General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Parade Pharmacy, 18 Main Parade, Chorleywood, RICKMANSWORTH, Hertfordshire, WD3 5RB

Pharmacy reference: 1032280

Type of pharmacy: Community

Date of inspection: 13/02/2024

Pharmacy context

The pharmacy is in a parade of businesses in Chorleywood in Hertfordshire. It provides health advice and dispenses private and NHS prescriptions. The pharmacy supplies medicines in multi-compartment compliance packs for people who have difficulty managing their medicines. Its other services include: smoking cessation, blood pressure case-finding, discharge medicines service, sexual health (emergency hormonal contraception and chlamydia screening), treatment for urinary tract infection, flu vaccination and pharmacy first.

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 pharmacy team manage the risks associated with providing services and protect the health and wellbeing of people who use the pharmacy.
		1.2	Good practice	The pharmacy reviews and monitors its services to make sure they are safe and effective
2. Staff	Standards met	2.2	Good practice	Members of the pharmacy team work well together and are supported and encouraged to complete ongoing training.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	Services are managed and delivered safely through preparation and providing appropriate training, equipment and resources.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The working practices of the pharmacy team members are safe and effective. They manage the pharmacy's services well. The pharmacy has suitable written instructions in place for the team to follow and effectively identify the risks associated with providing its services. Team members carry out regular audits and reviews of services to monitor their quality. They learn from their mistakes and take steps to prevent them happening again.

The pharmacy keeps the records required by law showing it supplies its medicines and services safely. Members of the pharmacy team are good at protecting 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. Members of the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. A pharmacist reviewed the mistakes on a monthly basis to look for patterns in the types of mistakes and share learnings with the team. Medicines involved in incidents, or were similar in some way, such as sertraline and spironolactone, were generally highlighted and separated from each other in the dispensary.

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 medicines. They referred to the pharmacist about interactions between medicines prescribed for the same person. And assembled prescriptions were not handed out until they were checked by the pharmacist or accuracy checking technician (ACT). Team members who prepared and checked prescriptions created an audit trail by initialling the dispensing labels. They highlighted prescriptions with high-risk medicines such as controlled drugs (CDs) with warning stickers. And they supplied warning cards such as for warfarin or lithium to make sure people had all the information they needed to use their medicines in the best way. These cards prompted team members to check recent blood test results and interventions were recorded on the patient medication record (PMR). Members of the team who handed out prescriptions confirmed the details on the address label on the bag and asked the person to check the label too.

The pharmacist described risk-assessing the pharmacy and its team in preparation for providing the flu vaccination service. The risk-assessment (RA) identified training to be completed, infection control measures, suitability of the premises and safeguarding vulnerable people. The pharmacy also risk-assessed suitability of some medicines to be re-packaged in multi-compartment compliance packs and noted any interventions on the patient medication record (PMR). The pharmacy undertook audits in line with the pharmacy quality scheme (PQS) and identified people who required an asthma plan to optimise their inhaler treatment. The anti-coagulant audit identified people prescribed medicines which interacted with warfarin and caused increased gastric bleeding. And another audit highlighted an antibiotic which was not included in the local medicines' formulary. The valproate audit was completed. The pharmacist explained planned audits for the Pharmacy First service to monitor different parts of the service such as diagnosis, compliance with the patient group direction (PGD) pathway and

signposting. The pharmacy had a business continuity plan for the team to refer to and it listed contact details and what to do if the pharmacist was not at the pharmacy when team members arrived.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these had been reviewed since the last inspection showing date of review, author and next review date. 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. They knew what they could and could not do, what they were responsible for and when they might seek help. 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 medicines, such as medicines liable to abuse to a pharmacist. The most recent SOPs related to dispensing high-risk medicines. The pharmacy had a complaints procedure. And it had received positive feedback through word of mouth. The RP had received praise from the residents in an article published in the local community news magazine. The practice leaflet detailed how people could express their views and make suggestions on how it could do things better.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy displayed a notice that told people who the RP was at that time and it kept a record to show which pharmacist was the RP and when. The pharmacy had a controlled drug (CD) register. Its team made sure the CD register was kept up to date. And a random check of the actual stock of a CD matched the amount recorded in the CD register. People's unwanted CDs were listed in patient returns CD destruction register. Records were maintained for new medicines service. The pharmacy kept records for the supplies of medicines it made via the community pharmacist consultation service (CPCS) on PharmOutcomes. The pharmacy recorded private prescriptions and unlicensed (specials) medicines it supplied. And these generally were in order. It recorded interventions on the PMR and information about people's treatment through the new medicine service (NMS) was retained and locked away in a folder. And the pharmacy kept records of consent to access people's summary care records (SCR). The clinical governance folder retained records such as complaints, medicines recalls and alerts, patient safety reviews.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice in two places 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 could not be seen by other people and was disposed of securely. Confidentiality agreements were signed and retained with other team related information. The pharmacy had a safeguarding SOP and where to report concerns was listed in the signposting folder. And the RP had completed a level 3 safeguarding training course. 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 team were signposted to the NHS safeguarding Ap.
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Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members who are qualified or training to have the appropriate skills and training for their roles. It supports learning and development. Members of the team work well together and manage their workload. The pharmacy team can provide feedback and concerns relating to the pharmacy's services.

Inspector's evidence

The pharmacy team consisted of two regular pharmacists one of whom was the superintendent pharmacist (the RP), a full-time accuracy-checking technician, and six part-time medicines counter assistants (MCA). The pharmacy relied upon its team to cover absences. The RP was supported at the time of the inspection by a third pharmacist and one of the MCAs was enrolled on the dispensing assistant accredited training to be able to assist in the dispensary.

The pharmacist described training completed to deliver the Pharmacy first service by the pharmacists and the ACT such as reading through the SOPs, watching Community Pharmacy England training videos, joining webinars and downloading the guidelines to read through. Members of the team completed accredited training online and they could have protected learning time. Some training was via eLearning for healthcare (elfh). Training topics included those required for the pharmacy quality scheme (PQS), product training, general data protection regulation (GDPR) annually, health and safety. The pharmacy maintained training records and certificates were displayed.

Team members 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 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 pharmacist conducted ongoing appraisals to support the team. And there were regular team meetings to share information and discuss current issues and pharmacy news. Team members created the window displays which promoted services and heath campaigns. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew how to 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. People can have a private conversation with a team member in the consultation rooms. The pharmacy prevents people accessing its premises when it is closed so it protects medicines stock and people's private information is safe.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure. And 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, and the dispensary at a higher level with a view of the retail area. There was storage space towards the back of the premises. The pharmacy had two consultation rooms where people could have a private conversation with a team member. The dispensary was well-organised and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy and its services are easily accessible to people. And it provides its services safely and effectively. People taking higher-risk medicines are provided with the information they need to use their medicines properly. The pharmacy obtains its medicines from reputable sources and manages them appropriately so that they are fit for purpose and safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy had a single manual door. And someone who used a wheelchair could enter the building. The pharmacy team tried to make sure these people could access the pharmacy services. The pharmacy had a notice showing when it was open. And other notices in its window told people about some of the other services the pharmacy offered. There was seating available for people who were waiting. Members of the pharmacy team were helpful. They could speak or understand Gujarati and Hindi to assist people whose first language was not English. They printed large font labels, so they were easier to read. And they signposted people to another provider if a service was not available at the pharmacy. Such as the minor injuries unit, to have ear wax removed or to have travel vaccinations. The pharmacist kept a signposting folder with useful information and described records which were maintained.

The pharmacy supplied medicines in a disposable a multi-compartment compliance pack for people who had difficulty taking them on time. The pharmacy team checked if the medicines were suitable to be re-packaged. It provided patient information leaflets (PILS) and a brief description of each medicine contained in the compliance packs. So, people had the information they needed to make sure they took their medicines safely. The team managed re-ordering of prescriptions according to a matrix and checked them for changes in medication. High-risk medicines were generally supplied separately to the compliance pack. The pharmacy supplied medicines administration record charts to representatives of people who received compliance packs and provided counselling on medicines not supplied in the packs such as eye drops.

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 pharmacist counselled people on how best to use their medicines and supplied warning cards for high-risk medicines such as steroids. For people taking warfarin, the pharmacist checked the INR was monitored and recorded the value on the PMR. The pharmacy provided a food list about foods which may affect their INR. 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 offered a stop smoking service and achieved four or five successful quits per year. The pharmacist had liaised with the local surgery and local pharmaceutical committee (LPC) ahead of commencing the Pharmacy First service. This was to ensure appropriate documentation and contact

details were in place. The pharmacist was the lead pharmacist in the Integrated Care Body (ICB) and had completed leadership training for the role which was to encourage effective communication pharmacies and nearby doctor's surgeries. In preparation, the pharmacy team had completed training, risk-assessed the pharmacy's premises (which had two consultation rooms) and the pharmacy team dynamics. There was nearly always extra pharmacist cover. The pharmacist had prepared a Pharmacy First folder with information on people who were suitable to treat and red flags for those who were not and should be referred elsewhere. For instance, the pharmacist could distinguish between different types of sore throat such as glandular fever. The pharmacy had already treated some people though the new service.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept medicines and medical devices in their original manufacturer's packaging. The dispensary was tidy. The pharmacy team checked the expiry date on medicines received from the wholesalers and carried out regular date checks of stock. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees 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 had a procedure for dealing with alerts and recalls about medicines and medical devices. And the pharmacist described the actions they took and explained what records they kept such as batch number and expiry date of the affected stock when the pharmacy received a concern about a product.

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 glass measures to measure liquid medicines. The blood pressure monitor was marked with a date of opening so the team knew when to replace it. Equipment to deliver the Pharmacy First service was in place. The pharmacy's stop smoking equipment was supplied and maintained by Hertfordshire County Council. The pharmacy had a fridge to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of the fridge. The CD cabinet was fixed with bolts. The pharmacy team disposed of confidential waste appropriately. 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.