General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Jersey Farm chemist, 7 St Brelades Place, ST. ALBANS, Hertfordshire, AL4 9RG

Pharmacy reference: 1032334

Type of pharmacy: Community

Date of inspection: 18/06/2024

Pharmacy context

The pharmacy is in a small shopping precinct in a residential area near St Albans in 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, blood pressure case-finding, COVID-19, travel medicines and seasonal flu vaccinations and Pharmacy First. The pharmacy has changed ownership since the previous visit.

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. 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 the mistake. They identified the types of mistakes they made and agree actions they could take to reduce the chances of them happening again. The pharmacy team did not routinely record near misses or what they had learnt so they could be missing opportunities to spot patterns with the mistakes they made. The RP explained that medicines which were involved in incidents, or were similar in some way, for instance pregabalin and gabapentin were generally separated from each other in the dispensary. Team members had grouped some medicines stock together such as antibiotics and inhalers which they found had helped to minimise picking errors. 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 and ordered medicines. When the medicines were delivered the team members could complete dispensing any outstanding items on 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 contacted the prescriber regarding queries on prescriptions. And recorded interventions on the patient medication record (PMR) 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 with high-risk medicines such as controlled drugs (CDs) prescriptions to make sure people had all the information, they needed to use their medicines effectively. And ensuring they supplied alert cards such as for warfarin or prednisolone was discussed. 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 responsible pharmacist and for the services it provided. The RP explained that most of the SOPs were due to be reviewed. The most recent 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 which was usually verbal from people who used the pharmacy and its services. They had business cards with the pharmacy contact details which were given out to people who used the pharmacy.

The pharmacy had risk-assessed the premises and updated the consultation room and access to it from the retail public area of the pharmacy. Risk assessments to provide the COVID-19 vaccination service identified vaccines storage, training, record keeping, hygiene control and dealing with clinical waste. In preparation for commencing the NHS Pharmacy First service, the pharmacy completed risk assessments to identify risks such as pharmacist training and knowledge and increasing support by local surgeries for the new service. The pharmacy had assessed if changes were needed to free up the RP's time for consultations and when it was quiet in the pharmacy. 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 explained how the pharmacy team planned and managed deliveries of medicines in compliance packs when the delivery person was on annual leave. This ensured people had a continual supply of their medicines and it meant possibly sending extra medicines the previous time or arranging for the patient's representative to collect medicines from the pharmacy. The RP described an audit of people prescribed inhalers and checking their inhaler technique, making sure they had a spacer device to optimise the effect of the inhaled medication and informing them how they could recycle inhalers when they were finished. 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 an electronic 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. Patient returned CDs were recorded manually. 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 correctly. The pharmacy provided COVID-19 vaccinations which were administered via patient group direction (PGD). 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 travel vaccination service was provided when a different pharmacist was on duty.

The pharmacy was registered with the Information Commissioners Office (ICO). The pharmacy team members had completed general data protection regulation (GDPR) training. They collected confidential wastepaper to be disposed of securely. Members of the team used their own NHS Smartcards. The pharmacy displayed a privacy notice. 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. 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 RP described how the team raised a safeguarding concern had about someone who visited the pharmacy. 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. There are suitable handover arrangements so information is shared with each pharmacist each day. The pharmacy supports learning and development 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 four regular pharmacists who cover different days of the week and provide certain services, one full-time dispensing assistant, two part-time medicines counter assistants and a part-time delivery person who was Disclosure and Barring Service checked. Team members were enrolled on or had completed accredited training in line with their roles. The pharmacy team was signposted to the GPhC requirements for training support staff and the Knowledge Hub. The SI explained that information and updates were shared among the pharmacists via the dispensing assistant who overlapped with the pharmacists every day. At the time of the visit, the pharmacy was supporting a ‘work experience’ student. The RP explained that the student had been briefed on keeping people’s information private.

The RP had completed training such as clinical skills and how to use an otoscope to deliver the Pharmacy First service. Team members completed training via eLearning for healthcare (elfh) and the superintendent pharmacist (SI) could monitor progress completing modules. Team members were allocated protected learning time if needed for accredited training. They had trained in topics including sepsis and antibiotic stewardship. Team members could discuss issues and provide the SI feedback and suggestions to improve services. The SI was in regular contact with the team members. One team member had suggested managing the services workflow by asking people to make appointments. And the team devised a form to communicate medicines in short supply to local doctors. And they backed up the shortages form with an email. Members of the team had regular informal team meetings when they could exchange 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 was seating 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 large 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 room for storage. The pharmacy’s consultation room was signposted, and people could have a private conversation with a team member. It was tidy and clean. Team members kept dispensary worksurfaces clean and clear to help avoid them becoming cluttered when the pharmacy was busy.

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. They help make sure people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy entrance had wide double doors and a sill between the floor and the pavement. It was almost level and directly in line with the medicines counter so team members could see if anyone needed assistance at the door. The service information was displayed and 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, usually the local doctors, if a service was not available at the pharmacy.

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 delivery person used a delivery App for monitoring the service. It was possible to log in and see what happened retrospectively. The pharmacy team rang the person about counselling and CD deliveries for which the pharmacy required a signature indicating a successful delivery.

The pharmacy team members were offering the blood pressure case-finding service at the time of the visit. The blood pressure readings were recorded on PharmOutcomes and the person was signposted to their regular doctor for treatment if needed. And they provided a service to discuss new medicines which were prescribed so people would take them in the best way. They followed up the first consultation and any intervention they had made by phone.
The pharmacy provided the COVID-19 vaccination service in line with the green book and to people over 75 years old and immunocompromised people. People generally made an appointment, and the vaccination was administered via the PGD. The pharmacy stored the vaccines in a medical fridge which was monitored to make sure the minimum and maximum temperatures were between two and eight Celsius. The pharmacist supervised the service and obtained consent, completed the clinical assessment and maintained records of who was vaccinated and the vaccine details. The pharmacy had adrenaline injector kits to treat anaphylaxis and bins for safe disposal of clinical waste. Team members who provided the service had completed the required training.

Following the visit, the SI explained that he was trained to provide the travel clinic medicines so this service was available when he was on duty. He explained that a risk assessment was completed prior to introducing a new service and it was updated annually or when there were changes to the service. The pharmacy's insurers were informed about the services. 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 and CDs were supplied within 28 days of the date the prescription was issued.

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. 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. 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.

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 such as NHS and Patient Choices. It had clean measures to measure liquid medicines stored near the dispensary sink. The pharmacy stored its pharmaceutical stock requiring refrigeration between two and eight Celsius which its team regularly checked and recorded. The CD cabinets were 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.