General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Normandy Chemist, 52 Waverley Road, ST. ALBANS, Hertfordshire, AL3 5PE

Pharmacy reference: 1032349

Type of pharmacy: Community

Date of inspection: 10/08/2022

Pharmacy context

The pharmacy is located in a residential area near the local hospital. 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 delivery, stop smoking, supervised consumption, community pharmacist consultation service (CPCS) and COVID-19 and seasonal flu vaccinations.

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

The pharmacy's working practices are safe and effective. The pharmacy has suitable standard operating procedures (SOPs) in place to make sure its team members know how to work safely. But it does not always keep them on the premises which makes it more difficult to refer to them. The pharmacy routinely assesses and documents the key risks associated with providing its services. Members of the team keep the records they need to up to date so they can show the pharmacy is supplying its services safely They manage and protect people's private information and they are 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. And they recorded them and the lessons they learnt from them on Pharmsmart, a medicines management app, on the pharmacy computer. Pharmacy team members tried to spot patterns or trends with the mistakes they made and take action to reduce the chance of making the same mistake again. So, shelf-edge alert stickers reminded the team to take extra care when picking certain medicines. And a member of the team explained that medicines involved in incidents, or were similar in some way, such as hydroxyzine and hydralazine, and ramipril tablets and capsules were generally separated from each other in the dispensary. The trainee pharmacy technician had arranged 'fastline' medicines in one place to improve workflow. And he regularly reviewed the near misses and created a patient safety review of his findings. The pharmacy had a complaints procedure to report incidents. And details of how to complain were on display. The pharmacy asked people for their views and suggestions on how it could do things better and it had received positive feedback from people.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. And these had been reviewed since the last inspection. The SOP folder was not available as a member of the team had taken them home to train in the SOPs . The pharmacy team was required to read and sign the SOPs relevant to each of their roles to show they understood them and would follow them. Members of the pharmacy team 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. 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. To minimise the chances of working alone, one team member picked medicines and one generated labels. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were clinically and accuracy checked by the responsible pharmacist (RP). Team members showed interactions between medicines prescribed for the same person to the RP in case an intervention, such as contacting the prescriber, was necessary. And interventions were recorded on the patient medication record (PMR).

The pharmacy had risk-assessed the services it provided such as COVID-19 vaccination. And risk

assessments were dated, stated who had completed the risk assessment and when the service was next due to be risk-assessed. Risk assessments were reviewed to make sure they were effective, and the risks identified with each service had been reduced. The pharmacy had risk-assessed the impact of COVID-19 upon its services and the people who used it. Team members had limited the number of people in the pharmacy and personal protective equipment was available to help reduce the risks associated with the virus. They washed their hands regularly and used hand sanitising gel when they needed to. The pharmacy team had undertaken audits required by the pharmacy quality scheme (PQS) to monitor safe and effective use of anti-coagulants, asthma and antibiotics.

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. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It kept the records it needed to on Pharmsmart. It had a controlled drug (CD) register. And a random check of the actual stock of one CD matched the recorded amount in the register. The pharmacy team members recorded patient returned CDs by hand in a separate register. There were patient group directions (PGDs) for vaccination services in a folder. They kept records for the supplies of the unlicensed medicinal products they made. And recorded the emergency supplies and the private prescriptions they supplied electronically. These records were generally in order.

The pharmacy had an information governance folder, and it displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy. Its team members had trained in general data protection regulation (GDPR) and signed confidentiality agreements. They had individual passwords to access pharmacy computer systems including Pharmsmart and each team member used their own NHS smart card. And the team made sure people's personal information could not be seen by other people and was disposed of securely. And one team member described procedures to protect private information. The pharmacy had a safeguarding SOP. And the RP had completed a level 2 safeguarding training course. Members of the pharmacy team knew what to do and explained who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work effectively together to manage the workload and deliver services safely. They are supported in completing training appropriate to their roles. Team members provide feedback about the pharmacy which improves its services.

Inspector's evidence

The pharmacy team consisted of one full-time regular locum pharmacist who covered four days per week and a second locum pharmacist who covered the remaining two days per week. The full-time dispensing assistant was enrolled on and studying the NVQ3 accredited training to be a pharmacy technician. The remaining team members were a full-time trained medicines counter assistant (MCA) and two part-time delivery drivers who were shared with other branches. On the day of the visit, a student pharmacist from a local university was on placement.

Members of the pharmacy team were supported doing accredited training relevant to their roles and had protected learning time where possible. They worked well together. So, people were served quickly, and their prescriptions were processed safely. The RP managed the pharmacy team supervising and overseeing the supply medicines and advice given by the pharmacy team. Members of the pharmacy team were training to provide the COVID-19 vaccination service. The pharmacy team members had completed training in line with the pharmacy quality scheme and topics included infection prevention and control and anti-microbial stewardship. The pharmacy had an OTC sales and self-care SOP which its team needed to follow. The MCA described the questions the team members needed to ask people when making OTC recommendations. And when they should refer requests to a pharmacist. They communicated with each other via WhatsApp and were comfortable about making suggestions on how to improve the pharmacy and its services. The trainee pharmacy technician had suggested a different way to label medicines administration record charts, and this had been implemented. The team knew who they should raise a concern with if they had one.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean, bright 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 had undergone a refit since the previous visit and were clean, bright and secure. Steps were taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a retail area, a counter, a spacious dispensary and storage. The pharmacy had a consultation room where people could have a private conversation with a team member. The dispensary had much more available workspace which improved workflow since the refit. So, there was room to store pharmacy stock, paperwork, equipment and prescriptions awaiting collection. And worksurfaces in the dispensary were generally clear. 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 offers a range of healthcare services and makes it easy for people with different needs to access them. Its working practices are safe and effective. The pharmacy obtains its medicines stock from reputable suppliers and stores it securely at the right temperature, so it is fit for purpose. Team members know what to do in response to alerts and product recalls and they keep records of any medicines or devices returned to the suppliers. They make sure people have the information they need to use their medicines safely.

Inspector's evidence

The pharmacy was on a rising site and there was a ramp and railings to make it easier for people to enter the building. People who found it difficult to climb stairs, such as someone who used a wheelchair, could enter through a door at the side of the pharmacy. This additional access point was useful when the pharmacy was running COVID-19 vaccination clinics and people could use one door for the clinic and the other to access regular services at the pharmacy. The pharmacy displayed its opening hours and health and services related information on a screen at the entrance. The pharmacy had seating for people to use if they wanted to wait. Members of the pharmacy team were helpful, and they could understand or speak other languages to advise and help people whose first language was not English. They signposted people to another provider if a service was not available at the pharmacy such as sexual health, the doctor’s surgery or the local hospital.

The pharmacy received referrals for the community pharmacist consultation service (CPCS) via PharmOutcomes. 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 used a disposable system for people who received their medicines in compliance aids. The pharmacy team checked whether a medicine was suitable to be re-packaged. If it was necessary to include a high-risk medicine in the compliance aid, the pharmacy generally dispensed and supplied one compliance aid at a time. It provided a brief description of each medicine contained within the compliance aids. The trainee pharmacy technician gave an assurance that patient information leaflets (PILs) were provided so people had the information they needed to make sure they took their medicines safely. The pharmacy supplied medicines with medicines administration record charts to a care home. The superintendent pharmacist (SI) visited the care home to monitor the service and provide training to their staff. The pharmacy had a business continuity plan for dealing with a systems failure and dispensing labels would be handwritten if necessary.

Members of the pharmacy team initialled the dispensing labels to identify which of them prepared a prescription. They 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. And they gave people alert cards with information about high-risk medicines such as lithium, steroids and methotrexate. The pharmacy team members explained counselling points to tell people who took warfarin and were aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed valproate needed to be counselled on its

contraindications. The pharmacy had the valproate educational materials it needed. Interventions were seen to be recorded on the PMR.

The pharmacy had provided a COVID-19 vaccination service for people over 16 years old between January and June 2022. It ran a daily clinic and up to 50 vaccinations were administered via PGD and recorded on PharmOutcomes. PGDs were signed and dated and there were SOPs for each stage of the patient journey and managing the vaccines. The vaccines were stored in a medical fridge which was monitored daily to ensure the minimum and maximum temperatures were in range two to eight Celsius. When people arrived using a different entrance to people who were visiting the pharmacy for 'business as usual' services, they were booked in. The pharmacist recorded consent and information specific to the vaccine on PharmOutcomes. The vaccine was prepared in the consultation room, administered and the person was counselled on possible aftereffects and given a PIL for their vaccine. The pharmacy team managed the queue and there was seating for people who were waiting. The pharmacy surfaces were cleaned after each person had left. The SI communicated with the team members via WhatsApp and followed up with documentation later. The team knew the location of the nearest defibrillator and the components of the anaphylaxis kit were all in date and included adrenaline ampoules.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices within their original manufacturer's packaging. And the dispensary was clean and tidy. The pharmacy team checked the expiry dates of medicines a few times a year and recorded when it had done a date-check. And it mostly stored its CDs, which were not exempt from safe custody requirements, securely. A methadone instalment was waiting to be labelled prior to collection. The pharmacy team contacted people to remind them if they had not collected their prescriptions. The pharmacy had procedures for handling the unwanted medicines people returned to it. And these 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 RP described the actions they took and demonstrated what records they kept on PharmSmart 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 to keep people's private information safe.

Inspector's evidence

The pharmacy team could restrict the number of people it allowed in the premises at a time if needed. The pharmacy had hand sanitisers for people to use and personal protective equipment for its team members. The pharmacy had glass measures to use with liquids and were marked if used only with certain liquids. The pharmacy team could access to up-to-date reference sources. The pharmacy had two refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of both refrigerators and recorded the information on Pharmsmart. The CD cabinets were fixed in line with requirements. The pharmacy collected confidential waste to be disposed of 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 used their own NHS smartcards. The pharmacy 'health and safety' folder contained any SOPs

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.