General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Questmoor Pharmacy, 96 High Street, POTTERS BAR, Hertfordshire, EN6 5AT

Pharmacy reference: 1032264

Type of pharmacy: Community

Date of inspection: 13/11/2019

Pharmacy context

The pharmacy is located in a parade of businesses on the 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 collection and delivery, substance misuse and anti-malaria medicines.

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	1.1	Good practice	The risks associated with providing services are identified and managed.
2. Staff	Standards met	2.1	Good practice	There are enough suitably qualified staff for the safe and effective provision of services.
		2.5	Good practice	Staff are encouraged to provide feedback to improve services.
3. Premises	Standards met	3.1	Good practice	The new design and layout of the dispensary improves the workflow for preparing compliance aids.
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 safe and effective. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy manages risk and keeps people's information safe. The pharmacy has written procedures which tell staff how to complete tasks effectively. The pharmacy mostly keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team members understand their role in protecting vulnerable people.

Inspector's evidence

Near misses were recorded and reviewed and discussed with staff. The area behind the dispensary had undergone a recent change in design and refit. A new area was designated for preparation of multi-compartment compliance aids. Medicines stock had been rearranged to improve the workflow and staff had taken the opportunity to separate certain medicines which may reduce picking errors. For instance: prednisolone and propranolol, different strengths of citalopram and bisoprolol had been separated. Key learning points identified in the annual patient safety report included near misses involving form or strength of medicine selected and lookalike and soundalike 'LASA' medicines to segregate. Learnings were shared with each team member at regular meetings to update staff. As a result, a significant improvement in near miss events with no error reaching patient level was noted.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. Labels were generated, and medicines were picked from reading the prescription. The pharmacist checked interactions between medicines for the same patient. One pharmacist demonstrated a website to check interactions between more complex medicines such as those supplied to HIV patients. The pharmacist performed the final check of all prescriptions prior to completing the dispensing audit trail to identify who dispensed and checked medicines. There was a procedure for the accuracy checking technician (ACT) and pharmacists to follow for final check. Prescriptions which were final checked by the ACT were endorsed to reflect final check was complete. The procedure and training records were confirmed following the visit. There were separate dispensing and checking areas.

There was a procedure for dealing with outstanding medication. The original prescription was retained 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. A list had been compiled of hormone replacement therapy items which could be obtained to inform the local prescribers and manage shortages and treatment.

Following the recent alteration to the pharmacy premises, multi-compartment compliance aids were prepared in a separate designated area with an extra computer terminal and dedicated medicine stock. The level of distraction was reduced as a result. Compliance aids were prepared for a number of patients on a rolling basis according to a matrix. There was an audit trail of activity from ordering and receipt of prescriptions to delivery or collection of compliance aids. The pharmacy 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. There was a folder containing discharge summaries and a copy of the weekly backing sheet for patients. Reprinting weekly backing sheets to reflect changes in medication rather than overwriting was discussed. 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 alendronate and sodium valproate were supplied separately from the compliance aid. The dates of CD prescriptions were managed to ensure supply within the 28-day validity of the prescription. Levothyroxine and lansoprazole were supplied in compartments positioned to ensure being taken before other medication or food and special instructions were highlighted.

The practice leaflet was displayed, and the annual patient questionnaire was conducted. A complaints procedure was displayed. The standard operating procedures (SOPs) had been reviewed recently and were demonstrated online during the visit. Changes to procedures were discussed with staff. The staff members who served at the medicines counter said they would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. A member of the public requesting three packs of Sudafed would be referred to the pharmacist.

To protect patients receiving services, there was professional indemnity insurance in place provided by NPA and expiring 30 Nov 2019. The responsible pharmacist notice was on display and the responsible pharmacist log was completed. Records for private prescriptions were missing some prescriber details but were generally complete. There was a small number of outstanding private prescriptions to be recorded which the pharmacist confirmed would be completed as soon as possible. There was a discussion about ensuring FP10PCD prescriptions were submitted to the prescription pricing department each month. Emergency supply records were electronic. Records for unlicensed medicines were complete. Patient group directions (PGDs) to supply medicines treating erectile dysfunction and malaria prophylaxis were in date and due for renewal. Medicines supplied via NHS Urgent Medicine Supply Advanced Service (NUMSAS) had been reported on PharmOutcomes although this service was replaced by NHS Community Pharmacist Consultation Service (CPCS) recently.

The CD registers were complete and a random check of the actual stock of two strengths of MST reconciled with the recorded balances in the CD registers. Footnotes correcting entries were signed and dated. Invoice number and name and part of the address of the supplier was recorded for receipt of CDs. Footnotes correcting entries were signed and dated. Headers in the methadone registers were completed. FP10MDA prescriptions were endorsed at the time of supply. Ensuring CDs including methadone were audited more regularly to detect discrepancies was discussed. Patient returned CDs were recorded in the destruction register for patient returned CDs.

Staff had signed confidentiality agreements and were aware of procedures regarding General Data Protection Regulation (GDPR). A privacy notice was displayed and the Data Security and Protection (DSP) toolkit had been completed. Staff were using their own NHS cards. Confidential waste paper was collected for safe disposal and a cordless phone enabled a private conversation. The pharmacy computer was password protected and backed up regularly. Staff had undertaken safeguarding and dementia friends training and the pharmacist was accredited at level 2 in safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to deliver its services safely. The team members work well together and manage the workload within the pharmacy. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: three full-time pharmacists, two full-time pre-registration pharmacists, one full-time ACT, one part-time registered pharmacy technician and four part-time medicines counter assistants (MCA). There was a part-time delivery driver.

Both pre-registration pharmacists were enrolled on ProPharmace training course and two of the regular pharmacists were pre-registration tutors. Pre-registration pharmacists attended monthly training days. Training topics had so far included respiratory conditions such as asthma and COPD, schizophrenia and calculation. Both pre-registration pharmacists were following action plans and studied in their own time. Progress in their roles was monitored through appraisals every thirteen weeks.

The superintendent pharmacist confirmed that staff involved with dispensary stock management were in the process of being enrolled on training appropriate to the task. The pharmacist discussed any changes when the SOPs were reviewed. The pharmacist had attended a pain management and suicide prevention training evening. Staff were in the process of training in Sepsis and Reducing 'LASA' errors for pharmacy quality scheme (PQS). There was no formal system of appraisal but the superintendent pharmacist (SI) was on the premises all the time to monitor performance. Staff were free to provide feedback and had suggested storing a range of medicines in the area where compliance aids were prepared to reduce the number of staff in the main dispensary by not having to access stock, a mechanical device to deblister tablets and capsules and an extra computer screen. All suggestions improved workflow. There was a whistleblowing policy. The pharmacist said targets and incentives were set but not in a way that affected patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean 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 public area of the pharmacy premises was clean and tidy and presented a professional image. The area to the rear of the main dispensary had been extended and re-configured to enhance workflow. Compliance aids were now prepared in a dedicated area with its own stock, extra computer screen and dispensary sink. The consultation room was located to the rear of the dispensary with separate access from the public area. Patient privacy was protected. The lavatory and staff area were generally clean and handwashing facilities were provided. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

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

Inspector's evidence

There was level access at the entrance to assist people with mobility issues. Large font labels could be printed to assist visually impaired people. Staff could converse in Swahili, Gujarati, Mandarin, Cantonese, Malay and Hokkien to assist patients whose first language was not English. Patients were signposted to other local services and information sources including Diabetes UK, Mind, NHS 111, sharps collection and patient.co.uk. Nicotine replacement therapy was provided via vouchers for members of the public accessing stop smoking service.

The pharmacist explained the procedure for supply of sodium valproate to people in the at-risk group. There was a folder containing information on the pregnancy prevention programme (PPP) which was explained to at-risk people. The pharmacist explained the procedure for supply of isotretinoin to people in the at-risk group. Isotretinoin should be prescribed by a specialist and supplied within seven days following a negative pregnancy test. The prescriber would be contacted regarding prescriptions for more than 30 days' supply of a CD. CD prescriptions were highlighted to ensure supply within the 28-day validity period. Ensuring interventions were recorded on the PMR moving forward was discussed.

Prescriptions for high-risk medicines such as CDs and fridge items were highlighted by marking the bag label. The pharmacist said when supplying warfarin, people were asked for their record of INR along with blood test due dates. INR was not always recorded on the patient medication record (PMR) but the pharmacist said moving forward INR would be recorded on the PMR. Side effects of bruising and bleeding were explained. Advice was given about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were reminded to have regular blood tests and about the weekly dose, when to take folic acid. People were advised to seek medical advice if they developed an unexplained fever.

Audits had been conducted to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking a non-steroidal anti-inflammatory drug (NSAID). The audits regarding prescription of salbutamol with no steroid inhaler for six months and for children who did not have a spacer or asthma plan had been conducted. At the time of the visit there was an audit of dates of last foot checks and retinopathy screening for diabetic people and the pharmacist demonstrated intervention records on the PMR. An audit was planned for sodium valproate, lithium and the pre-registration pharmacists were to conduct the next NSAID audit. The pharmacist explained being involved in a pilot scheme with a local surgery and visiting a care home to review stock management and reduce medicines waste. Health campaigns to increase public awareness of children's oral health had been undertaken.

Medicines and medical devices were delivered outside the pharmacy by a delivery person. A drop sheet was prepared and the deliveries were marked off by the driver as they were completed. Ensuring there was a robust audit trail to deal with queries relating to failed deliveries was discussed. The pharmacist delivered CDs himself and contacted the patient first to plan the delivery.

Medicines and medical devices were obtained from Alliance, AAH, Phoenix, Sigma, Doncaster and Colorama. Floor areas were clear, and stock was neatly stored 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 mostly stored in original manufacturer's packaging. There was a discussion about stability of deblistered tablets and ensuring medicines were stored in appropriately labelled containers, so the pharmacy could identify stock affected by drug alerts or date checks. Cold chain items were stored in two medical fridges. Uncollected prescriptions were cleared from retrieval regularly and patients were contacted depending on the type of medication. Waste medicines were stored separately from other stock. Falsified medicines directive (FMD) hardware and software was not operational at the time of the visit. Drug alerts were received via the wholesalers and email and actioned. The pharmacist gave an assurance that moving forward a record of responses to drug alerts would be maintained.

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's equipment keeps people's private information safe.

Inspector's evidence

There were current reference sources. The dispensary sink was clean and there were clean standard glass measures to measure liquids including separate marked measures for methadone. The medical fridges were in good working order. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinets were fixed with bolts. Staff were using their own NHS cards. Confidential waste paper was collected for safe disposal and a cordless phone enabled a private conversation. 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.