General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Abbots Langley Pharmacy, 78 High Street, ABBOTS LANGLEY, Hertfordshire, WD5 0AW

Pharmacy reference: 1120385

Type of pharmacy: Community

Date of inspection: 26/07/2019

Pharmacy context

The pharmacy is located in a parade of businesses in a residential area and has healthy living status. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance packs for people who have difficulty managing their medicines. Services include prescription collection and delivery, substance misuse and seasonal flu vaccination.

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 safe and effective. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy manages risk and keeps people's information safe. The pharmacy has written procedures which tell staff how to complete tasks effectively. The pharmacy generally keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team members understand their role in protecting vulnerable people.

Inspector's evidence

Near misses were recorded, reviewed and actions taken to prevent a repeat near miss were completed for each incident. Monthly and annual patient safety reviews (PSR) were completed. Key learning points highlighted identification and pro-active separation of medicines with similar packaging and regular staff meetings to discuss factors contributing to improved patient safety. 'Look alike, sound alike' (LASA) medicines including quinine and quinine bisulphate had been separated on the dispensary shelves to reduce picking errors.

Workflow: baskets were in use to separate prescriptions and medicines during the dispensing process. Labels were generated and medicines were picked from reading the prescription. There were separate dispensing and checking areas. The pharmacist performed the clinical and final check of prescriptions prior to completing the dispensing audit trail to identify who dispensed and checked medicines. Bagged prescription items awaiting collection were re-checked prior to handing out to members of the public. Interactions were printed and shown to the pharmacist. 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 packs were prepared for a number of patients including two care homes. The pharmacy managed prescription re-ordering on behalf of patients. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance pack. If compliance packs were to be supplied following a Medicines Use Review (MUR), the risk assessment was discussed with the doctor.

Labelling included a description to identify individual medicines and the pharmacist gave an assurance that moving forward patient information leaflets (PILs) would be supplied with each set of compliance packs. High-risk medicines such as alendronate and schedule 2 controlled drugs (CDs) were supplied separately from the compliance pack. Schedule 3 and 4 CDs were included in the compliance pack. The dates of CD prescriptions were managed to ensure supply within 28 day validity of the prescription. The stability of sodium valproate supplied in a compliance pack would be checked with the manufacturer.

The practice leaflet and details of how to comment or complain were on display. The annual patient questionnaire had been conducted and results and feedback had not yet been received. There was a set of standard operating procedures (SOPs) last reviewed December 2017 which included CD and responsible pharmacist (RP) procedures. Training records were available.

The pharmacy recently introduced an online doctor service. Members of the public could complete a consultation with a doctor via a dedicated laptop in the consultation room. There was equipment available supplied by the online service including a thermometer and blood pressure monitor which the doctor could instruct the person to use as part of the consultation. If appropriate, a prescription was issued via email to the pharmacy and dispensed. The prescription was stored on the website and recorded on the private prescription register. Medicines which could be prescribed did not include CDs other than painkillers such as co-codamol. There was a PIN to verify the prescriber and a link to the General Medical Council to check registration status. The questionnaire completed by the patient had an option to inform the regular doctor's surgery about the consultation.

To protect patients receiving services, there was professional indemnity insurance in place provided by NPA expiring 20 October 2019. The responsible pharmacist (RP) notice was on display and the responsible pharmacist log was completed. Records for private prescriptions were electronic and printed out to be filed. The prescriber details were added manually after printing. Special supplies records were generally complete.

The CD registers were complete and the balance of CDs was audited regularly although not always monthly in line with the SOP. Some registers were generic and accounted for mixed brands which may make it difficult to investigate discrepancies. A random check of actual stock of two strengths of MST reconciled with the recorded balance in the CD registers. Footnotes correcting entries were signed but not always dated. Invoice details for receipt of CDs included invoice number, name and sometimes the address of the supplier. Patient returned CDs were recorded in the destruction register for patient returned CDs.

Staff had signed confidentiality agreements and were aware of procedures regarding the General Data Protection Regulation (GDPR). Confidential waste paper was collected for shredding and there was a cordless phone to enable a private conversation. Staff used their own NHS cards. The privacy notice was displayed. There was a safeguarding procedure in the SOP folder and the pharmacist and pre-registration pharmacist were accredited at level 2 in safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy and it works well together. The team members are supported in keeping their knowledge up to date. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: two regular full-time pharmacists, one full-time pre-registration pharmacist and one full-time dispenser who was on leave at the time of the visit. There was a staff vacancy at the time of the visit. There was a part-time delivery person who the pharmacist said had read the delivery SOP and signed a confidentiality agreement.

The dispenser had undertaken Buttercups NVQ2 training and was accredited as a medicines counter assistant. The RP was the pre-registration tutor and the pre-registration pharmacist said he was enrolled on the NPA training course. There were monthly training days and training topics included the antibiotics section of the BNF and calculations. The pre-registration pharmacist studied when it was quiet in the pharmacy and described to staff what he had learnt this week at staff meetings. Staff had completed children's oral health and risk management training.

There was a quarterly appraisal to monitor progress of pre-registration training. The pre-registration pharmacist said he felt able to provide feedback and had suggested re-arranging his work pattern to facilitate preparation for the forthcoming pre-registration examination. Targets and incentives were set but staff did not believe patient safety and wellbeing was adversely affected.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the provision of its services.

Inspector's evidence

The pharmacy was generally clean and tidy. The dispensary sink required treatment to remove some limescale. The staff lavatory facility required treatment to remove some staining, but handwashing equipment was provided.

The consultation room was located to the rear of the premises and was not locked. The pharmacist explained that the space was more usually used to prepare multi-compartment compliance packs for the care homes. There were some medicines and patient sensitive information in the consultation room. The laptop and equipment for the online doctor service was located on a table top in the consultation room. There was a discussion about ensuring there was no patient sensitive information visible and security of any medicines if a member of the public was accessing a service in the consultation room. The pharmacist said that no private information was on show when people were taken to the consultation room. Beyond the consultation room was a staff area. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective, and it gets its medicines from reputable sources. The pharmacy team takes the right action if any medicines or devices need to be returned to the suppliers. The pharmacy's team members are helpful and give advice to people about where they can get other support. They also make sure that people have all the information they need so that they can use their medicines safely. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe and effective.

Inspector's evidence

There was not wheelchair access due to steps at the entrance so staff went to the door to assist people with mobility aids or signposted them to another local pharmacy if appropriate. Large font labels could be printed to assist visually impaired patients. Staff could converse in Spanish, Cantonese, Mandarin and Hindi and Gujarati to assist patients whose first language was not English.

Patients were signposted to other local services including the optician, podiatrist services. The pharmacy had healthy living status and there were health campaigns to raise public awareness including Stoptober, Dry January and men's health. Audits were conducted including for referral for prescription of a proton pump inhibitor for gastric protection while taking a non-steroidal anti-inflammatory drug (NSAID) and both phases of the sodium valproate audit. Staff had completed children's oral health and risk management training. The pharmacist had audited the managed repeat prescription ordering service. The pharmacist visited the care homes every four to six months to audit medicines management.

The pharmacist was aware of the procedure for supply of sodium valproate to people in the at-risk group and information on the Pregnancy Prevention Programme (PPP) would be explained. The pharmacists explained the procedure for supply of isotretinoin to people in the at-risk group. The prescriber would be contacted regarding prescriptions for more than 30 days' supply of CD. Interventions were not always recorded on the patient medication record (PMR) of checks that medicines were safe for people to take and showing appropriate counselling was provided to protect patient safety.

Prescriptions were highlighted with a 'speak to pharmacist' sticker to indicate that the pharmacist would provide counselling on high risk medicines. The RP said he re-checked every prescription before it was handed out and was alerted to counselling needs. Ensuring the other regular pharmacist followed a similar procedure was discussed. When supplying warfarin people were asked about blood test dates and for their record of INR which was recorded on the PMR. The timing of dose of the warfarin was explained. Advice was given about side effects of bruising and bleeding. Advice was given about over-the-counter medicines such as miconazole oral gel and diet containing green vegetables which could affect INR. Patients taking methotrexate were reminded of the weekly dose and taking folic acid on a different day.

Medicines and medical devices were obtained from Alliance, AAH, Doncaster and Colorama. Floor areas were clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and

recorded. Stickers were attached to highlight short-dated stock. No date-expired medicines were found in a random check. Medicines were generally stored in original manufacturer's packaging. Cold chain items were stored in the medical fridge. Waste medicines were stored separately. Falsified Medicines Directive (FMD) hardware and software were operational at the time of the visit. Drug alerts were annotated and filed after checking stock for affected batches.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

Current reference sources included the BNF, Drug Tariff and the MEP online. There were British standard glass measures to measure liquids. The medical fridge was in good working order. Minimum and maximum fridge temperatures were monitored daily and found to be within 2 to 8 degrees Celsius.

The CD cabinet was fixed with bolts. There was an empty sharps bin on the table in the consultation room. Confidential waste paper was collected for shredding and there was a cordless phone to enable a private conversation. Staff used their own NHS cards.

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.