General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Fernville Pharmacy, Fernville Surgery, Midland Road, HEMEL HEMPSTEAD, Hertfordshire, HP2 5BL

Pharmacy reference: 1032204

Type of pharmacy: Community

Date of inspection: 12/06/2024

Pharmacy context

The pharmacy is within a health centre premises in Hemel Hempstead, West Hertfordshire. It sells medicines over the counter and provides health advice. The pharmacy dispenses private and NHS prescriptions. It supplies medicines in multi-compartment compliance packs for people who have difficulty taking their medicines at the right time. Its other services include delivery, substance misuse, COVID-19 and seasonal flu vaccinations and Pharmacy First.

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 suitable written instructions for members of the team to follow to help to manage risks in providing its services. Team members learn from their mistakes and take action to prevent the same thing happening again. Team members can describe their responses to people's feedback. The pharmacy keeps the records it needs to by law to show how it supplies its medicines and services safely. Members of the pharmacy team protect people's private information. And they understand their role in safeguarding the welfare of vulnerable people.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. When the responsible pharmacist (RP) identified near misses, members of the pharmacy team were encouraged to discuss and correct their mistakes. They identified the types of mistakes they made and they agreed actions they could take to reduce the chances of them happening again. The pharmacy team recorded near misses and the RP used the records to compile a patient safety review regularly. The RP explained that medicines which were involved in incidents, or were similar in some way, for instance procyclidine, prochlorperazine and promethazine were generally separated from each other in the dispensary. Team members had grouped some medicines stock together such as fast-moving lines which were dispensed more frequently. And the RP showed how different formulations of aspirin, different strengths of atenolol and amitriptyline were arranged to minimise picking errors. The RP shared alerts such as medicines with similar packaging via a WhatsApp group for other pharmacies within the company. The pharmacy had a complaints procedure to report incidents to the superintendent pharmacist (SI).

The team downloaded Electronic prescription service (EPS) prescriptions regularly throughout the day, generated dispensing labels, ordered medicines and filed the prescriptions alphabetically with the dispensing labels. When the medicines were delivered the team members could dispense the prescriptions. If people presented a prescription at the medicines counter, a member of the team completed a legal check of prescriptions to make sure the required fields were filled in. Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medicines and to help them prioritise their workload. They referred to prescriptions when labelling and picking medicines. They checked interactions between medicines prescribed for the same person with the pharmacist. If necessary, they could speak the prescriber regarding queries on prescriptions. And making sure they recorded interventions on the patient medication record (PMR) was discussed in case the intervention was queried at a later date. Assembled prescriptions were not handed out until they were checked by the RP. Team members who prepared and checked prescriptions initialled the dispensing labels to create an audit trail. They highlighted prescriptions for delivery to people's homes and high-risk medicines. For instance, controlled drugs (CDs) prescriptions which were only valid for 28 days. And they supplied warning cards such as for warfarin or prednisolone to make sure people had all the information, they needed to use their medicines effectively. Members of the team who handed out prescriptions confirmed the person's details on the address label on the prescription bag and checked the date of birth if needed.

The pharmacy had standard operating procedures (SOPs) for the services it provided. The RP explained

that the SOPs had been reviewed recently and the latest SOPs related to the Pharmacy First service. The pharmacy team trained in the SOPs relevant to their roles. A member of the team described the sales protocol for recommending over-the-counter (OTC) medicines to people. Team members knew what they could and could not do, what they were responsible for and when they should refer to the pharmacist. They 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 medicines, such as medicines liable to abuse to a pharmacist. Along with the complaints procedure, the pharmacy team members invited feedback from people who used the pharmacy and its services. And they gave examples of how they acted on feedback to improve their services. It displayed a notice with details of how to contact the pharmacy and the superintendent pharmacist (SI) who was also the RP. The RP explained changes he had implemented in response to Google reviews. In once case, how the team informed people about limiting the number of people in the pharmacy at the same time.

The pharmacy had risk assessed the premises and how it would provide the COVID-19 vaccination service. This included vaccines storage, training, record keeping, hygiene control and dealing with clinical waste. In preparation for commencing the NHS Pharmacy First service the RP completed risk assessments to identify and manage risks such as pharmacist training and knowledge and increasing GP support for the new service. The pharmacy had assessed whether the pharmacy team needed to make changes to free up the RP's time for consultations and concluded that no changes were required at that time. The RP had read the patient group directions (PGDs) and completed face-to-face training in how to use the otoscope. Records were kept on PharmOutcomes. The RP monitored the service through audits such as general data protection regulation (GDPR) with increased access to people's medical records. The RP followed up people by phone following treatment.

The RP had conducted an audit of people prescribed anti-coagulants but was unable to meet the required sample size. The RP had compared the treatment for simple urinary tract infection and the recommended duration of treatment with prescribed antibiotics against the treatment regime available through the pharmacy first service. And had increased his knowledge of products he could recommend for self-treatment to help avoid taking antibiotics. The pharmacy team had completed a clinical audit of people taking valproates and they were aware there were new rules for dispensing a valproate.

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. It maintained a controlled drug (CD) register and CDs were audited regularly to check how much stock it had of each CD. A random check of the actual stock of a CD matched the amount recorded in the register. The pharmacy kept records for the supplies it made of private prescriptions and unlicensed medicines ('specials') and these were generally complete although sometimes prescriber details were not recorded. The pharmacy provided COVID-19 vaccinations which were administered via patient group directions (PGDs) and national protocol. And records for vaccinations included the person's details, the vaccine details such as batch number and expiry date and when they were administered. The pharmacy team recorded the daily fridge temperatures.

The pharmacy was registered with the Information Commissioners Office (ICO). The pharmacy team members had completed GDPR training. They collected confidential wastepaper to be disposed of securely. Members of the team used their own NHS Smartcards. The pharmacy privacy notice required re-printing and displaying. The pharmacy team had all trained in the safeguarding procedure in line with the pharmacy quality scheme (PQS). The training module was completed through eLearning for healthcare professionals (elfh). The RP had completed level 3 safeguarding training and described an ongoing scenario with a person who used the pharmacy's services. The RP had reported the issue to the

local safeguarding team. 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. The pharmacy team was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together to manage the workload and to deliver services safely. Learning and development are supported and they are suitably qualified or in training for their roles. The pharmacy team feel able to provide feedback to improve the pharmacy's services.

Inspector's evidence

The pharmacy team comprised: the RP and a regular locum pharmacist, a trainee pharmacist, three full-time dispensing assistants, one part-time medicines counter assistant and a part-time delivery person. The RP's absences were covered by the locum pharmacist. The delivery person had undertaken accredited training for delivery persons and was Disclosure and Barring Service checked. Team members were enrolled on or had completed accredited training in line with their roles.

The trainee pharmacist was enrolled on an external foundation training course and attended their monthly training days. The pharmacy allocated regular study time to read and revise topics such as sections of the British National Formulary (BNF) and the RP was the trainee pharmacist's tutor. The trainee pharmacist was able to ask the RP for referrals to information sources appropriate to the role. The RP provided feedback to the trainee pharmacist via the required program of appraisals and review. The RP had completed training to deliver the Pharmacy First service. Team members completed training via elfh and Centre for Pharmacy Post-graduate Education (CPPE).

Team members were allocated protected learning time if needed for accredited training. They had also trained in topics in line with the NHS Pharmacy Quality Scheme (PQS) including sepsis, risk assessment and asthma. Team members could discuss issues and provide feedback and suggestions to improve services. One team member had suggested a different schedule for preparing multi-compartment compliance packs to improve time management in the dispensary. And had designed a spreadsheet to complete at each stage of preparation. The RP described annual appraisals with members of the team and regular team meetings during which they could exchange feedback. And the pharmacy had a whistle-blowing policy for sensitive feedback. Members of the pharmacy team 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 and self-care SOP which described the questions the team member needed to ask people when making OTC recommendations. And when they should refer to the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are bright, clean, secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed to protect people's private information and to keep its medicines stock safe. People can have a private conversation with a team member in the consultation room.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. There were chairs for people who wanted to wait. And action had been taken to make sure the pharmacy and its team did not get too warm. The pharmacy had a retail area and a medicines counter at the back of the pharmacy where people could buy medicines or other sundry items. The dispensary was up a step behind the retail area. There was limited room for storage. The pharmacy’s consultation room was signposted, and people could have a private conversation with a team member. A chaperone policy and first aid posters were displayed. It was tidy and clean. Team members kept dispensary worksurfaces clean and clear to help avoid them becoming cluttered when the pharmacy was busy. The pharmacy team cleaned the workbenches regularly.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy and its services are easily accessible to people with different needs. And its working practices are generally safe and effective. The pharmacy obtains its medicines from reputable sources so that they are fit for purpose. It stores them securely at the right temperature to help make sure they are safe to use. People are provided with the information they need to help them use their medicines properly. The pharmacy team members know what to do when they receive medicine alerts and recalls and they help make sure people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy entrance had a single wide door and a ramp from the pavement. The door could be operated manually or automatically and the team tried to make sure people with different needs could access the pharmacy services. The service information was displayed at the front entrance. There was seating available for people who were waiting. Members of the pharmacy team were helpful. They could speak or understand some different languages to assist people whose first language was not English. And they signposted people to another provider if a service was not available at the pharmacy such as a nearby pharmacy with which there as a reciprocal arrangement.

The pharmacy's delivery person delivered medicines for people who could not attend the pharmacy in person and maintained an audit trail to help show the medicines had been delivered to the correct person. If the delivery could not be completed the medicines were returned to the pharmacy. The delivery was either re-arranged or collected by the patient or their representative. The pharmacy was not actively offering the blood pressure case-finding service at the time of the visit. The RP had looked into supporting people who were prone to simple urinary tract infection (UTI) which was treated with specific anti-biotics. People were prescribed anti-biotics for different numbers of days not always in line with guidance. The RP supplied treatment available through pharmacy first but recommended over-the-counter preparations which would help prevent the UTI progressing and may circumvent the need for anti-biotic treatment.

The pharmacy provided the COVID-19 vaccination service to people over 75 years old and immunocompromised people in line with the green book. The vaccination was administered via the PGD or national protocol to people who had made an appointment. The pharmacy stored the vaccines in a medical fridge which was monitored to make sure it was between two and eight Celsius. The pharmacist supervised the service and obtained consent, completed the clinical assessment and maintained records. The documentation such as SOPs and PGDs were retained in a folder. The pharmacy had adrenaline injector kits and clinical waste bins. Team members who provided the service had completed the required training. The RP explained that a risk assessment had been completed, the pharmacy insurers had been informed about the service and there was a business continuity plan to deal with untoward events so the pharmacy could make alternative arrangements regarding its services.

The pharmacy supplied medicines in disposable multi-compartment compliance packs for people who had difficulty taking them on time. The pharmacy team re-ordered prescriptions for some people and checked them for changes in medicines since the previous time. Members of the team said they would

make sure medicines were suitable to be re-packaged if necessary. They provided a brief description of each medicine contained in the compliance packs and patient information leaflets (PILS) with each set of packs to help ensure people had the information they needed to take their medicines safely. High-risk medicines were generally supplied separately to the compliance pack. Following a patient's hospital stay, the pharmacy sometimes received a discharge summary via PharmOutcomes showing changes in treatment.

In the event of a systems failure people would be signposted to another nearby pharmacy and their nomination switched to that pharmacy. Members of the team initialled dispensing labels so they could identify who 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. The RP counselled people on how best to use their medicines. For people taking warfarin, the RP checked the INR was monitored and reminded them about foods and medicines which may affect their INR. The pharmacy provided the new medicines service (NMS) and after the initial consultations, people were followed up by phone. The RP and the pharmacy team members were aware of the new up-to-date guidance and rules for supplying valproate-containing medicines which 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 used recognised wholesalers to obtain its pharmaceutical stock. It generally kept medicines and medical devices in their original manufacturer's packaging. Liquid medicines were marked with the date of opening. The dispensary was tidy. The pharmacy team carried out regular date checks of stock. The pharmacy stored its stock, which needed to be refrigerated, between two and eight Celsius. And it stored its CDs securely in line with safe custody requirements. The pharmacy's waste medicines were kept separate from stock in one of its pharmaceutical waste bins. The pharmacy checked through uncollected prescriptions and contacted people to check if they still required the medicines. 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 explained what records they kept when the pharmacy received a concern about a product on a pharmacy WhatsApp group.

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 team had access to up-to-date and online reference sources. It had clean measures to measure liquid medicines stored near the dispensary sinks. And measures for use with methadone were segregated from measures used to measure water. The pharmacy stored its pharmaceutical stock requiring refrigeration between two and eight Celsius which its team regularly checked and recorded. The CD cabinet was fixed securely. There were bins for clinical waste disposal. Checking when the blood pressure monitoring equipment was due to be recalibrated was discussed. The pharmacy team collected confidential wastepaper to be disposed of securely. The pharmacy restricted access to its computers and PMR 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.

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.