General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Esom Pharmacy, Unit 5, Market Place, 34 Prestwick Road, South Oxhey, Watford, Hertfordshire, WD19 7EU

Pharmacy reference: 9011500

Type of pharmacy: Community

Date of inspection: 22/11/2021

Pharmacy context

The pharmacy has re-located to new premises due to re-development of the local area on the outskirts of Watford. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. Services include prescription delivery, COVID-19 vaccinations, seasonal flu and travel vaccinations, community pharmacist consultation service (CPCS), stop smoking and supervised consumption. The inspection took place during the COVID-19 pandemic. All aspects of the pharmacy were not inspected.

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 generally safe and effective. It has adequate written procedures which tell team members how to manage risks and work safely but some need reviewing to make sure they are up to date. The pharmacy enables people to give their views on how it can improve its services. The pharmacy's team members mostly keep satisfactory records they need to by law so they can show the pharmacy is providing safe services. They have introduced new ways of working to help protect people against COVID-19 infection. The pharmacy's team members understand their role in protecting vulnerable people. And they keep people's private information safe.

Inspector's evidence

The pharmacy had systems to review dispensing errors and near misses. Members of the pharmacy team discussed the mistakes they made to learn from them and reduce the chances of them happening again. But they didn't routinely record all of them or the lessons they learnt from them. So, they could be missing opportunities to spot patterns or trends with the mistakes they made. The responsible pharmacist (RP) explained that medicines involved in incidents, or were similar in some way, such as their names or packaging, were generally separated from each other in the dispensary. Members of the pharmacy team responsible for making up people's prescriptions used baskets to separate each person's prescription and medication and to help them prioritise their workload. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not handed out until they were checked by the responsible pharmacist (RP).

The pharmacy had standard operating procedures (SOPs) which included RP procedures and dealing with complaints. And these were due for review to update some information and reflect the move to the new premises. There were training records which showed members of the pharmacy team had read and understood the SOPs relevant to their roles. The pharmacy had assessed the impact of COVID-19 upon the pharmacy and the people who used its services. An occupational COVID-19 risk assessment for each team member was not seen. The RP knew that any work-related infections needed to be reported to the appropriate authority. Team members were self-testing for COVID-19 twice weekly. The pharmacy had fitted screens between the medicines counter and the ceiling and from side to side to help reduce the risks associated with the virus. And people used hand sanitising gel when they needed to.

The pharmacy displayed a notice that told people who the RP was. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. A team member explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products, such as medicines liable to abuse, misuse or overuse, to a pharmacist. This was in line with the procedure for selling medicines over the counter. The pharmacy had received positive feedback from people online. And it had a complaints procedure. The pharmacy had current insurance arrangements in place, including professional indemnity, for the services it provided.

The pharmacy kept a record to show which pharmacist was the RP and when. But sometimes the RP did not sign out at the end of the session. The pharmacy had controlled drug (CD) and methadone registers which were kept up to date and generally complete. And the stock levels recorded in the registers were checked regularly. So, the pharmacy team could spot mistakes quickly. A random check of the actual stock of two CDs matched the amount recorded in the CD register. The pharmacy kept records for the supplies of the unlicensed medicinal products it made. But it didn't always record the prescriber's details. The pharmacy recorded the emergency supplies it made and the private prescriptions it supplied electronically. And these generally were in order. But the name and address of the prescriber were sometimes incorrectly recorded. The RP recorded details of interventions on the patient medication record (PMR).

The pharmacy team members had undertaken general data protection regulation (GDPR) training. A notice telling people how their personal information was gathered, used and shared by the pharmacy was not seen. They tried to make sure people's personal information couldn't be seen by other people and was disposed of securely. The RP had completed level 2 safeguarding training. Members of the pharmacy team knew what to do and who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to deliver its services safely. They work well together to manage the workload. And keep their knowledge and skills up to date. Team members can make suggestions to improve services.

Inspector's evidence

The pharmacy team consisted of two full-time pharmacists, two full-time pharmacy technicians, a part-time medicines counter assistant (MCA) and one full-time and one part-time delivery driver. The RP and another full-time pharmacist worked alternate weeks at this branch and a second nearby branch of the pharmacy. On the day of the visit, another full-time pharmacist was providing the COVID-19 vaccination service. A pharmacy team member in the dispensary had completed pre-registration training but had not taken the final examination yet. A locum dispenser was covering a staff vacancy as the pharmacy was in the process of recruiting new team members. Following the visit, the pharmacy confirmed that a staff member had been recruited.

Members of the pharmacy team worked well together. So, people were served and their prescriptions were processed in a timely manner. The RP described training which had been undertaken in line with the pharmacy quality scheme (PQS) and it included risk assessment (infection prevention and control), inhaler technique, anti-microbial stewardship, health inequalities and weight management for adults. The pharmacists and a pharmacy technician had completed flu and COVID-19 vaccination programme training. The pharmacy team did not have allocated learning time and studied in their own time. The RP said there were regular pharmacy team meetings to discuss items including the day's work schedule. And she read COVID updates and the superintendent pharmacist provided COVID information. There was a whistleblowing policy. The inspector signposted the RP to the GPhC knowledge Hub. The pharmacy didn't set targets for its team.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's new premises are clean, secure and suitable for the provision of healthcare services. The pharmacy's team members have introduced new ways to help protect people from COVID-19 infection. The pharmacy prevents people accessing its premises when it is closed so that it keeps its medicines and people's information safe.

Inspector's evidence

The registered pharmacy premises were bright, clean and secure. The pharmacy had re-located to this new site from older premises nearby. Steps were taken to make sure the pharmacy and its team didn't get too hot. The pharmacy was well lit. There was a wide, automatic door at the entrance and chairs available just inside the entrance for people who were waiting. The medicines counter was at the back of the retail public area and was fitted with large screens to help protect people from infection. The dispensary was very spacious and on the same level beyond the medicines counter. The pharmacy had two consulting rooms which were signposted. So, people could have a private conversation with a team member. Both consulting rooms were spacious with hand washing facilities and were in use to administer COVID-19 vaccinations. The pharmacist described the cleaning routine during the vaccination service. Members of the pharmacy team were responsible for keeping the pharmacy's premises clean and tidy. So, floors were swept daily and the dispensary benches were wiped down regularly.

The pharmacy's website displayed details of its other local branches, opening times and information on services which were available. People could re-order their repeat prescriptions but could not purchase medicines through the website.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can easily access the pharmacy's services. The pharmacy's working practices are mostly safe and effective. It generally obtains, stores and supplies its stock appropriately. But it doesn't store patient returned medicines appropriately before disposal. The pharmacy team members know what to do if any medicines or devices need to be returned to the suppliers. And they make sure people have all the information they need to use their medicines safely.

Inspector's evidence

The pharmacy had an automated door. And its entrance was level with the outside pavement. So it was easier for people who had difficulty climbing stairs, or who used a wheelchair, to enter the pharmacy. The pharmacy team tried to make sure these people could use the pharmacy services. There was a hearing loop to assist people with impaired hearing and team members could speak or understand other languages such as Romanian and Gujarati to help people whose first language was not English. The pharmacy displayed information on a screen in the main retail area and in its window, which told people about some of the other services the pharmacy offered and promoted uptake of the COVID-19 vaccinations. The pharmacy had a seating area for people to use if they were waiting. And this area was set away from the counter to help people keep apart. Members of the pharmacy team were helpful and signposted people to another provider if a service wasn’t available at the pharmacy.

The pharmacy had been providing the COVID-19 vaccination service for around a month at the time of the visit. On the day of the visit, both consultation rooms were in use. There was sufficient seating for people waiting before their vaccine was administered along with people who would be observed for 15 minutes after being vaccinated. People arriving for a vaccination checked in at the medicines counter. A team member confirmed the details on the NHS booking system. The person was given a number which was called by the vaccinator when it was their turn. The person was asked to answer a series of questions which were part of the clinical assessment. The pharmacist checked the answers to assess if the person should have the vaccination. The pharmacist gained consent to vaccinate the person and to view their summary care record (SCR) if necessary. At the time of the visit, the pharmacist explained that most people were wanting the third booster dose of vaccination.

The pharmacy maintained a waiting list of people who could come for a vaccination at short notice if there were left over vaccine doses at the end of a session. The pharmacist recorded the batch number and expiry date of the vaccine and the date and time on which had been administered on the person’s clinical assessment form. Later, the information on the clinical assessment form was recorded on Outcomes4Health which linked through to the doctor’s surgery to inform the doctor. The pharmacist completed a vaccination record card and there were patient information leaflets (PILs) which were offered to people. After the vaccination, the person moved on to the seating area to be observed for 15 minutes in case they had an adverse reaction to the vaccine.

One of the pharmacists described receiving a delivery of vaccines and recording the temperature during transportation, the batch number and expiry date of the vaccines. The pharmacy stored the packs of vaccines in the medical fridge in the dispensary. The minimum and maximum fridge temperatures were monitored and recorded on the pharmacy computer system daily.

The pharmacist cleaned the preparation area in the consultation room before preparing the vaccine using aseptic technique. The pharmacist then drew up the vaccine into syringes and recorded the batch number and time of preparation to make sure the syringes would be used up within the six-hour window since dilution. Ensuring the vaccine was drawn up just before being injected was discussed. After administration of the vaccine, the syringes, vials and packaging were disposed of appropriately. The pharmacists on the vaccination team explained the cleaning routine for the consultation room, the seats in the waiting area and around the medicines counter.

The pharmacy had six staff members who were trained to vaccinate. They administered Pfizer vaccines via the NP. The vaccination team had received training in basic life support for adults and children. There were two pharmacists present each day and both were trained to vaccinate but one pharmacist managed the main pharmacy services, and the other pharmacist managed the vaccination service. They said a staff rota was not drawn up, but much the same people were there each day. In the event of staff absence, another trained vaccinator would be available. The pharmacist was signposted to the Knowledge Hub on the GPhC website where examples of notable practice were recorded.

The pharmacy provided the community pharmacist consultation service (CPCS) which connected people who had a minor illness or needed an urgent supply of a medicine with a community pharmacy. The pharmacy was notified of any referrals for CPCS via PharmOutcomes and any information regarding supply of any medicines was recorded on PharmOutcomes. It ran the seasonal walk-in flu vaccination service separately from the COVID-19 vaccination service for people over 18 years old. Flu vaccinations were administered via a NP. People aged 18 to 25 years could access emergency hormonal contraception (EHC) which was supplied via a patient group direction (PGD) on PharmOutcomes. The pharmacy could provide people trying to quit smoking with nicotine replacement therapy when they presented a code given to them by their doctor. It maintained records for these services and the medicines supplied following a consultation (usually with the pharmacist) on PharmOutcomes.

The pharmacy offered a repeat prescription collection service. And people could order their prescriptions through the pharmacy and its website. The pharmacy provided a delivery service to people who couldn't 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 person. The pharmacy supplied COVID-19 rapid lateral flow tests that people could use at home. This was to help find cases in people who didn't have symptoms but were still infectious. It signposted people to where they could obtain a 'collect code' which the pharmacy needed to record before supplying the lateral flow tests. The pharmacy also offered people the new medicines service (NMS) which helped people make the most out of newly prescribed medicines

Members of the pharmacy team knew which of them prepared a prescription. And they marked prescriptions to highlight when a pharmacist needed to speak to the person about their medication or having a flu vaccination. They were aware of the valproate pregnancy prevention programme. And they knew that girls or women in the at-risk group who were prescribed a valproate needed to be counselled and given information on taking valproates safely. The RP was aware of counselling needs and guidance given to people taking other high-risk medicines such as warfarin, methotrexate and mycophenolate. And the pharmacy had educational materials it needed to give to people.

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 generally tidy. The pharmacy team checked the expiry dates of medicines when they were putting away newly delivered stock and as part of the final check when dispensing a prescription. And it generally attached coloured stickers to highlight short-dated medicines. The pharmacy stored its cold chain stock between two and eight degrees Celsius. And it stored its CDs securely. The pharmacy

accepted unwanted medicines people returned to it. These medicines were kept separate from stock but were not placed into pharmaceutical waste bins prior to removal by a contractor. The pharmacy had a procedure for dealing with alerts and recalls received about medicines and medical devices. It checked stock, quarantined affected batches and signed and dated 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 to keep people's private information safe.

Inspector's evidence

The pharmacy team had access to up-to-date reference sources. The pharmacy had plastic screens at the medicines counter to help protect people against infection. It had hand sanitiser for people to use if they wanted to and personal protective equipment for its team members if needed. The pharmacy had glass measures for use with liquids, and some were used only with certain liquids. It had equipment for counting loose tablets and capsules. The pharmacy had fridges to store pharmaceutical stock requiring refrigeration. And its team regularly checked the maximum and minimum temperatures of the fridges. But it didn’t always record these. The pharmacy had a revolving shelf unit (Megamat RS 350) to maximise storage space in the dispensary. The pharmacy collected confidential wastepaper for shredding. The pharmacy restricted access to its computers and patient medication record 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.

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.