General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: F.T. Taylor (Watford) Ltd, 137 Courtlands Drive, WATFORD, Hertfordshire, WD24 5LL

Pharmacy reference: 1032409

Type of pharmacy: Community

Date of inspection: 29/01/2020

Pharmacy context

The pharmacy is located in a parade of businesses in a mainly residential area of Watford. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy supplies medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include: substance misuse, stop smoking, emergency hormonal contraception and seasonal flu vaccination.

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	3.1	Good practice	The pharmacy's premises present a professional image and are suitable for the provision of services.
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 generally safe and effective. The pharmacy team members record mistakes they make so they can learn from them and prevent the same sort of mistakes happening again. The pharmacy has written procedures which tell pharmacy team members how to complete tasks safely. It generally keeps its records up to date which show medicines are supplied safely and legally. The pharmacy team members keep people's private information safe and understand their role in protecting vulnerable people.

Inspector's evidence

Near misses were recorded and reviewed and the information was collated into a monthly and annual patient safety review (PSR). Action points to improve patient safety included double checking patient details against the bag label and prescription when handing out prescriptions. Learning points were discussed and shared at staff meetings to reduce mistakes in the dispensing process. Drug alerts and recalls were to be actioned immediately and staff were to take a mental break if working alone when dispensing.

To minimise picking errors, 'lookalike, soundalike' (LASA) medicines were separated on the dispensary shelves, ramipril capsules and tablets were separated, different strengths of the same medicine were highlighted to alert staff when picking medicines. Stock was arranged neatly and well-spaced on the dispensary shelves with gaps in between different medicines. Due to good available storage, overflow stock could be stored and used to refill gaps on the dispensary shelves more frequently avoiding 'overcrowding' of medicines.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. Two people were involved in the dispensing and checking process and there were separate dispensing and checking areas. The pharmacist performed the clinical and final check of prescriptions. The dispensing audit trail was completed by staff to identify who dispensed and checked the prescription. Interactions between medicines for the same patient were shown to the pharmacist. There was a procedure for dealing with outstanding medication. The original prescription was retained, but an owing slip was not always issued to the patient. The patient was informed about the outstanding medicines which were delivered to the patient upon receipt of the stock. 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.

Multi-compartment compliance aids were prepared by the trainee pharmacy technician or pre-registration pharmacist on a rolling basis according to a matrix. There was a separate preparation area. Most patients had a carer to assist with administration of medication. The pharmacy managed prescription re-ordering on behalf of patients. The pharmacy 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 of information relating to compliance aid patients. Each patient's information was retained in a polythene sleeve and included a neatly printed backing sheet. Backing sheets were re-printed following any changes in medication and the old backing sheet was retained. Prescriptions were clinically checked by the pharmacist and there was an audit trail of any checks made on the patient record of care. The pharmacy noted which patients were in hospital. A note was added to the patient

medication record (PMR)when the patient was reminded about a blood test to monitor a high-risk medicine such as lithium. Labelling included a description to identify individual medicines and patient information leaflets were supplied with each set of compliance aids.

High-risk medicines such as alendronate were generally supplied separately from the compliance aid. Controlled drugs (CDs) except for schedule 2 CDs were supplied in the compliance aids and the dates of CD prescriptions were managed to ensure supply within the 28-day validity of the prescription. Sodium valproate would not be supplied in compliance aids. If possible, levothyroxine was supplied in a separate compartment in the compliance aid and instructions to ensure it was taken before other medication and 30 minutes before food were highlighted on the backing sheet.

Standard operating procedures (SOPs) were currently under review and included responsible pharmacist, CD and complaints procedures and supply of high-risk medicines. Recent staff training records were available. The staff member at the medicines counter said she would not give out a prescription or sell a pharmacy only medicine if the pharmacist had left the pharmacy premises. She said she would not sell Solpadeine Max and Nurofen Plus to the same person because they both contain codeine. The annual community pharmacy patient questionnaires had been submitted and the practice leaflet was due to be re-printed.

To protect patients receiving services, there was professional indemnity insurance in place provided by the NPA expiring 31 March 2020. The responsible pharmacist notice was on display and the responsible pharmacist (RP) log was completed. Records for private prescriptions, emergency and 'specials' supplies were generally complete, but some prescriber details were missing. A small number of FP10PCD prescriptions required submission to the Prescription Pricing Division. In date patient group directions (PGDs) were seen for emergency hormonal contraception and chlamydia screening and treatment. A range of other PGDs were online and in date.

The CD and methadone registers were mostly complete. A small number of headers required completion in the CD registers. A random check of the actual stock of two strengths of modified release morphine tablets reconciled with the recorded balance in the CD registers. A random check of entries in the methadone register complied and the FP10MDA prescriptions were endorsed at the time of supply. Invoice number and name of the supplier but not the address was recorded for receipt of CDs. Footnotes correcting entries were not always signed and dated. Patient returned CDs were recorded in the destruction register for patient returned CDs.

Staff had signed a confidentiality procedure and the pharmacist had undertaken training regarding General Data Protection Regulation (GDPR). A privacy notice was displayed. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards. The pharmacy computer was password protected and backed up regularly. Staff explained that they would refer any safeguarding concerns to the pharmacist who had undertaken Centre for Pharmacy Postgraduate Education (CPPE) level 2 safeguarding. The pharmacist had a list of contacts to report safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members work well together to manage the workload. They are comfortable about providing feedback to the pharmacist to improve services.

Inspector's evidence

Staff comprised: one full-time pharmacist, one full-time pre-registration pharmacist (enrolled on National Pharmacy Association (NPA) training course), one full-time trainee pharmacy technician (Buttercups), two part-time medicines counter assistants (one trainee and one accredited) and one part-time delivery person.

The pharmacist was the pre-registration tutor. The pre-registration pharmacist attended regular NPA training days and training topics included the central nervous system, first aid and calculation. The pre-registration pharmacist maintained a book of learning points recorded as they occurred in the day to day running of the pharmacy. The pre-registration pharmacist said he studied at weekends and that there would be allocated study time prior to the pre-registration examination. There was an appraisal at 13 weekly intervals with the pharmacist to monitor progress in completing pre-registration training.

In line with the Pharmacy Quality Scheme (PQS) staff had undertaken training in safeguarding, sepsis, reducing LASA medicine errors and risk management in which staff knowledge of sepsis symptoms and referral to the doctor or A&E had been risk assessed. There were planned staff appraisals and weekly meetings to provide updates on pharmacy related matters such as the new exemption to prescription charges. The pharmacy team were able to provide feedback to improve services and had suggested maintaining an inventory of excess stock in cupboards which were high above the dispensary shelves and a communications book to record queries when the pharmacist was not in the pharmacy. There was a whistleblowing policy. The pharmacist said targets and incentives were not set in a way that affected patient safety and wellbeing.

Principle 3 - Premises ✔ Standards met

Summary findings

The design and layout of the pharmacy's premises are suitable for the nature of its activites. It provides a safe and suitable environment for people to receive healthcare. The consultation room is used regularly so people can speak to the pharmacy team members in private.

Inspector's evidence

The pharmacy has been re-fitted since the previous visit. It was light, bright and presented a professional image. The dispensary was on the same level behind the medicines counter. The dispensary benches were clean and generally clear. There were three seats for waiting patients. The consultation room was signposted and located to one side of the medicines counter. The consultation room was suitable for wheelchair users. The chaperone policy was displayed and patient privacy was protected. There were lockable cabinets to secure documents and equipment. Lavatory facilities were hygienic and handwashing equipment was provided. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are easy to access by people with a range of needs. The pharmacy's team members source, store and manage medicines safely and take the right action when medicines need to be returned to the suppliers. They are helpful and give advice to people about where they can get other support. And make sure people have all the information they need to use their medicines in the right way.

Inspector's evidence

There was wheelchair access to the pharmacy premises via the front door and into the consultation room to assist people with mobility issues. The table in the consultation room folded down if necessary. Large font labels could be printed to assist visually impaired people. Staff could converse in or understand Arabic, Hebrew, Polish and Eritrean to assist patients whose first language was not English. Pharmacy services were listed in the pharmacy window. Patients were signposted to other local services such as the podiatrist and to an ear-syringing service at the local opticians. The pharmacy was alerted to receipt of referrals through the NHS Community Pharmacist Consultation Service (CPCS) via email showing a referral on PharmOutcomes.

The pharmacist said there were no patients in the at-risk group currently but explained the procedure for supply of sodium valproate to people in the at-risk group. Information on the pregnancy prevention programme (PPP) would be explained. There was information which could be printed if necessary, to give to patients on PPP. The intervention was recorded on the PMR. The pharmacist was aware of the procedure for supply of isotretinoin to people in the at-risk group. The treatment had to be initiated by a consultant and the prescription was dispensed within seven days of issue following a negative pregnancy test result. Information on the PPP would be discussed with the patient and the intervention would be recorded on the PMR. Regarding prescriptions for more than 30 days’ supply of a CD as good practice, the prescriber would be contacted, and an intervention would be added to the PMR. CD prescriptions were highlighted to ensure supply within the 28-day validity period.

Prescriptions for high-risk medicines were highlighted by writing on the bag label that the prescription contained a fridge item, CD or other high-risk medicine to prompt counselling to people in an at-risk group. Sometimes counselling was information was given during a medicines use review. The pharmacist said when supplying warfarin, people were asked for their record of INR and if they attended for regular blood tests. The patient had to produce evidence of the INR to re-order their prescription. Advice was given about side effects of bruising and bleeding along with advice about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were reminded about the weekly dose, when to take folic acid and to attend for regular blood tests. People were advised to seek medical advice if they developed an unexplained fever. Interventions were seen to be recorded on the PMR.

Audits included an audit to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking non-steroidal anti-inflammatory drugs (NSAID). Current audits included monitoring dates of last foot checks and retinopathy screening for diabetic people, people in the at-risk group taking sodium valproate and lithium. Use of inhalers to treat asthma in adults and children had been monitored. The health promotion displays increased public awareness and included information

on dry January and alcohol consumption and previously Stoptober. The pharmacy offered a blood pressure (BP) monitoring service on behalf of Hertfordshire County Council to people who had not had a BP check in the previous year, who were not pregnant or on medication to treat blood pressure. People with elevated blood pressure readings were referred to their doctor. People accessing the stop smoking service were supplied nicotine replacement therapy or were referred to the doctor to be prescribed Champix.

Medicines and medical devices were delivered outside the pharmacy but the current procedure was under review to improve the audit trail. Patient signatures were obtained for CD deliveries. Medicines and medical devices were obtained from Alliance, AAH, Sigma, Colorama and Doncaster Floor areas were clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and recorded. Short-dated stock was marked with a black spot. No date-expired medicines were found in a random check. Liquid medicines were marked with the date of opening and medicines were stored in original manufacturer's packaging. Cold chain items were stored in the medical fridge. Uncollected prescriptions were cleared from retrieval every three months after contacting the patient and making a record on the PMR. CD prescriptions were highlighted. Waste medicines were stored separate from other stock. Falsified medicines directive (FMD) hardware and software was operational at the time of the visit. Drug alerts were received, printed, actioned and filed in a folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. These are used appropriately to protect people's private information.

Inspector's evidence

Reference sources included NPA, NICE online, BNF and Drug Tariff. The NICE website showed all possible diseases and illnesses associated with the symptoms when they were typed in to the search function which was helpful with the CPCS referrals. The dispensary sink was very clean and there were very clean stamped measures to measure liquid including a marked measure for methadone. The medical fridge was in good working order. Minimum and maximum temperatures were monitored daily by a digital recorder which sounded an alarm if out of range two to eight Celsius. The CD cabinets were fixed with bolts. The blood pressure and carbon monoxide monitors were supplied and maintained by Hertfordshire County Council for use in providing BP monitoring and stop smoking services. There were three closed sharps bins in the consultation room awaiting collection by the contractor. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. Staff used their own NHS cards. 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.