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: 12/03/2024

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

Follow this link to find out what the inspections possible outcomes mean

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 has suitable written instructions which identify risks and tell team members how to complete tasks safely. Pharmacy 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 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. The pharmacy team discussed their mistakes and agreed on actions to minimise the risk of them making the same mistakes again. They maintained records of mistakes on the pharmacy computer and reviewed the records to identify patterns in the types of mistakes. A member of the team described how they had changed their procedure to help them avoid mistakes in the quantity of tablets or capsules when dispensing a prescription. And medicines were well spaced on the dispensary shelves which helped to reduce mistakes when picking medicines.

The pharmacy received prescriptions electronically and members of the pharmacy team checked if there were any new messages or changes since the previous time of dispensing. They emailed any queries to care home staff or the prescriber which created an audit trail. And they emailed the prescriber to arrange an alternative to medicines which were unavailable. A manifest sheet was created. Members of the pharmacy team responsible for making up people’s prescriptions used baskets to separate each person’s medication and to help them prioritise their workload. Pharmacy team members prepared prescriptions according to a matrix and they could refer to the communications section on the computer screen. They made sure the computer picking list matched the prescription when labelling and picking products. They highlighted interactions between medicines prescribed for the same person and they kept a record of interventions. The pharmacist clinically checked prescriptions. And assembled prescriptions along with a copy of the manifest sheet were not dispatched for delivery until they were checked by the pharmacist or the accuracy checking technician (ACT). The pharmacy was a distance-selling pharmacy so people did not visit it in person to access services. The SI was aware of the new rules for dispensing valproate products as complete packs.

The pharmacy had standard operating procedures (SOPs) for the services it provided and these were endorsed with a review date. Members of the pharmacy team had protected learning time to read, understand and sign the SOPs relevant to their roles. They understood their roles and responsibilities and knew what they could and could not do, what they were responsible for and when they might seek help. A team member explained that they would not dispatch prescriptions for delivery if a pharmacist was not present. The pharmacy had a complaints procedure through which people could provide feedback. The pharmacy received feedback from the homes it served by email.

The pharmacy kept a record to show the time at which the pharmacist was the responsible pharmacist (RP) and it displayed a notice showing who was RP at the time. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The

pharmacy had an electronic controlled drug (CD) register. The pharmacy kept records for the supplies of the unlicensed medicines it made. And these generally were in order. The pharmacy did not make emergency supplies of medicines or dispense private prescriptions.

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. Pharmacy team members had signed confidentiality agreements and they disposed of confidential wastepaper appropriately. The pharmacy had a safeguarding SOP and the team members had completed safeguarding training to protect vulnerable people. The SI had undertaken level 3 safeguarding training. The SI 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 deliver its services and manage the workload. They are mostly enrolled on training or qualified for the jobs they do. The pharmacy supports its team with allocated time for them to complete training. The superintendent pharmacist organises regular meetings to update the team.

Inspector's evidence

The pharmacy team at the time of the visit consisted of the SI and the RP, one full-time ACT, five qualified dispensing assistants (three full-time and two part-time), three trainee full-time dispensing assistants (one of whom had yet to be registered on accredited training) and the operations manager. One of the dispensing assistants was enrolled on the NVQ3 technician training.

In addition to those present on the day of the inspection, the pharmacy also employed three full-time delivery drivers, and also engaged two locum pharmacy technicians. The drivers had not completed accredited training in line with GPhC requirements for the education and training of pharmacy support staff (October 2020). But they have been trained in the relevant SOPs including those for handling CDs. The SI agreed to enrol team members, who had not yet been enrolled, on the appropriate accredited training modules for their roles.

The pharmacy's team members were allocated protected learning time for training. They displayed their training certificates showing the accredited courses completed by the ACT and several of the dispensing assistants. A member of the team described completing recent safeguarding training plus training on their new pharmacy computer system. A dispensing assistant described attending a training meeting every week, including recent training on their new computer system. The SI had provided the team with updates which included training on current topics at the weekly meeting. He also had the GPhC standards for registered pharmacy professionals on display and described how he would run training on the standards one at a time. The SI had completed training on the Pharmacy First service such as the Centre for Pharmacy Postgraduate Education training video for otoscope.

The SI observed new team members for their first six months before conducting an appraisal, which was followed up again after 12 months. The SI organised meetings to update the team members and encouraged open discussions with them. The SI contacted team members at the other branches of the pharmacy via a WhatsApp group. The pharmacy team were signposted to the GPhC knowledge hub.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, bright 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. It displays information on its website about the pharmacy's services.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure. There were measures in place to help keep the pharmacy and its team at a comfortable temperature. And there was a portable air-conditioning unit which could be used in warmer weather. The pharmacy's entrance was wide and level with the outside approach to the building. The dispensary was spacious and well organised with several workstations. Each workstation consisted of a large workbench with its own networked computer and equipment for assembling compliance packs. Stock was stored tidily on shelving around the perimeter walls of the premises. The pharmacy had stockrooms at the back used for holding backup stock for the robot, and for the computer servers. The pharmacy team members were responsible for keeping the premises clean and tidy. They hoovered daily and the shelves were cleaned regularly. Building maintenance was undertaken by the freeholder. The pharmacy did not have a consultation room.

The pharmacy did not sell medicines through its website. It displayed information about the pharmacy and contact details. But the pharmacy's SI details were not displayed in line with the GPhC guidance for registered pharmacies providing pharmacy services at a distance including on the internet (updated March 2022). Following the visit, the website was updated showing the corrected information.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are safe and effective. It obtains its medicines from reputable sources. And it stores and manages them to help make sure they are fit for purpose and safe to use. 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 they receive a recall or alert and medicines or devices need to be returned to the suppliers.

Inspector's evidence

The entrance to the pharmacy was secured and people had to wait for a member of the team to open the door. The pharmacy operated a 'hub and spoke' service where medicines were dispensed and labelled for people against prescriptions at this pharmacy (the hub). The pharmacy team dispensed prescriptions for nursing and care homes for the other pharmacies in 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 packs.

The pharmacy dispensed prescriptions according to a matrix which showed when they were due. The pharmacist clinically checked prescriptions and contacted the surgery by NHS email with any queries. Interventions were recorded on the patient medication record (PMR). The pharmacy checked if medicines were suitable for re-packaging. They generated dispensing labels, along with electronic medicines administration record (MAR) charts if required.
The pharmacy had two different PMR systems, one it used for Bottisham Pharmacy's prescriptions and the other for Arches Pharmacee.

The system used for Bottisham Pharmacy was also linked to the automated dispensing robot used for preparing multi-compartment compliance packs. The prescription information was entered via the computer system. A dispenser explained how they had to de-blister the tablets and capsules and load them into cannisters before they could be loaded in the robot. The dispenser demonstrated how they loaded the first tray with the necessary tablets or capsules so that the robot would know which compartment or slot should be used for each one. The team could confirm they had selected the correct tablet or capsule by scanning the barcode on its original packaging so they knew the batch number, expiry date and manufacturer. Some medicines such as finasteride were not suitable to be loaded into a cannister. The empty multi-compartment pack was placed in position. The robot could sense when medicines had been placed in the wrong compartment. And for medicines which were added by hand the correct slot was illuminated in green and the incorrect slot was illuminated in red. There was also a machine for photographing an example of each tablet or capsule so the robot could apply the correct product description.

The pharmacy provided patient information leaflets. So, people had the information they needed to make sure they took their medicines safely. The pharmacist obtained medicines information from Northwick Park Hospital and emailed counselling information to the care homes. 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. The pharmacy had a business continuity plan and the SI described actions taken during a power cut to ensure the homes

were able to obtain their medicines.

The pharmacy team members knew which of them prepared a prescription. They highlighted prescriptions which contained a high-risk medicine or if other items such as fridge items needed to be added. The pharmacist contacted people's doctors to arrange an alternative to medicines which were unavailable. Members of the pharmacy team were aware of updated guidance and new rules for supplying valproates. 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 for supply to their patients. Bag labels included a QR code to be scanned at the destination home and both the driver and care home staff signed on completion of the delivery.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices in their original manufacturer's packaging and liquid medicines were marked with the date of opening. The pharmacy team checked the expiry dates of medicines on a regular basis. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. CDs were stored securely in line with safe custody requirements. The pharmacy had procedures for handling waste medicines. And these medicines were kept separate from stock in pharmaceutical waste bins. And were frequently collected by the waste contractor. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. The ACT described the actions taken for MHRA alerts which were received by email. They were downloaded, printed and annotated with the actions taken, when and who by. Records were maintained on the pharmacy computer system and reviewed annually.

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 pharmacy team had access to up-to-date online reference sources. The dispensary's workstations were equipped with a computer and the necessary equipment for the team to dispense compliance packs. The pharmacy's computers were supported by both the PMR supplier and by the company's inhouse IT manager. 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. And he explained that the pharmacy was planning to use a different system in the near future which would require individual login details. The team collected confidential waste for secure disposal. The CD cabinets were fixed in line with requirements.

The pharmacy had two large medical fridges, one used for 'goods in' which was stock ready for dispensing. The second was for 'goods out' or dispensed items either ready for delivery or awaiting a final accuracy check. They appeared to be well organised with clearly labelled baskets for the stock. The pharmacy had a maintenance contract in place so the team knew who to contact if there was a problem with either fridge. There were two stamped 100ml measures and one 500ml measure by the sink. They were clean but required treatment to remove some limescale. There was equipment for counting loose tablets and capsules, including one kept solely for use with methotrexate.

The pharmacy team cleaned the automated dispensing robot every day, and it was serviced by the manufacturer every three months. The pharmacy team knew how to contact the manufacturer if they had a problem and needed their assistance.

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.