General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Watford Pharmacy, Bre Group, Bucknalls Bricket Wood, Block 15.3 Room 105 D, Watford, Hertfordshire, WD25 9NH

Pharmacy reference: 9011415

Type of pharmacy: Internet / distance selling

Date of inspection: 27/07/2022

Pharmacy context

The pharmacy is in a business park on the outskirts of Watford in Hertfordshire. It is not open for people to visit in person as it provides its services at a distance. The pharmacy assembles prescriptions and it dispenses medicines in multi-compartment compliance aids for other pharmacies within the same company.

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. The pharmacy has suitable written instructions which tell team members how to complete tasks and work safely. But not all member adequately undertand them. Pharmacy team members learn from the mistakes they make and this helps prevent similar mistakes happening again. The pharmacy keeps the records it needs to by law so it can show it is providing safe services. It has a procedure for protecting the welfare of vulnerable people. Members of the pharmacy team keep people's private information safe.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. It had a complaints procedure online. The pharmacist completed a patient safety review and members of the pharmacy team discussed the mistakes they made to learn and reduce the chances of them happening again. They maintained records of mistakes on paper or on the 'Pharmapod' computer system. A pharmacy team member explained that medicines involved in incidents, or were similar in some way, such as amitriptyline and amlodipine, were generally separated from each other in the dispensary. And medicines were well spaced on the dispensary shelves which helped to reduce mistakes when picking medicines.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided. Although a small number of the SOPs did not apply to current practice, these had been reviewed recently. 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. They knew what they could and couldn't do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. A team member explained that they wouldn't dispatch prescriptions to be delivered if a pharmacist wasn't present. The pharmacy had risk assessed the impact of COVID-19 upon its services and members of the pharmacy team. They were self-testing for COVID-19 regularly and there was personal protective equipment and hand sanitising gel available to help protect against infection.

The pharmacy operated as a 'hub and spoke' pharmacy. Prescriptions were transmitted to the pharmacy from its other branches and downloaded. The pharmacy team members processed the prescriptions according to a tracker to ensure the medicines were dispatched to the correct people via the right branch of the pharmacy. Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's medication. They referred to prescriptions when labelling and picking products. A pharmacist clinically and final checked prescriptions. And assembled prescriptions were not returned to the originating pharmacy until they were checked by a pharmacist.

The pharmacy kept a record to show which pharmacist was the responsible pharmacist (RP) and when. Some RPs did not always sign out at the end of the session. At the start of the visit, the RP notice was not displayed but the RP printed a notice to display so people knew who the RP was. The pharmacy had insurance arrangements in place, including professional indemnity, for the services it provided. A pharmacy team member explained that the pharmacy did not have a controlled drug (CD) register. It only supplied CDs which did not require records of supply and receipt to be maintained in a register. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. And when

one of these products was received, who it was supplied to and when. The pharmacy did not make emergency supplies of medicines or dispense private prescriptions, so no records were available.

The pharmacy was registered with the Information Commissioner's Office. It displayed a notice on the website 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 couldn't be seen by other people and was disposed of securely. All the pharmacy team members including delivery drivers had signed confidentiality agreements. The pharmacy had a safeguarding SOP but those staff questioned didn't appear to have a clear understanding of safeguarding. The manager was signposted to the NHS Safeguarding app as a useful resource for local contacts.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members work well together to manage the workload and to deliver its services safely. They are appropriately trained for the jobs they do and they can make suggestions to improve services.

Inspector's evidence

There were seven dispensing assistants (DAs) on duty at the time of the inspection. Four of them had completed GPhC accredited NVQ2 dispensing assistants training courses, and the other three were still working through them. One of the qualified DAs was also the pharmacy manager. He explained that three of the qualified DAs would shortly be starting NVQ3 training under a government apprenticeship scheme. There were certificates on display for two of the qualified DAs. Training records were available and those examined confirmed that the trainees had been registered on the necessary training courses. Those trainees confirmed that they were supported by their manager and by the pharmacist who usually worked at the pharmacy. Both delivery persons were trained in manual handling, general data protection regulation (GDPR) and the procedures for delivery to a person's home, a nursing or care home and a pharmacy.

The responsible pharmacist was a locum who hadn't worked at the pharmacy before. He explained that his brief was to focus on accuracy checking and that he had read the pharmacy's SOPs. One of the directors of the company owning the pharmacy was also present. There was a human resources folder containing the staff handbook, job description, terms and conditions of employment and details of policies such as safeguarding, chaperoning and whistleblowing. New employees were provided with an induction in their first three months. The manager described how all staff were expected to read these policies. But a signature sheet was not available to confirm this.

The manager used a workload planner to help him plan staffing levels. The plan was organised on a four-weekly cycle to match the demand for multi-compartment compliance aids. Annual leave was usually planned at least two weeks in advance. The manager would draw upon staff from one of their other pharmacies to help cover staff absence. If necessary, he would book an additional locum pharmacist.

Team members described how the manager held a briefing meeting every morning to discuss the previous days progress and the workplan for the day. He also held a more structured meeting every two weeks to discuss any near misses or errors, and to share any learnings. These meetings were not documented, but upon reflection he agreed that it would be a good idea to do so.

There was a large whiteboard listing the care homes whose compliance aids needed to be completed that week, together with the number of prescription items and the dispensing staff initials. Team members explained that this formed their only targets, and helped to manage the workload so that it was complete by the end of the week. They could discuss any problems within the team and could go to their manager if they needed help.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and suitable for the provision of healthcare services. It protects the privacy of people receiving its services and prevents unauthorised access to its premises when it is closed. So it keeps its stock and people's information safe.

Inspector's evidence

The registered pharmacy premises were bright and secure and in a large building. Steps were taken to make sure the pharmacy and its team didn't get too hot. The pharmacy had an entrance hall, a large, spacious dispensary and a staff area with its own sink and equipment for preparing hot drinks. This was clean and tidy. The dispensary sink was nearby. Just inside the entrance was a goods-in area where stock from their wholesalers was kept until it had been booked in. This was a despatch area where completed prescriptions were awaiting delivery to the company's other pharmacies for onward dispatch to their care homes. Entry could only be gained by ringing the bell and waiting for a member of staff to open the door. Inside the door was an electronic keypad with fingerprint identification. The owner explained that this was used to monitor who was in the building at all times in case of emergencies, and also as a means of clocking staff in and out. The pharmacy didn't have a consulting room. Members of the pharmacy team were responsible for keeping the pharmacy's premises clean and tidy.

The pharmacy did not sell medicines through its website. It displayed information about the pharmacy and contact details. But the pharmacy's owner details were not prominently displayed. Members of the pharmacy team were signposted to the GPhC guidance for registered pharmacies providing pharmacy services at a distance including on the internet (updated March 2022). The premises were clean and tidy and in a good state of repair. There were eight workstations including the area where the pharmacist completed the accuracy checks. Each workstation consisted of a large workbench with its own networked computer, large waste bin and equipment for assembling compliance packs. Stock was stored tidily on shelving around the perimeter walls of the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are mostly safe and effective. It displays information on its website so people with different needs can access the pharmacy's services. It obtains its medicines from reputable sources. And it stores and manages them so it can be sure they are fit for purpose and safe to supply. Members of the pharmacy team make sure people have all the information they need to use their medicines in the right way. And they know what to do if any medicines or devices need to be returned to the suppliers.

Inspector's evidence

Entry could only be gained to the pharmacy by ringing the bell and waiting for a member of staff to open the door. The pharmacy did not have an NHS contract at the time of the visit. It operated a 'hub and spoke' service where medicines were dispensed and labelled for people against prescriptions at this pharmacy (the hub). The pharmacy team assembled prescriptions for nursing and care homes on behalf of other pharmacies within the same company. The 'home' pharmacy team managed re-ordering of prescriptions and any discharge medicines information. Some medicines were supplied in their original manufacturer's packaging or re-packaged into multi-compartment compliance aids. A pharmacist clinically checked prescriptions and contacted the surgery by NHS email with any queries. Interventions were seen to be recorded on the patient medication record (PMR).

The pharmacy team checked whether a medicine was suitable to be re-packaged. When they were generating dispensing labels, an electronic medicines administration record sheet was created if required. The pharmacy provided a brief description of each medicine contained within the compliance packs. And it provided patient information leaflets. So, people had the information they needed to make sure they took their medicines safely. Members of the pharmacy team visited the care and nursing homes to audit and monitor the service. They provided training to staff at the homes in processes such as medicines administration.

Members of the pharmacy team knew which of them prepared a prescription. They marked some prescriptions to highlight when they contained a high-risk medicine or if other items such as CDs or fridge items needed to be added. There was a process for dealing with outstanding medicines which were owed on a prescription. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The pharmacy had the valproate educational materials it needed. The pharmacy provided a delivery service as people could not attend its premises in person. And it kept an audit trail for the deliveries it made to show that the right medicine was delivered to the right pharmacy to be supplied to their patients.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices within their original manufacturer's packaging. The dispensary was tidy. The pharmacy team checked the expiry dates of medicines on a monthly basis. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. The pharmacy had procedures for handling the unwanted medicines such as those people returned to it. And these medicines were kept separate from stock or were placed in one of its pharmaceutical waste bins. And were collected by the waste contractor twice a week. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. It was informed by email from one of the

'spoke' pharmacies of any alerts and recalls.

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 to store its medicines securely at the right temperature.

Inspector's evidence

The dispensary's workstations were equipped with a computer and the necessary equipment for staff to assemble compliance aids. The computers were supported by both the PMR supplier and by the company's inhouse IT manager. NHS Smartcards were not used, and the computers still had the suppliers default login details. Upon reflection the manager agreed that it would be more secure, and provide a better audit trail, if team members had their own login details. He did point out that they were planning to use a different system in the near future which would require individual login details. All of the computers had online access to reference sources. The team collected confidential waste for secure disposal.

There were two large medical fridges which appeared to be in good working order and were equipped with data loggers to monitor temperatures. The team used one fridge for stock and the other for dispensed items awaiting despatch. Both were tidy and free of frost. The manager explained that if anything went wrong with one of the fridges, they would simply replace it. One of the DAs explained that if anything broke, they reported it to the manager and it would be repaired as soon as possible. There were two crown stamped conical measures for measuring liquid medicines. Both CD cabinets were fixed in line with requirements.

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.