General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Globe Pharmacy (Chiswell), 196 Watford Road, Chiswell Green, ST. ALBANS, Hertfordshire, AL2 3EB

Pharmacy reference: 1032348

Type of pharmacy: Community

Date of inspection: 18/10/2023

Pharmacy context

The pharmacy is in a residential area of St Albans in Hertfordshire. It dispenses NHS and private prescriptions and provides health advice. Services provided by the pharmacy include Community Pharmacist Consultation Service (CPCS), delivery, discharge medicines service (DMS), new medicines service (NMS), and flu vaccination service. The pharmacy supplies medicines in multi-compartment compliance aids for people who have difficulty managing their 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	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

Overall, the pharmacy's working practices are safe and effective. It has adequate standard operating procedures in place to manage risks and make sure its team members work safely. The pharmacy team members do discuss their mistakes and take action to prevent them happening again although they do not always record them so they may be missing opportunities to spot patterns and learn from their mistakes. The pharmacy mostly keeps the records it needs to by law. So it can show the pharmacy is generally providing safe services. Members of the pharmacy team protect people's private information, and the pharmacist is 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. When the responsible pharmacist (RP) identified mistakes, they were highlighted to the other members of the pharmacy team and discussed so everyone could learn from them and reduce the chances of them happening again. The RP described a recent trend in near misses the team had spotted involving lisinopril 10mg tablets and ramipril 10mg tablets. This was due to similar packaging, strengths and, to a lesser degree, names. So the team members had attached alert labels to the shelves to alert people to take care with similar medicines. They did not always record their mistake or the lessons they learnt from them. So, they could be missing opportunities to spot patterns or trends with the mistakes they made but medicines involved in incidents or were similar in some way were generally 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 products. And assembled prescriptions were not handed out until they were clinically and final checked by the RP. Members of the team highlighted high-risk medicines by writing on the bag label and were able to show one label endorsed 'FRIDGE' to indicate there was a fridge item to be included with the prescription when it was collected. They initialled dispensing labels to show who dispensed and checked prescriptions. And they alerted the RP to check interactions between medicines prescribed for the same person. They recorded interventions on the patient medication record (PMR). The pharmacy did conduct a valproate audit which showed that there were no people in the at-risk group taking a valproate.

The regular pharmacist was not present on the day of the visit but confirmed that the pharmacy had standard operating procedures (SOPs) for most of the services it provided in the SOP folder in the consultation room. 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. A member of the team explained the sales protocol for recommending or selling over-the-counter (OTC) medicines and knew what the team members could or could not do when the RP was absent. A member of the team described what information they asked for to confirm who they were handing out prescriptions to.

The pharmacy team informed people who visited the pharmacy about the flu vaccination service. The pharmacy displayed information to encourage more people and their carers to have a flu vaccination. Trained team members administered flu vaccinations via private and NHS patient group directions (PGDs) which they had signed and retained along with the SOPs and blank risk-assessment forms to be

completed for people who were having a vaccination. Business continuity plans had been documented for the pharmacy to follow so that it could continue providing its services in the event of a systems failure. The pharmacy team cleaned the consultation room surfaces between vaccinations.

The pharmacy displayed a notice that told people who the RP was and kept a record to show which pharmacist was the RP and when. Members of the pharmacy team knew what they could and could not do, what they were responsible for and when they might seek help. And they would refer repeated requests for the same or similar products, such as medicines liable to misuse to a pharmacist. The pharmacy had a complaints procedure. And it had a feedback form for people to complete when the pharmacy asked people for their views and suggestions on how it could do things better.

The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. 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 an electronic CD register which had restricted access to designated people. And a random check of the actual stock of a CD matched the recorded amount in the CD register. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. The pharmacy recorded the private prescriptions it supplied although there were sometimes missing details such as the quantity of medicine prescribed. But generally the pharmacy's records were in order.

The pharmacy was registered with the Information Commissioner's Office (it had a Data Protection Registration Certificate). The privacy notice needed to be re-printed telling people how their personal information was gathered, used and shared by the pharmacy and its team members. Team members tried to make sure people's personal information could not be seen by other people and was disposed of securely. The pharmacy was using an NHS card of a staff member who was working at that time. The RP had completed a safeguarding level 3 training course. Members of the pharmacy team would make the RP aware if they had concerns about the safety of a child or a vulnerable person. The RP was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work well together to manage their workload. The pharmacy supports them training and gives them protected learning time. Members of the team are able to raise concerns.

Inspector's evidence

The pharmacy team consisted of the RP, four part-time dispensing assistants who were enrolled or had completed accredited training, and a part-time delivery driver. The pharmacy relied upon its team to cover absences and the RP could call on a family member to cover staff absence if needed. The RP was supported at the time of the inspection by two team members. The RP was signposted to the GPhC Knowledge Hub.

The pharmacy team members worked well together serving people and processing their prescriptions. 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 detailed the questions the team members needed to ask people when making OTC recommendations. A member of the pharmacy team explained when requests for medicines liable to misuse were referred to a pharmacist.

The RP had completed the necessary training including level 3 safeguarding training which was required to deliver the flu vaccination service. The team members had previously undertaken pharmacy quality scheme (PQS) training. They could study in the consultation room when it was quiet. The RP explained that the regular pharmacist would speak to a staff member if there were any issues. The team messaged each other at handover between shifts. And felt they could give the RP feedback if they needed to.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, bright, secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe, and people's private information is protected.

Inspector's evidence

The registered pharmacy premises were bright 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 counter, and a small dispensary. It had a consultation room where people could have a private conversation with a team member. The dispensary had limited workspace and storage available. But team members were constantly tidying the work benches. The pharmacy had a sink and potable water. Members of the pharmacy team were responsible for keeping the pharmacy’s premises clean and tidy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team members try to make sure people with different needs can easily access the pharmacy's services. Their working practices are generally safe and effective. They make sure the pharmacist knows which people require more information and support to use their medicines properly. The pharmacy team members make sure people who are supplied medicines in multi-compartment compliance aids have the information they need to use their medicines safely. The pharmacy obtains its medicines from reputable sources so they are fit for purpose and safe to use. They store medicines securely, at the correct temperature and they keep a record of any medicines or devices that need to be returned to the suppliers.

Inspector's evidence

The pharmacy's entrance was not level with the outside pavement and there was a wide manual door. This made it harder for someone who used a wheelchair, to enter the building. But the pharmacy team went to the entrance to help make sure these people could use the pharmacy services. The pharmacy had a notice that told people when it was open. There was health-related information on display telling people about the vaccination service.

Members of the pharmacy team were helpful and could speak or understand other languages such as Bangladeshi, French, Pakistani and Urdu to help people whose first language was not English. They were able to print large font labels which some people found easier to read. And they signposted people to another provider if a service was not available at the pharmacy. The pharmacy provided a delivery service to people who could not attend its premises in person. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right person.

The pharmacy team members used disposable packs for people who received their medicines in multi-compartment compliance aids, and they managed re-ordering of prescriptions according to a matrix on behalf of these people. They checked new prescriptions for changes in medication. And checked whether medicines were suitable to be re-packaged. The pharmacy provided a brief description identifying each medicine contained within the compliance aids and it provided patient information leaflets (PILs). So, people had the information they needed to make sure they took their medicines safely. Medicines administration record charts were provided for people. Care home staff signed for and collected multi-compartment compliance aids on behalf of people who lived in nearby assisted living accommodation.

The pharmacy was providing the seasonal flu vaccination service via patient group directions (PGDs). The pharmacy had completed a risk assessment to identify and manage risks when providing the service such as cleaning to control infection. And the RP kept records for each vaccine to be injected and checked people had no flu-like symptoms. Then the RP administered the vaccine and gave the person a PIL for the vaccine. The pharmacy had clinical waste and sharps bins to dispose of vaccine waste items safely.

Members of the pharmacy team marked some prescriptions to highlight when a pharmacist needed to speak to the person about the medication they were collecting or if other items needed to be added.

They highlighted prescription bags containing CDs to remind members of the team to check that the prescription was in date before giving the CD to the person collecting it. And it was not more than 28 days since the date the prescription was issued. The pharmacy team removed uncollected prescriptions after three months. The RP was aware of the valproate pregnancy prevention programme (PPP). And the RP knew that people in the at-risk group who were prescribed a valproate needed to be counselled on its contraindications. The RP was signposted to 'Information for healthcare professionals and organisations.' (Full pack dispensing of valproate-containing medicines).

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. The dispensary bench was clean and tidy. No expired medicines were found on the shelves. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. The RP demonstrated how the thermometer operated and the 'hi' and 'lo' temperatures were seen to be within range. The pharmacy stored its CDs securely in line with safe custody requirements. Obsolete medicines, such as unwanted medicines people had returned, were kept separate from stock in pharmaceutical waste containers. These were in the lavatory due to limited space in the dispensary and were removed by the licensed waste contractor every three months. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the actions were recorded up to date on a matrix.

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 had measures for use with liquids. The pharmacy team had access to up-to-date reference sources for information and guidance. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And its team members checked and recorded the maximum and minimum temperatures of the refrigerator. The pharmacy team members disposed of confidential waste appropriately. The pharmacy restricted access to its computers and patient medication record system. So 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.

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.