General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Crown Pharmacy, 65 High Street, Redbourn, ST. ALBANS, Hertfordshire, AL3 7LW

Pharmacy reference: 1103267

Type of pharmacy: Community

Date of inspection: 18/06/2024

Pharmacy context

The pharmacy is on the high street in the heart of this Hertfordshire village. 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, COVID-19 and 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 which help them to manage the risks in providing its 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 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. When the responsible pharmacist (RP) identified near misses, members of the pharmacy team were encouraged to discuss and correct their mistakes. They recorded the near miss, identified the type of mistake they had made and they agreed actions they could take to reduce the chances of them happening again. The pharmacy team recorded near misses and the RP used the records to review patient safety regularly. The RP explained that medicines which were involved in incidents, or were similar in some way, for instance both strengths of methotrexate, were generally separated from each other in the dispensary to minimise picking errors. Team members had grouped some medicines stock together such as fast-moving lines which were dispensed more frequently. The RP could share information such as medicines with similar packaging via a team member's WhatsApp group. The pharmacy had a complaints procedure to report incidents to the superintendent pharmacist (SI). The pharmacy displayed a poster of actions to take if there had been a dispensing error.

The 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 member of the team completed a legal check of prescriptions to make sure the required fields were filled in. 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 referred to prescriptions when labelling and picking medicines. They checked interactions between medicines prescribed for the same person with the pharmacist. If necessary, they could contact the prescriber regarding queries on prescriptions. They retained the email as a record of the intervention in case the intervention was queried at a later date. When the medicines order was delivered the 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 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 effectively. Members of the team who handed out prescriptions confirmed the person's post code and other details on the address label on the prescription bag.

The pharmacy had standard operating procedures (SOPs) for the services it provided. The SOPs were endorsed with information about who prepared them and on what date. The pharmacy had training

records to show team members had trained in the SOPs relevant to their roles. A member of the team described the sales protocol for recommending over-the-counter (OTC) medicines to people. Team members knew what they could and could not do, what they were responsible for and when they should refer to the pharmacist. They 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. Along with the complaints procedure, the pharmacy team members invited feedback from people who used the pharmacy and its services. People could record their feedback on an iPad attached to a shelf unit in the retail area near the medicines counter.

The pharmacy had risk assessed the premises and how it would provide the COVID-19 vaccination service. This included vaccines storage, training, record keeping, hygiene control and dealing with clinical waste. 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 doctors locally. The RP had monitored the length of time consultations were taking which was around 20 minutes and how this would affect other pharmacy services. Team members had been trained to manage referrals received on PharmOutcomes. 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 RP completed clinical audits such as promoting monitoring of hypertension via the blood pressure case-finding service. The pharmacy displayed posters with information on hypertension or elevated blood pressure. 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.

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 an electronic controlled drug (CD) register and it was possible to identify which team member had accessed the register and amended the entries. CDs were audited regularly to check how much stock it had of each CD and if that was the amount recorded in the register. A random check of the actual stock of a CD matched the amount recorded in the register and the required fields of the record were completed. The pharmacy kept records for the supplies it made of private prescriptions and unlicensed medicines ('specials') and these were generally complete although sometimes prescriber details were not recorded. The pharmacy provided COVID-19 vaccinations which were administered via national protocol. And records for vaccinations included the person’s details, the vaccine details such as batch number and expiry date and when they were administered. The pharmacy team recorded the daily minimum and maximum fridge temperatures.

The pharmacy was registered with the Information Commissioners Office (ICO). The pharmacy team members had completed GDPR training. They collected confidential wastepaper to be disposed of securely. Members of the team used their own NHS Smartcards. The pharmacy displayed a privacy notice. The pharmacy team had all trained in the safeguarding procedure in line with the pharmacy quality scheme (PQS). The training module was completed through eLearning. The RP had completed level 3 safeguarding training. A member of the team described the protocol for ‘Safe space’ gaining the person’s consent and offering assistance. 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. Learning and development are supported and they are suitably qualified or in training 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, three full-time and one part-time dispensing assistants, three part-time medicines counter assistants and two part-time delivery persons. The pharmacy team members covered Saturdays. The delivery persons were Disclosure and Barring Service checked. Team members were enrolled on or had completed accredited training in line with their roles. The RP was signposted to GPhC guidance or requirements for training support staff (Oct 2020).

The RP had completed training to deliver the Pharmacy First service. Team members completed training via Virtual Outcomes which had appropriate training modules for all the team. Team members were allocated protected learning time when it was quiet in the pharmacy if needed to complete training. They had trained in topics such as skin conditions and hay fever. The RP tried to match topics to season as people were likely to want hay fever remedies in the spring or summer. The RP described ongoing appraisals with members of the team. The team had regular meetings, sometimes with the owners, during which they could exchange feedback. They could discuss issues, near miss trends and provide suggestions to improve services.

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 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. 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. There were chairs 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 behind the medicines counter. 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 dispensary worksurfaces clean and clear to help avoid them becoming cluttered when the pharmacy was busy. The pharmacy team cleaned the workbenches regularly.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy and its services are easily accessible to people with different needs. And its working practices are generally safe and effective. 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 help them use their medicines properly. The pharmacy team members know what to do when they receive medicine alerts and recalls and they help make sure people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy entrance had double wide doors and a ramp and steps from the pavement. The door could be operated manually and the team tried to make sure people with different needs could access the pharmacy services. Services information was displayed 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 some different languages to assist people whose first language was not English. And they signposted people to another provider if a service was not available at the pharmacy such as a nearby pharmacy. The team signposted people to a local urgent care service. Records were maintained.The pharmacy's delivery persons delivered medicines to 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. If the delivery 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 pharmacy provided the COVID-19 vaccination service to people over 75 years old and immunocompromised people in line with the green book. The vaccination was administered via the national protocol to people who had made an appointment or just walked into the pharmacy. The pharmacy stored the vaccines in a medical fridge which was monitored to make sure it was between two and eight Celsius. The pharmacist supervised the service and obtained consent, completed the clinical assessment and maintained records on PharmOutcomes. The documentation, such as SOPs, was retained in a folder. The pharmacy had adrenaline injector kits and clinical waste bins for safe disposal of sharps. Team members who provided the service had completed the required training. The RP explained that a risk assessment had been completed, the pharmacy insurers had been informed about the service and there was a business continuity plan to deal with untoward events so the pharmacy could make alternative arrangements regarding its services.

The pharmacy supplied medicines in disposable multi-compartment compliance packs for people who had difficulty taking them on time. The pharmacy allocated each person a folder to hold a template backing sheet and any information relating to that person and their compliance packs. The pharmacy team re-ordered prescriptions for some people and checked them for changes in medicines since the previous time. Members of the team said they would make sure medicines were suitable to be re-packaged if necessary. 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. High-risk medicines were generally supplied separately to the compliance pack. Following a patient's hospital stay, the pharmacy sometimes received a discharge summary via PharmOutcomes showing changes in treatment.

In the event of a systems failure people would be signposted to another nearby pharmacy and their nomination switched to that pharmacy. 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. 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 pharmacy provided the new medicines service (NMS) and after the initial consultations, people were followed up by phone. The pharmacy was offering the blood pressure case-finding service at the time of the visit. The RP and 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 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. The pharmacy checked through uncollected prescriptions and checked if people still required the medicines. If they did not need the medicines anymore they were returned to stock and the EPS prescriptions were returned to the NHS spine. Part-supplied medicines were claimed.

The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. A CD alert was highlighted with marker pen and displayed beside the pharmacy computer so team members could compare it easily with prescriptions. And the RP described the actions they took and explained what records they kept when the pharmacy received a concern about a product. They contacted people who had been supplied the medicine or device in the alert.

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 sinks. 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. There were bins for clinical waste disposal. Marking the blood pressure monitoring equipment 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.