General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Abbey Pharmacy, 45 High Street, Abbotts Langley, WATFORD, Hertfordshire, WD5 0AA

Pharmacy reference: 1032420

Type of pharmacy: Community

Date of inspection: 11/03/2020

Pharmacy context

The pharmacy is located on the high street near a residential area of Abbots Langley. 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 collection and delivery.

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 generally safe and effective. The pharmacy team satisfactorily manages the risks associated with the provision of its services. The pharmacy has written procedures which tell staff how to complete tasks safely. It keeps the records it needs to show medicines are supplied safely and legally. The pharmacy team members make sure that people have the information they need so that they can use their medicines safely. They understand their role in protecting the welfare of vulnerable people and keeping people's information secure.

Inspector's evidence

There was a book to record near misses although the pharmacist generally worked alone so taking a mental break in the dispensing and checking procedures was discussed. Lookalike and soundalike (LASA) medicines had been separated to minimise picking errors. Different strengths of atenolol tablets were separated by amlodipine tablets. All the medicines used to treat diabetes were grouped together to reduce the possibility of picking errors.

Workflow: baskets were used to separate medicines and prescriptions during dispensing and checking processes. The pharmacist performed the final check prior to completing the dispensing audit trail on the dispensing labels to show who dispensed and checked the prescription. Interactions between medicines for the same patient were considered by the pharmacist as part of the clinical check. There was a procedure for dealing with outstanding medication. The original prescription was retained and an owing slip was issued to the patient. 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 for a number of patients at a separate dispensing area away from the main dispensary. The pharmacy managed prescription re-ordering on behalf of patients. New prescriptions were checked against the previous prescription, discharge summary or backing sheet for changes. Queries were clarified with the patient or their doctor. There was an audit trail of responses to queries including notes on the patient medication record (PMR) if needed. The backing sheet was reprinted when there were changes in medication. Each patient had their own labelled container which contained compliance aids, backing sheet and repeat prescription.

The pharmacy liaised with the doctor's surgery when new patients were identified who would manage administration of medicines better if supplied in a compliance aid. Backing sheets mostly included a description identifying individual medicines and patient information leaflets (PILs) were supplied with each set of compliance aids. High-risk medicines such as alendronate were generally not supplied in a compliance aid. Checking stability of sodium valproate prior to supply in a compliance aid was discussed. If controlled drugs (CDs) were supplied in the compliance aid the date on the prescription was managed to ensure supply within the 28-day validity period. Levothyroxine tablets were supplied in the compliance aid and special instructions highlighted to the patient to ensure being taken correctly.

There was a folder of standard operating procedures (SOPs) which included responsible pharmacist, CD and complaints procedures. The SOPs were due for update and review in April 2020. The pharmacy team member at the medicines counter said she would not give out a prescription or sell a pharmacy

only medicine if the pharmacist was not on the premises. Patients feedback was obtained through the annual community pharmacy patient questionnaire. The practice leaflet was displayed.

To protect patients receiving services, there was professional indemnity insurance in place provided by the National Pharmacy Association (NPA) expiring 31 Mar 2020. The responsible pharmacist notice was on display and the responsible pharmacist log was completed.

The CD registers were complete and the balance of CDs was audited weekly in line with the SOP. A random check of the actual stock of MST 10mg tablets reconciled with the recorded balance in the CD register. The supplier name, address and invoice number were recorded for receipt of CDs. Records for supply of medicines for private prescriptions were generally complete.

The pharmacist and staff were aware of General Data Protection Regulation (GDPR) procedures. Staff had signed confidentiality agreements and were using their own NHS cards. The data security and protection toolkit was due to be completed. Confidential waste paper was collected for shredding. The pharmacy computer was password protected and backed up regularly. There was a safeguarding procedure to protect vulnerable adults and children.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely and manage the workload. The pharmacy team members are comfortable about suggesting ways to improve the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time pharmacist, one part-time pharmacist, one full-time dispenser and medicines counter assistant (MCA) two part-time MCAs and one part-time delivery person. Following the visit, the pharmacist confirmed that arrangements had been made for staff to complete accredited training appropriate to their roles. The pharmacist said that staff were provided ongoing training to deal with patients, managing the queue and explaining supply problems. There were Counter Skills booklets to refer to for product knowledge. The pharmacist was on the premises most of the time to monitor staff performance. Staff felt able to provide feedback and had suggested how the prescription retrieval system would be organised so prescriptions which needed a fridge item to be added were located in one place and the fridge item would not be omitted. The pharmacist said targets and incentives were not set for staff in a way that affected patient safety and wellbeing.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally clean, secure and suitable for the services provided. The pharmacy prevents people accessing the premises when it is closed and keeps medicines and information safe.

Inspector's evidence

The pharmacy’s premises were generally clean. There were older fixtures and fittings. The dispensary was very small but organised to make best use of available space. The lavatory and handwashing facilities were upstairs in the staff area. There was no consultation room, but patients could have a quiet word with the pharmacist if necessary. There was sufficient ventilation and lighting.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy tries to make its services accessible to everyone. It gets its medicines from reputable suppliers and makes sure they are stored securely at the correct temperature. The pharmacy team members know what to do if any medicines need to be returned to the suppliers. They highlight prescriptions for high-risk medicines and provide people with the information they need to take their medicines safely. And they give advice to people about where they can get other support.

Inspector's evidence

There was not wheelchair access to the pharmacy premises but staff went to the door to assist people with mobility issues. Large font labels could be printed to assist visually impaired people. Patients were signposted to other local services such as the doctor's surgery, optician and other nearby pharmacies.

The pharmacist 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 to give to patients on PPP. The intervention was recorded on the PMR. The procedure for supplying isotretinoin following a negative pregnancy test result and within seven days of the date on the prescription was discussed. Information on the PPP would be explained. The treatment would be initiated by a consultant. The pharmacist said he would contact the prescriber and record the intervention regarding prescriptions for more than 30 days' supply of a CD. CD prescriptions were highlighted and dispensed when the patient came to the pharmacy to ensure supply within the 28-day validity period.

Prescriptions for CDs and fridge items were highlighted to prompt counselling to the patient. The pharmacist said when supplying warfarin, people were asked for their record of INR along with blood test dates. INR was not always recorded on the PMR. 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 asked if they had regular blood tests and reminded about the weekly dose and when to take folic acid. People were advised to seek medical advice if they developed an unexplained fever. There was an alert sticker on the shelf for methotrexate where it was located in the dispensary.

An audit had been conducted to identify people in the at-risk group taking sodium valproate and to explain the PPP. An audit had been completed to identify people for referral for prescription of a proton pump inhibitor for gastric protection while taking non-steroidal anti-inflammatory drugs (NSAID). Recent audits included monitoring people taking lithium to ensure they understood signs of toxicity and attended regular blood tests. Health promotions to increase public awareness included Stoptober, Dry January and stroke. The pharmacy displayed the 'What you can expect when visiting this pharmacy' poster and had just received NHS Coronavirus information and procedures to follow.

Medicines and medical devices were delivered outside the pharmacy. Reviewing the procedure to incorporate a more robust audit trail was discussed. Following the visit, the pharmacist confirmed that a duplicate delivery record book had been ordered to record all the delivery details. Medicines and medical devices were obtained from Alliance, AAH and Sigma. Floor areas were generally clear, and stock was neatly stored on the dispensary shelves. Stock was date-checked and recorded. Medicines

were generally stored in original manufacturer's packaging. Cold chain items were stored appropriately between two and eight Celsius. Uncollected prescriptions were cleared from retrieval within one month and the patient was contacted. Prescriptions containing CDs and fridge items were highlighted. Waste medicines were stored separate from other stock. Falsified medicines directive (FMD) hardware and software was installed but not activated at the time of the visit. Drug alerts were received via email and actioned. Improving the audit trail for actions taken in response to alerts and recalls was discussed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It uses these appropriately to keep people's private information safe.

Inspector's evidence

Current reference sources included BNF and Drug Tariff. There were clean stamped measures to measure liquid medicines. The dispensary sink was stained. Minimum and maximum fridge temperatures were monitored daily and found to be within range two to eight Celsius. Confidential waste paper was collected for shredding. 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.