General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Acorn Pharmacy, 256 High Street, BERKHAMSTED, Hertfordshire, HP4 1AQ

Pharmacy reference: 1074893

Type of pharmacy: Community

Date of inspection: 22/02/2024

Pharmacy context

The pharmacy is on the High Street in Berkhamsted, 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 managing their medicines. Its other services include delivery, blood pressure case-finding, seasonal flu and travel vaccination 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 generally safe and effective. It has suitable written instructions which members of the team follow to manage the risks associated with providing pharmacy services. Team members learn from their mistakes and take action to prevent the same thing happening again. 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. The responsible pharmacist (RP) favoured quick feedback and asked members of the pharmacy team to identify their own mistakes. Team members discussed mistakes to learn from them by taking action and reducing the chances of the same thing happening again. The RP explained that medicines involved in incidents, or were similar in some way, such as esomprazole and escitalopram were generally separated from each other in the dispensary. The RP had highlighted a trend in errors selecting ramipril tablets and capsules as the packs were so alike. The pharmacy's medicines stock was arranged so fast-moving or frequently dispensed medicines were separated from other medicines which were less frequently dispensed. And this helped separate medicines such as atenolol which were available in several strengths. The pharmacy had a complaints procedure, and the team could report incidents via the incident form which was submitted to the superintendent pharmacist (SI).

Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medicines and to help them prioritise their workload. They highlighted interactions between medicines prescribed for the same person to the pharmacist. And assembled prescriptions were not handed out until they were checked by the pharmacist. Team members who prepared and checked prescriptions initialled the dispensing labels to create an audit trail. They attached warning stickers to highlight prescriptions for high-risk medicines. For instance, controlled drugs (CDs) prescriptions which were only valid for 28 days. And they supplied warning cards such as for warfarin or prednisolone to make sure people had all the information they needed to use their medicines in the best way. Team members recorded interventions such as the outcomes for a new medicines service consultation on the patient medication record (PMR). Members of the team who handed out prescriptions confirmed the person's details on the address label on the prescription bag and checked the date of birth if needed.

The pharmacy had standard operating procedures (SOPs) for the services it provided. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. A member of the team described the sales protocol for recommending over-the-counter (OTC) medicines to people. The team members knew what they could and could not do, what they were responsible for and when they should 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. The pharmacy received feedback from people verbally, and via NHS Choices. The pharmacy asked people for their views and suggestions on how it could do things better.

The pharmacy team had completed a risk-assessment of the pharmacy and the consultation room to make sure it was ready to provide the seasonal flu vaccination service. And the team members had completed a pharmacy quality scheme (PQS) audit to identify people who required more information about how to use their asthma inhalers more effectively. The team completed an audit of people prescribed antibiotics to make sure they followed the dosage instructions and understood their side-effects. The pharmacy team had completed a clinical audit of people taking valproates and they were aware of the new rules when dispensing a valproate. Planning audits to monitor different parts of the Pharmacy First service was discussed such as diagnosis, compliance with the patient group direction (PGD) pathway and signposting.

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 RP also recorded the daily fridge temperatures on signing in as RP. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. It maintained a controlled drug (CD) register. CDs were audited weekly. A random check of the actual stock of a CD matched the amount showing in the register. The pharmacy kept records for the supplies of the unlicensed medicines it made and generally made emergency supplies via the community pharmacist consultation service (CPCS) and NHS 111. It recorded these supplies on PharmOutcomes. The private prescription records were generally complete. The RP provided travel vaccinations which were administered via PGDs recently been renewed. And records of each vaccine included the person's details, the vaccine details such as batch number and expiry date and when they were administered.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Its team tried to make sure people's personal information could not be seen by other people and was disposed of securely. A member of the team described how the pharmacy protected people's private information. And members of the team used their own NHS Smartcards. The pharmacy had a safeguarding procedure. The RP had completed level 3 safeguarding training. And the team had completed safeguarding training in line with the PQS requirements. 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. And the pharmacy team was signposted to the NHS safeguarding App.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are qualified or in training for the roles they have. Members of the team work well together to manage their workload. They can provide feedback and know how to raise concerns relating to the pharmacy's services.

Inspector's evidence

The pharmacy team consisted of the RP and two or three other regular locum pharmacists to cover Saturdays, one trainee pharmacist, two full-time and two part-time dispensing assistants, three full-time medicines counter assistants and a full-time delivery driver. The pharmacy mostly relied upon its team to cover absences. All the team members were either qualified or enrolled on accredited training courses.

The trainee pharmacist was enrolled on an external foundation training course and attended their monthly training days. The pharmacy allocated regular weekly study time to read and revise topics such as sections of the British National Formulary (BNF) and the RP was the trainee pharmacist's tutor. The trainee pharmacist was able to ask the RP for referrals to information sources appropriate to the role. The RP had provided feedback to the trainee pharmacist via the required appraisal and reviews. The trainee pharmacist was signposted to the GPhC knowledge hub.

The RP described training completed to deliver the Pharmacy First service such as using the equipment, reading through the SOPs, the patient group directions (PGDs) and the guidelines. The master authorisation sheet was signed and retained in a folder with other Pharmacy First documentation. Members of the team had protected learning time to undertake training which was sometimes via eLearning for healthcare (elfh). For instance, training required for the pharmacy quality scheme (PQS), such as protecting the welfare of vulnerable people. And they also read health-related product information provided by wholesalers.

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 by the pharmacy team. The pharmacy had an OTC sales and self-care SOP which described the questions the team member needed to ask people when making OTC recommendations. And when they should refer to the RP. The RP organised regular team meetings to plan the day's activities or tell the team about training they needed to complete. Members of the team were able to feedback how they could improve pharmacy services to the RP. And team members could raise concerns through the whistleblowing SOP.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are bright, clean and 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. People can have a private conversation with a team member in the consultation room.

Inspector's evidence

The registered pharmacy premises were clean, bright and secure. The pharmacy had been re-fitted since the previous visit. And action had been taken to make sure the pharmacy and its team did not get too hot. The pharmacy had a retail area and counters where people could buy medicines or cosmetic products. The dispensary was spacious and there was room for storage. The pharmacy had a consultation room which was signposted, clean and tidy and had handwashing facilities. So, people could have a private conversation with a team member. Team members constantly cleared worksurfaces to make sure the dispensary did not become cluttered when the pharmacy was busy. 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 it generally provides its services safely and effectively. The pharmacy obtains its medicines from reputable sources so that they are fit for purpose. It stores them securely at the right temperature to help make sure they are safe to use. People are provided with the information they need to use their medicines properly. The pharmacy team members respond to medicine alerts and recalls to ensure people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy's front entrance had double doors which opened automatically and a level entrance from the pavement. So someone who used a wheelchair could enter the building. The pharmacy also had a rear entrance with steps up from a municipal carpark. The team tried to make sure people with different needs could access the pharmacy services. The pharmacy displayed its opening hours and service information at the front entrance. There was seating available for people who were waiting. Members of the pharmacy team were helpful. They could speak or understand Gujarati, Hindi, Romanian, Persian and Swahili to assist people whose first language was not English. They could print large font labels, so they were easier to read. And they signposted people to another provider if a service was not available at the pharmacy. Such as the local general practitioner, NHS 111 or another pharmacy for rabies vaccinations which were in short supply. The pharmacy had a business continuity plan and bottles water and snacks to help manage services in the event of a systems failure or staff illness.

The pharmacy supplied medicines in disposable multi-compartment compliance packs for people who had difficulty taking them on time. The pharmacy team re-ordered prescriptions for these people and checked them for changes in medicines since the previous time. Members of the team made sure medicines were suitable to be re-packaged if necessary, provided a brief description of each medicine contained in the compliance packs, and always provided patient information leaflets (PILS). So people had the information they needed to make sure they took their medicines safely. High-risk medicines were generally supplied separately to the compliance pack. The pharmacy supplied medicines administration record charts to representatives of people who received compliance packs and provided counselling on medicines. The team prepared and delivered compliance packs for people in a care home. Its staff re-ordered their own prescriptions. The RP visited the care home to monitor the service and provide training for staff on medicines administration.

Members of the team initialled dispensing labels so they could identify who prepared a prescription. And they marked some prescriptions to highlight 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 and supplied warning cards for high-risk medicines such as steroids. For people taking warfarin, the RP checked the INR was monitored and recorded the value on the PMR. The RP reminded people about foods and medicines which may affect their INR.

The pharmacy delivery person delivered medicines for people who could not attend the pharmacy in person and maintained an audit trail to help show the medicines had been delivered to the correct

person. The pharmacy team members were aware of the new up-to-date guidance and rules for supplying valproate-containing medicines which must always be dispensed in the manufacturer's original full pack. And no-one under the age of 55 – both men and women - should be started on a valproate unless two specialists independently agree and document that there is no other safe and effective medication, or that there are compelling reasons why the reproductive risks linked to valproate, do not apply.

The RP had liaised with the local surgery ahead of commencing the Pharmacy First service. In preparation, the RP had completed training, risk-assessed the pharmacy's premises and consultation room. The pharmacy team had raised awareness of the service. The RP had prepared a Pharmacy First folder with information on conditions which could be treated, people who were suitable to treat and red flags for those who were not and should be referred elsewhere. The pharmacy had already treated some people through the new service. The pharmacy offered the blood pressure case-finding service. People who had accessed the new medicines service generally had follow up consultations by phone. The pharmacy offered a travel vaccination service via PGDs and records were maintained manually.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It 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 one of its pharmaceutical waste bags. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And the pharmacist 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 glass measures to measure liquid medicines. The pharmacy had fridges to store its pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures for each fridge. The CD cabinet was fixed securely. The pharmacy team disposed of confidential waste appropriately. It displayed a privacy notice and chaperone policy. 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.