General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Woods Pharmacy, 2 Bellgate, Highfield, HEMEL HEMPSTEAD, Hertfordshire, HP2 5SB

Pharmacy reference: 1032189

Type of pharmacy: Community

Date of inspection: 01/02/2024

Pharmacy context

The pharmacy is in a parade of businesses in a residential area of Hemel Hempstead. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance packs (blister packs) for people who have difficulty managing their medicines. Services include substance misuse, smoking cessation, sexual health and seasonal flu vaccination services.

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 mostly safe and effective. It has adequate standard operating procedures in place for the team to follow to manage the risks associated with providing services. The pharmacy generally keeps all the records required by law showing it supplies its medicines and services safely. It has systems in place for the team members to learn from their mistakes and take action to prevent them happening again. Members of the pharmacy team protect people's private information, and they are appropriately trained in how to safeguard the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Pharmacy team members discussed the mistakes they made to learn from them and reduce the chances of them happening again. The accuracy checking technician (ACT) explained that medicines involved in incidents, or were similar in some way, such as cyclizine and cetirizine, were generally separated from each other in the dispensary. And highlighted with a shelf-edge label to alert the team members picking medicines. The ACT collated the near miss and incident information to produce a patient safety review (PSR).

The pharmacy team used colour-coded baskets when making up people's prescriptions to separate each person's medication and to help prioritise their workload. Members of the team referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP). Members of the team initialled the dispensing labels so they could identify who prepared prescriptions. They recorded interventions on the patient medication record (PMR). The ACT was able to describe two recent interventions and how they were identified and recorded. Team members highlighted medicines that the pharmacist needed to discuss with the person or their carer. And they checked the name, address and date of birth of the person for whom the prescription was prepared before handing it to the person collecting it.

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 and sign the SOPs relevant to their roles to show they understood them and would follow them. The ACT checked prescription items in line with the SOP for accuracy checking where the clinical check has been completed by a pharmacist. A medicines counter assistant (MCA) described the sales protocol for recommending over-the-counter (OTC) medicines. Members of the pharmacy team knew what they could and could not do, what they were responsible for and when they might seek help. And their roles and responsibilities were described in the SOPs. A team member explained that they would not hand out prescriptions or sell medicines if a pharmacist was not present. And they would refer repeated requests for the same or similar products, such as medicines liable to misuse to a pharmacist. The pharmacy had a complaints procedure. Details of how to comment or complain were detailed on the practice leaflet and people could post feedback online.

The pharmacy undertook pharmacy quality scheme (PQS) clinical audits to help identify if people could improve the way they took anti-coagulant medicines or used their asthma inhalers and reduce overuse of antimicrobial medicines to limit resistance. The ACT explained completing the valproates audit recently and was aware of new guidance and rules for prescribing and dispensing valproate medicines.

The ACT and the locum pharmacist were signposted to the guidance which included education materials and how to use them. The pharmacy team had completed risk assessments (RAs) for the PQS. The ACT described assessing the risks associated with administering flu vaccinations. And the risks included vaccine storage, infection control and sharps and clinical waste disposal. The RP checked the identity of the person, checked the PMR for contraindications, obtained consent and explained possible side effects before vaccinating them.

The pharmacy displayed a notice that told people who the RP was. But at the beginning of the visit there were several notices on display which the medicines counter assistant (MCA) removed. 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 a controlled drug (CD) register. And the stock levels recorded in the CD register were checked regularly. A random check of the stock of one CD did not match the recorded amount. But the pharmacy notified the inspector within a few hours of the inspection to say that the discrepancy had been resolved. The pharmacy kept records for the supplies of the unlicensed medicinal products and of the private prescriptions it supplied. And these generally were in order.

The pharmacy's registration certificate with the Information Commissioner's Office was being updated and the notice that told people how their personal information was gathered, used and shared by the pharmacy and its team needed to be reprinted. Members of the team tried to make sure people's personal information was not seen by other people and was disposed of securely. They could access the pharmacy computer system when they entered their own password, and they used their own NHS smartcards. The pharmacist and ACT had undertaken level 3 safeguarding training. The pharmacy had a safeguarding procedure and 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 were signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are qualified and have the appropriate skills and training for their roles. They work well together and manage their workload. Members of the team are aware of the potential to abuse some OTC medicines so they follow a protocol, ask appropriate questions and offer suitable advice when they sell medicines.

Inspector's evidence

The pharmacy team consisted of four regular pharmacists, a part-time ACT, one full-time and one part-time dispensing assistants, and two part-time medicines counter assistants. The pharmacy relied upon its team to cover absences. At the time of the visit there was a locum pharmacist who was supported by the ACT, a dispensing assistant and an MCA. The ACT explained that there was often double pharmacist cover.

The pharmacists had commenced training in preparation for providing the Pharmacy First service. The ACT had completed the training required to deliver the smoking cessation service. Members of the pharmacy team had undertaken accredited training relevant to their roles. They had trained in topics in line with the PQS such as safeguarding, signs of sepsis, infection control and antimicrobial stewardship through 'eLearning for Healthcare' (elfh).

The pharmacy team worked well together so people were served quickly, and prescriptions were processed safely. The RP oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had an OTC sales and self-care SOP which described the questions the team members needed to ask people when making OTC recommendations. They knew when to refer requests to a pharmacist, and that they could not sell certain medicines or give out prescriptions if the pharmacist was not on the premises. The ACT conducted the team members appraisals to monitor and identify training needs. Members of the pharmacy team knew who they could raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are bright, secure 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 private information is protected.

Inspector's evidence

The registered pharmacy premises were safe, secure and well lit. Steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a retail area, a medicines counter, a small dispensary and a storeroom. The pharmacist had a workstation between the dispensing area and where the MCA was positioned greeting people, handing out prescriptions and selling medicines.

The pharmacy had signposted its consulting room. So, people could have a private conversation with a team member. The dispensary workbench space was in constant use and regularly tidied by the team. The pharmacy had storage shelving available but sometimes stored larger items on the floor. The pharmacy had a sink and a supply of hot and cold water. 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's working practices are generally safe and effective. It tries to make sure people with a range of needs can easily access the pharmacy's services. The pharmacy obtains its medicines from reputable sources. And it stores its medicines securely at the correct temperature so they are fit for purpose and safe to use. Members of the pharmacy team mark prescriptions for high-risk medicines to alert the pharmacist to people who require more information and support to use their medicines properly. The pharmacy team knows what to do when it receives a drug alert or recall.

Inspector's evidence

The pharmacy had a wide door and its entrance was level with the outside pavement. This made it easier for people who used a wheelchair to enter the building but members of the team went to the door to assist people if necessary. The pharmacy team tried to make sure people could use the pharmacy services. They could print large font labels which were easier to read. The pharmacy had a notice that told people when it was open. And other notices in its window told people about some of the services the pharmacy offered. And they signposted people to another provider if a service was not available at the pharmacy. For instance, the doctor or nurse at the local surgery and other nearby pharmacies. The ACT could supply a 'stop smoking' freephone number and signposted people to local community-based weight loss programmes which would monitor and support them throughout their diet.

The pharmacy provided a stop smoking service supporting people by supplying nicotine replacement therapy (NRT) and monitoring the level of carbon monoxide in their body to show they had not smoked recently. The pharmacy used a disposable system for people who received their medicines in multicompartment compliance packs. The pharmacy team managed repeat prescription requests for some people and checked whether the medicines were suitable to be re-packaged. It provided patient information leaflets but labelling did not always include a description for people to identify individual tablets or capsules. So sometimes they did not have the information they needed to make sure they took their medicines safely. Members of the pharmacy team generally supplied high-risk medicines separately from the compliance packs. And if requested, medicines administration record (MAR) charts were prepared for some people. Members of the pharmacy team initialled the dispensing labels to show who prepared a prescription. They highlighted some prescriptions to show when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added.

The pharmacy had provided the seasonal flu vaccination service mostly to walk-in people. The pharmacist obtained consent and completed a clinical assessment, maintaining records on PharmOutcomes so the person's regular doctor would be informed. The pharmacy stored the vaccines in the fridge and monitored its temperature. And there were arrangements for clinical and sharps waste disposal. Team members kept records for infection control of the consultation room. The pharmacist recorded the supply on PharmOutcomes. The ACT explained that the pharmacy received a small number of referrals through PharmOutcomes from NHS 111 for the community pharmacist consultation service (CPCS).

The pharmacy team members were aware of the valproate pregnancy prevention programme. They knew that girls or women in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. And any interventions should be recorded on the PMR. Valproate-containing medicines must always be dispensed in the manufacturer's original full pack and no-one under the age of 55 – both men and women - should be started on a valproate unless two specialists independently agree and document that there is no other safe and effective medication, or that there are compelling reasons why the reproductive risks linked to valproate, do not apply.

The pharmacy obtained its pharmaceutical stock from recognised wholesalers. It kept most of its medicines and medical devices in their manufacturer’s packaging marked with a date of opening if appropriate. But a few loose strips of tablets on the dispensary shelves were highlighted and members of the team gave assurances about retaining them in their original packs with all the relevant information such as batch numbers. The pharmacy team regularly checked the expiry dates of medicines and recorded when it had completed a date-check. No expired medicines were found on the shelves amongst in-date stock. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it mostly stored its CDs securely in line with safe custody requirements. The pharmacy stored waste medicines separate from stock in pharmaceutical waste bins. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. The alerts were printed, relevant stock was checked and the alert was annotated and filed in the patient safety folder.

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 and keeps people's private information safe.

Inspector's evidence

The pharmacy had access to up-to-date reference sources online. It had a fridge to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the fridge. The pharmacy disposed of confidential waste appropriately. It had separate clean, marked measures for use with different liquids. The pharmacy had the equipment it needed to support the stop smoking service which was supplied and maintained by Hertfordshire County Council. The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them with their own password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members were using 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.