

Registered pharmacy inspection report

Pharmacy Name: Village Pharmacy, 7 Village Centre, Leverstock Green, HEMEL HEMPSTEAD, Hertfordshire, HP3 8QG

Pharmacy reference: 1032211

Type of pharmacy: Community

Date of inspection: 08/01/2020

Pharmacy context

The pharmacy is located in a small shopping precinct in 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 for people who have difficulty managing their medicines. Services include prescription collection and delivery, stop smoking and supervised consumption.

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 generally safe and effective. The pharmacy team makes sure that people have the information they need so that they can use their medicines in the right way. The pharmacy manages risk and it has written procedures which tell staff how to complete tasks effectively. It keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team keeps people's information secure.

Inspector's evidence

Near misses were recorded and reviewed. All fields of the near miss record were completed and learnings were shared with staff. Allopurinol and atenolol had been separated after a picking error trend had been identified through near miss records. Stock was stored neatly on the dispensary shelves. There was a complaints procedure and incidents were recorded and reported to the NHS National Reporting and Learning System (NRLS) central database of patient safety incident reports.

Workflow: baskets were used to separate prescriptions and medicines during the dispensing process. Labels were generated from scanning the bar-code on the prescription or manually from reading the prescription. Medicines were picked from reading the prescription. Where possible two people were involved in the dispensing and checking procedures. Interactions between two medicines for the same person were shown to the pharmacist. The dispensing audit trail was completed identifying who dispensed and checked the prescription. Medicines, labels and the prescription were retained in an unsealed bag in a cardboard box which were awaiting a final check by the pharmacist. There was a procedure for dealing with outstanding medication. The original prescription was retained until stock was received and an owing slip was issued to the patient. For 'manufacturer cannot supply' items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Multi-compartment compliance aids were prepared for a number of people. The pharmacy generally managed prescription re-ordering on behalf of patients and liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance aid. A risk assessment for patient suitability for medicines supplied in compliance aids included storage arrangements, patient health and whether a carer would administer the medicines. There was a folder of information relating to compliance aids and each patient had their own polythene sleeve to contain patient records including a sample backing sheet and discharge summaries. Backing sheets were reprinted to reflect changes in medication. Labelling included a description to identify individual medicines and patient information leaflets (PILs) were supplied with each set of compliance aids.

High risk medicines such as sodium valproate, alendronate and controlled drugs (CDs) were generally supplied separately to the compliance aid. The dates of controlled drug (CD) prescriptions were managed to ensure supply within the 28-day validity of the prescription. Where possible instructions for taking levothyroxine and lansoprazole were highlighted to ensure they were taken before other medication and food in the morning.

There was a set of standard operating procedures (SOPs) due for review by the pharmacist in Jan 2021 and which included a complaints procedure. Current CD accountable officer details were listed. The

delivery SOP had been read by both delivery drivers. The practice leaflet was on display and included details of how to comment or complain. The annual patient questionnaire was currently being conducted. To protect patients receiving services, there was professional indemnity insurance in place provided by the NPA expiring 30 April 2020. The responsible pharmacist notice was on display and the responsible pharmacist log was completed manually.

Records for private prescriptions, emergency and 'specials' supplies were mostly complete. The CD and methadone registers were generally complete. The frequency of audit of CDs was not specified in the CD SOPs but the pharmacist said the balance of a CD was checked after each entry in the CD register. A random check of the actual stock of three strengths of MST reconciled with the recorded balance in the CD registers. Footnotes correcting entries were mostly signed and dated. Invoice details for receipt of CDs were complete. FP10MDA prescriptions were endorsed at the time of supply. Patient returned CDs were recorded in the destruction register for patient returned CDs although a small number of patient returned CDs required listing and destruction.

Staff were aware of General Data Protection Regulation (GDPR) procedures. A confidentiality policy was displayed. Staff had signed confidentiality agreements. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly. The pharmacist was accredited at level 2 safeguarding training via Centre for Pharmacy Postgraduate Education (CPPE). Safeguarding contact details to report concerns were displayed.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough suitably trained staff to deliver its services safely and manage the workload. They work well together and are comfortable about providing feedback to improve the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time pharmacist, one full-time and one part-time dispenser both enrolled on National Pharmacy Association (NPA) dispenser training course, two part-time medicines counter assistants (MCA) of whom one had completed accredited training and the other MCA was newly recruited, one person who covered Saturdays and was enrolled on NPA pharmacy assistant training and two part-time delivery persons.

Staff had been provided ongoing training via NPA approved Care training booklets which included topics such as digestive health, children's ailments and coughs and colds. In line with the Pharmacy Quality Scheme (PQS) the pharmacist was undertaking sepsis training and had completed Community Pharmacy Consultation Service (CPCS) training to deliver the service. Other PQS training included safeguarding, reducing 'lookalike soundalike LASA' medicine errors and risk management (RM). For RM, staff safety had been risk assessed. There was a system of staff appraisal for new staff and to discuss next steps. Staff were able to provide feedback and had suggested a review of storage and date checking of dispensary medicines. Staff said they knew how and who to contact with whistleblowing concerns. Targets and incentives were not set.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are generally secure and suitable for the provision of its services. The pharmacy prevents people accessing the premises when it is closed to keep medicines and information safe.

Inspector's evidence

The premises were generally clean although there were older fixtures and fittings. The dispensary was on a higher level than the retail public area allowing the pharmacist a view of the medicines counter. Dispensary benches were clean and clear providing work space. The dispensary sink area was clean. Lavatory facilities were clean and handwashing equipment was provided. The consultation room sink required treatment to remove lime scale. The consultation room protected patient privacy. The door was not locked at the time of the visit. There was sufficient lighting and ventilation.

Principle 4 - Services ✓ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable sources to protect people from harm. It makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe to use. The pharmacy team takes the right action if any medicines or devices need to be returned to the suppliers. They make sure that people have all the information they need so that they can use their medicines safely. The pharmacy team members give advice to people about where they can get other support.

Inspector's evidence

There was wheelchair access and wide aisles in the pharmacy to assist people with mobility issues. Large font labels could be printed to assist visually impaired people. Staff could converse in Gujarati and Hindi to assist people whose first language was not English. Patients were signposted to other local services including NHS 111 and a local walk-in centre. There was signposting information available.

The pharmacist was aware of the procedure for supplying sodium valproate to people in the at-risk group and information on the pregnancy prevention programme (PPP) to be explained. The intervention would be recorded on the patient medication record (PMR). The pharmacist was aware of the procedure to supply isotretinoin to people in the at-risk group. The treatment had to be initiated by a consultant and would be supplied following a negative pregnancy test result. The patient would be counselled on PPP and the intervention recorded on the PMR. A protocol for supply of isotretinoin was displayed in the dispensary. The prescriber was contacted regarding prescriptions for more than 30 days' supply of a CD as good practice. Interventions were recorded on the PMR to show checks that medicines were safe for people to take and appropriate counselling was provided to protect patient safety.

Warning stickers were in use to alert staff to high-risk medicines such as fridge items, methotrexate and lithium. CD stickers were in use and prescriptions for schedule 4 CDs were highlighted to ensure CDs were not given out after the 28-day validity period. The pharmacist said that when supplying warfarin people were asked for their record of INR along with blood test due dates. INR was recorded on the PMR. Advice was given about side effects of bruising and bleeding including internal bleeding. Advice was given about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were reminded about the weekly dose and when to take folic acid. Counselling was given to people to seek medical advice if they developed an unexplained fever.

An audit had been conducted to ensure people taking lithium were counselled appropriately including therapeutic monitoring through blood tests, interactions with other medicines and on signs of toxicity. There was an audit regarding amiodarone and therapeutic monitoring. Diabetic patients were asked when they had last attended retinopathy screening and foot checks. Health promotion information was displayed to raise public awareness included reducing treatment with antibiotics to minimise antibiotic resistance, stop smoking and reducing heart age. Health campaigns included alcohol awareness, Stoptober and 'Get Active'.

Medicines and medical devices were delivered outside the pharmacy by two delivery persons. Three

bag labels were printed for each delivery and one label was attached to the bagged prescription items, one to a drop sheet for the driver and one to a duplicate drop sheet which remained at the pharmacy. Patient signatures were recorded to indicate a successful delivery of medicines to the patient home.

Medicines and medical devices were obtained from Alliance, AAH, Phoenix, Sigma and Colorama. Floor areas were mostly clear. Stock was stored neatly on the dispensary shelves. Stock was date checked and recorded. No date-expired medicines were found in a random check. Liquid medicines were marked with the date of opening and medicines were generally stored in original manufacturer's packaging. Some tablets had been removed (de-blistered) from original manufacturer's packaging and were stored in labelled dispensing containers. These were removed from stock. De-blistering tablets and capsules from manufacturer's packaging may affect stability of the medication. Cold chain items were stored in the medical fridge. Uncollected prescriptions were cleared from retrieval monthly after contacting the patient. CD prescriptions were highlighted to ensure they were not given out after the 28-day validity period. Waste medicines were stored separate from other stock in pharmaceutical waste bins. Falsified medicines directive (FMD) hardware and software was not operational at the time of the visit. Drug alerts and recalls were printed, actioned, annotated and filed.

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

Current reference sources included eBNF, Drug Tariff and NPA medical information. The dispensary sink was clean and there were clean stamped glass measures to measure liquids including separate marked measures for methadone. Minimum and maximum fridge temperatures were monitored daily and found to be within the range two to eight Celsius. The CD cabinets were fixed with bolts and CD destruction kits were available. There was a new blood pressure monitor and a carbon monoxide monitor which was supplied and maintained by the CCG. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly.

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.