatric. On arrival the MCAs explained the service and asked the person being vaccinated to read through the laminated questionnaire. The RP then went through the answers during the clinical assessment. The advice, consent and counselling provided was recorded by the RP on PharmOutcomes. The RP had positioned anaphylaxis kits to treat anaphylaxis in several places for accessibility when needed. There was a supply of sick bags and notices asking carers and parents to stay near the person who may faint after a vaccination. The RP had introduced a card system to provide an extra check before vaccinating. On arrival, younger people were given a card with a teddy bear picture. The same card was stuck to the outside of the box containing the children's dose vaccines so the RP checked the person's card and age and accessed the vaccines in the container with the corresponding card on the outside.

The pharmacy provided a delivery service to a small number of 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 had sold COVID-19 rapid lateral flow tests that people could use at home. This was to help find cases in people who didn't have symptoms but were still

infectious. The pharmacy used a disposable system for people who received their medicines in multi-compartment compliance aids. 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 it provided patient information leaflets. 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 too. 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. The team kept a record of interventions when they checked medicines were safe to take. 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 its medicines and medical devices within their original manufacturer's packaging. The dispensary could become a little cluttered when it was busy. The pharmacy team checked the expiry dates of medicines a few times a year. And it generally 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 in line with 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. 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 on PharmSmart 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 team could restrict the number of people it allowed in the premises at a time if needed. The pharmacy had hand sanitisers for people to use if they wanted to. The pharmacy had glass measures for use with liquids, and some were used only with certain liquids. The pharmacy team had access to up-to-date reference sources. And it could contact the National Pharmacy Association to ask for information and guidance. The pharmacy had two refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the refrigerator. The pharmacy could dispose of confidential waste 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 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.