General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Lex Pharmacy, 24 Little Oxhey Lane, WATFORD, Hertfordshire, WD19 6FR

**Pharmacy reference:** 1032431

**Type of pharmacy:** Community

**Date of inspection:** 09/07/2024

## Pharmacy context

The pharmacy is in a parade of businesses in a residential area of Watford 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, oral contraception, COVID-19 and seasonal flu vaccinations and Pharmacy First.

## 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. And these are due to be updated to help make sure the risks in providing services are managed. The pharmacy identifies prescriptions for high-risk medicines and controlled drugs. And this helps its team members supply these safely and make sure people use them properly. 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. The responsible pharmacist (RP) generally worked alone. But tried to separate the dispensing process stages, picking medicines, labelling, clinical and final checking and lastly bagging medicines. If possible, the RP took a mental break at different stages because mistakes were generally more obvious when returning after a break. The RP explained that medicines which were involved in incidents, or were similar in some way, for instance both strengths of amlodipine, were generally separated from each other in the dispensary to minimise picking errors. The pharmacy had a complaints procedure to report incidents to the superintendent pharmacist (SI).

The RP downloaded Electronic Prescription Service (EPS) prescriptions regularly throughout the day, generated dispensing labels and ordered medicines. If people presented a prescription at the medicines counter, the medicines counter assistant (MCA) completed a legal check of prescriptions to make sure the required fields were filled in. The RP used baskets to separate each person's medicines and to help prioritise the workload. And referred to prescriptions when labelling and picking medicines. The RP checked interactions between medicines prescribed for the same person. If necessary, she contacted the prescriber regarding queries on prescriptions. And retained the email as a record of the intervention in case it was queried at a later date.

When the medicines order was delivered the RP could dispense any outstanding medicines. Assembled prescriptions were not handed out until they were checked by the RP. The RP prepared and checked prescriptions so there was a single initial on the dispensing labels to create an audit trail. The RP highlighted prescriptions for delivery to people's homes and those which contained high-risk medicines. For instance, controlled drugs (CDs) prescriptions which were only valid for 28 days. And the RP supplied warning cards such as for warfarin or prednisolone to make sure people had all the information, they needed to use their medicines effectively. When either the RP or MCA handed out prescriptions, they confirmed the person's name and address on the address label on the prescription bag.

The pharmacy had standard operating procedures (SOPs) for the services it provided, and these were due to be updated. Archiving the SOPs no longer in use was discussed. The MCA described the sales protocol for recommending over-the-counter (OTC) medicines to people. And the MCA knew what she could and could not do, what she was responsible for and when she should refer to the pharmacist. She explained that she would not hand out prescriptions or sell medicines if a pharmacist was not present.

And she would refer repeated requests for the same or similar medicines, such as medicines liable to abuse to a pharmacist. Along with the complaint procedure, the pharmacy team invited feedback from people who used the pharmacy and its services. People could refer to the practice leaflet details about making complaints, comments and suggestions.

The pharmacy had risk-assessed the premises and how it would provide the COVID-19 and flu vaccination services. This included checking the suitability of the consultation room and vaccines storage, training, record keeping, hygiene control and dealing with clinical waste. But the risk assessments were not formalised. In preparation for commencing the NHS Pharmacy First service the RP had risk-assessed factors such as making sure locum pharmacists were trained to provide the service and that there was support from local doctors. The RP had monitored the length of time consultations were taking which was around 20 minutes and how this would affect other pharmacy services when the pharmacy received referrals. 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 most common condition the RP treated was sore throat.

The RP completed audits such as how many people visited the pharmacy, what advice was given and prescription figures. Another audit which was pre–Pharmacy First had targeted people who were treated for urinary tract or upper respiratory tract infections and the advice they were given. The RP had completed a Pharmacy Quality Scheme audit to monitor whether people finished courses of antibiotics. The pharmacy displayed posters with information on hypertension or elevated blood pressure promoting monitoring of hypertension via the blood pressure case-finding service. Team members invited people who did not believe they had higher blood pressure to participate in the service and have their blood pressure measured over 24 hours. The results were recorded on PharmOutcomes and people were signposted to their doctor. The pharmacy team had completed a clinical audit of people taking valproates and they were aware there were new rules for dispensing a valproate. And recently updated guidance for dispensing topiramate.

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 a controlled drug (CD) register and CDs were audited to check stock levels. But completing more frequent balance checks would mean mistakes in the CD register would be detected and investigated at an earlier stage. A random check of the actual stock of a CD matched the amount recorded in the register. Patient-returned CDs were recorded in separate register. The pharmacy kept records for the supplies it made of private prescriptions including veterinary prescriptions which were dispensed ‘under the cascade’. The RP described the records which were maintained for the supply of unlicensed medicines ('specials'). The pharmacy’s records for Pharmacy First service and people’s consent were seen on PharmOutcomes.

The pharmacy was registered with the Information Commissioners Office (ICO). The pharmacy team had completed GDPR training. They collected confidential wastepaper to be disposed of securely. Members of the team used their own NHS Smartcards. The pharmacy needed to reprint and display a privacy notice. The RP had recently met the deadline for completing the NHS Data Security and Protection toolkit. 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 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. They are suitably qualified and have the appropriate skills for their roles. The pharmacy team feel able to provide feedback to improve the pharmacy's services.

### Inspector's evidence

At the time of the visit, the pharmacy team comprised: the RP and one full-time medicines counter assistant. A regular pharmacist covered Saturdays. Two delivery persons were based at another branch and the RP was unsure of training they may have completed.
The RP was signposted to GPhC guidance or requirements for training support staff (Oct 2020).

The RP had certificates for completed training to deliver the Pharmacy First service. The MCA had completed accredited training which included dispensing assistant training. The RP relayed relevant information about services and the MCA read the pharmacy practice and industry publications. The RP described ongoing appraisals approximately every three months with the MCA. The team had regular meetings during which they could exchange feedback and ideas. They could discuss issues, near miss trends and provide suggestions to improve services. And the MCA had suggested rearranging stock on the pharmacy’s shelving, so it was more accessible or saleable.

Both 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. The pharmacy had an over-the-counter (OTC) sales and self-care SOP which described the questions the team member needed to ask people when making OTC recommendations. And when she knew when she 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. The consultation room is signposted and used regularly by people who want a private conversation with the pharmacist.

### Inspector's evidence

The registered pharmacy premises were clean, bright and secure. There were folding chairs available 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 with a medicines counter to one side of the pharmacy where people could buy medicines or other sundry items. The dispensary was at a slightly higher level behind the medicines counter, so the RP had a good view of the medicines counter and the rest of the pharmacy. The pharmacy's consultation room was signposted, and people could have a private conversation with a team member. It was tidy and clean. Health-related posters were displayed. Team members kept the dispensary worksurfaces clean and clear to help avoid them becoming cluttered when the pharmacy was busy. The pharmacy team cleaned the pharmacy's fixtures and fittings such as workbenches regularly. Although they did not keep records to show this.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy and its services are easily accessible to people with a variety of needs. And its working practices are generally safe and effective. The pharmacy obtains its medicines from reputable sources to help make sure they are fit for purpose and safe to use. The pharmacy team provides people with the information they need to help them use their medicines properly. The pharmacy team members carry out checks when they receive medicine alerts and recalls to help make sure people get medicines and medical devices that are safe to use.

### Inspector's evidence

The pharmacy entrance had a single, wide manually operated door and the pharmacy's opening hours were displayed. There was a slight step from the pavement into the pharmacy. The team tried to make sure people with different needs could access the pharmacy services. Services 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, such as a nearby larger branch of this pharmacy, if a service was not available at this pharmacy. The team signposted people to a local osteopath if appropriate.

The pharmacy's delivery persons delivered medicines to people who could not attend the pharmacy in person. They used a delivery App which maintained an audit trail to help show the medicines had been delivered to the correct person. The deliveries were trackable and if they 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 RP was seeing 'walk-in' people accessing the Pharmacy First Service. The pharmacy offered all areas of treatment. Records of the consultation were entered onto PharmOutcomes. The superintendent pharmacist and the RP had liaised with local surgeries to raise awareness about the service and potential benefits. The pharmacy had been providing the COVID-19 vaccination service to people who were over 75 years old or immunocompromised in line with the green book. The RP explained that it had finished recently but outlined how the service was delivered and the business continuity plan. The local pharmacists including surgery pharmacists were in a WhatsApp group. They could share information about shortages of medicines and in the event of any systems failure, they could alert other people and re-direct prescriptions and people. The pharmacy participated in a local county council scheme to supply contraception free-of-charge and the patient group directions were in date.

The pharmacy supplied medicines in multi-compartment compliance packs for people who had difficulty taking them on time. Some people lived in a care home. The RP prepared the packs following a colour-coded matrix to make sure they were ready to go out to people in a timely manner. The pharmacy team re-ordered prescriptions for most people and checked them for changes in medicines since the previous time. The care home staff checked what was re-ordered on their behalf by the pharmacy. The RP generally supplied high-risk medicines separately and not in the compliance pack. 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. Following a patient's hospital stay, the pharmacy sometimes received a discharge summary via PharmOutcomes showing changes in treatment.

The RP initialled dispensing labels to identify who prepared a prescription. And highlighted some prescriptions 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. For people taking warfarin, the RP checked the dates of blood tests and that the INR was monitored. The RP reminded them about foods and medicines which may affect their INR. The RP was successful at providing the new medicines service (NMS) and a follow up consultation to help people take new medicines effectively. The pharmacy was offering the blood pressure case-finding service at the time of the visit. The RP was aware of the new up-to-date guidance and rules for supplying valproate-containing medicines and recently updated guidance for topiramates.

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. Obsolete CDs required destruction. The pharmacy's waste medicines were kept separate from stock but did require uplifting. 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. 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 cabinet was fixed securely. Marking the blood pressure monitor with the date of when it 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. |