General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Prestwick, 315 Prestwick Road, South Oxhey, WATFORD, Hertfordshire, WD19 6UT

Pharmacy reference: 1032434

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, support with smoking cessation, seasonal flu vaccinations and Pharmacy First.

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 mostly safe and effective. It has suitable written instructions for members of the team to follow. And these are up to date to help make sure the risks in providing services are managed. The pharmacy identifies prescriptions for high-risk medicines and controlled drugs to help 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 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. Members of the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. They recorded them with the lessons they learnt from them to spot patterns or trends with the mistakes they made. The responsible pharmacist (RP) explained that medicines involved in incidents, or were similar in some way, such as some inhalers, were generally separated from each other in the dispensary. Fast moving medicines were stored separately from other medicines which also helped separate some medicines prone to picking errors so reducing the chance of the same mistake happening again. The pharmacy had a complaints procedure to report incidents to the superintendent pharmacist (SI).

The pharmacy team 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, a medicines counter assistant (MCA) completed a legal check of prescriptions to make sure the required fields were filled in. Team members used baskets to separate each person's medicines and to help prioritise the workload. And referred to prescriptions when labelling and picking medicines. The pharmacy team checked interactions between medicines prescribed for the same person and if necessary, contacted the prescriber regarding queries on prescriptions. And retained the email or noted the call as a record of the intervention in case it was queried at a later date.

When the medicines order was delivered team members could dispense any outstanding medicines. Assembled prescriptions were not handed out until they were checked by the RP. Team members who prepared and checked prescriptions initialled the dispensing labels to create an audit trail. They 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 pharmacy supplied warning cards for some medicines such as steroids to make sure people had all the information, they needed to use their medicines effectively. When the team members handed out prescriptions, they confirmed the person's name and address on the address label on the prescription bag and date of birth.

The pharmacy had standard operating procedures (SOPs) for the services it provided, and these were all recently reviewed and updated. Team members had trained in the SOPs. 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 certain 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. The practice leaflet was on display and people could refer to details about making complaints, comments and suggestions.

The pharmacy had risk-assessed the premises and how it would provide the flu vaccination service. 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 on how to use the otoscope. Records were kept on PharmOutcomes. The most common condition the RP treated was sore throat.

The RP had completed audits such as those required by the pharmacy quality scheme (PQS) to monitor anti-coagulant, asthma and antibiotic therapies administered to people. The pharmacy provided elevated blood pressure monitoring 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 initially prior to over a 24 hour period. The results were recorded on PharmOutcomes and people were signposted to their doctor if appropriate. 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. 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. 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 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 and manage the workload and deliver services safely. They are suitably qualified or training to have the appropriate skills for their roles. The pharmacy team is comfortable about providing feedback to improve the pharmacy's services.

Inspector's evidence

The pharmacy team consisted of a full-time pharmacist (the RP), a locum pharmacist and a part-time pharmacist who covered Saturdays. Supporting staff included a full-time registered pharmacy technician, a part-time dispensing assistant, a part-time trainee dispensing assistant, two part-time medicines counter assistants and a part-time delivery driver. The pharmacy relied upon its team to cover absences.

Members of the pharmacy team were qualified or enrolled on accredited training relevant to their roles. They could study during protected learning time. The pharmacy was updating stop smoking training as it ran a successful service supporting people to not smoke.

Team members 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 by the pharmacy team. The pharmacy had an OTC sales and self-care SOP which its team needed to follow. This described the questions the team member needed to ask people when making OTC recommendations. And they knew when to seek help and refer requests to a pharmacist. The pharmacy team members discussed pharmacy matters which were topical such as Pharmacy First service and how best to manage it. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one. There was a whistle-blowing policy.

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 by people who want a private conversation with the pharmacist.

Inspector's evidence

The registered pharmacy premises were clean, 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, a small dispensary and a storeroom. The pharmacy had a consulting room and the chaperone policy was displayed. People could have a private conversation with a team member. The dispensary workspace was clean and tidy. 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 and its services are easily accessible to people with a variety of needs. And its working practices are mostly 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 effectively. 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 had a wide, single, manual door. And its entrance was not level with the outside pavement. This made it harder for someone who used a wheelchair, to enter the building. But the pharmacy team went to the door to assist people to make sure they could use the pharmacy services. The pharmacy had a notice that told people when it was open. And there was information about services the pharmacy offered. The pharmacy had a seat for people to use if they wanted to wait. Members of the pharmacy team were helpful and they could speak Gujarati and Hindi to help people whose first language was not English. And they could print large font labels which were easier to read. And they signposted people to another provider if a service was not available at the pharmacy such as local GPs or NHS 111.

The pharmacy's delivery person delivered medicines to people who could not attend the pharmacy in person. And there was an audit trail to show the prescription was delivered to the correct person. The RP was mostly seeing people who were referred to the pharmacy to access the Pharmacy First Service. The pharmacy offered all areas of treatment. Records of the consultation were entered onto PharmOutcomes. The superintendent pharmacist had liaised with local surgeries to raise awareness about the service and potential benefits. The business continuity plan was laminated and displayed for staff to refer to. And people's nomination could be switched to a nearby pharmacy.

The pharmacy supplied medicines in multi-compartment compliance packs for people who had difficulty taking them on time. The RP prepared the packs following a 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 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. There was a laminated aide memoire displayed for counselling on isotretinoin. The RP provided 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. The pharmacy's waste medicines were kept separate from stock in 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 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.