General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Vik's Pharmacy, Unit 4, Station Approach, South Oxhey, Watford, Hertfordshire, WD19 7DT

Pharmacy reference: 9011501

Type of pharmacy: Community

Date of inspection: 25/11/2021

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. The pharmacy supplies medicines in multi-compartment compliance packs to people who find it difficult to manage their medicines. Services include prescription delivery, discharge medicines service (DMS) and new medicines service (NMS). 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 satisfactory written procedures to help make sure the team works safely. But some need reviewing so they are all up to date. The pharmacy's team members generally keep the records they need to by law to show the pharmacy is providing safe services. The pharmacy's team members understand their role in safeguarding vulnerable people. And they know how to protect people's private information. The pharmacy has introduced new ways of working to help reduce the risk of COVID-19 infections.

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. They routinely recorded them on the pharmacy computer. So, they could spot patterns or trends with the mistakes they made. The responsible pharmacist (RP) explained that medicines involved in incidents or were similar (in name or packaging) were generally separated from each other in the dispensary drawers. The RP described how the pharmacy would deal with a dispensing incident following the pharmacy's complaints procedure. The incident was reported on the National Reporting and Learning System (NRLS). Members of the pharmacy team who made up people's prescriptions used baskets to separate each person's medication and to help manage the workload. They referred to prescriptions when picking and labelling products. The dispensed prescriptions were not handed out until they were checked by the RP.

The pharmacy had standard operating procedures (SOPs) for most of the services it provided including selling medicines over the counter, managing controlled drugs (CDs), community pharmacist consultation service (CPCS) and RP procedures. Some SOPs required a review to update certain information and reflect the change of pharmacy premises. Training records showed members of the pharmacy team had read and signed the SOPs relevant to their roles. They knew what they could do and when they should refer to the pharmacist. Their roles and responsibilities were described within the SOPs. People could give feedback via the pharmacy complaints procedure and leave a review online with suggestions on how the pharmacy could do things better.

The pharmacy had assessed the impact of COVID-19 upon its services and the people who used its services. The RP knew that any work-related infections needed to be reported to the appropriate authority. Pharmacy team members were self-testing for COVID-19 twice weekly. There was personal protective equipment (PPE) available such as fluid resistant face masks to help reduce the risks associated with COVID-19. And they washed their hands regularly and used hand sanitising gel when they needed to. There were screens around much of the medicines counter to help protect people against infection and a notice at the entrance reminded people to cover their faces when entering the pharmacy.

The pharmacy displayed a notice that told people who the RP was. The RP was working alone at the

time of the visit but a staff member came from the nearby branch of the pharmacy when needed. The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy kept a record which was mostly complete and showed which pharmacist was the RP and when. The pharmacy had a controlled drug (CD) register it kept up to date. And the stock levels recorded in the CD register were checked regularly. So, the pharmacy team could spot mistakes quickly. A random check of the actual stock of two CDs matched the recorded amount in the CD register. The pharmacy kept records for the supplies of medicines it made by emergency supply and against private prescriptions electronically. And these generally were in order. But the name and address of the prescriber were sometimes incorrectly recorded.

The RP had completed general data protection regulation (GDPR) training. A notice was not seen on display that told people how their personal information was gathered, used and shared by the pharmacy and its team. The pharmacy team tried to make sure people's personal information was not visible other people and was disposed of securely. The pharmacy computer could only be accessed by team members using a password. The RP had completed a level 2 safeguarding training course and knew what to do or who to 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 manage the workload and provide its services safely. They work well together 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 and a full-time pharmacy technician. Both pharmacists and the pharmacy technician divided their time between this pharmacy and the nearby branch of the pharmacy. The pharmacy shared the part-time delivery driver with other local branches of the pharmacy. The pharmacy relied upon its team to cover absences.

The RP described training which had been completed such as risk assessment, training for the flu and COVID-19 vaccination services and paediatric basic life support, first aid, infection prevention and control, anti-microbial stewardship, health inequalities and weight management for adults. The superintendent pharmacist (SI) provided COVID-19 updates for the team members to read. And when it was quiet, usually on a Saturday morning, the SI had a team meeting and discussed plans for the week ahead such as managing the new medicines service (NMS) or sourcing alternatives to items which were out of stock at the wholesalers. The pharmacists also shared a WhatsApp group to keep in touch at other times.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's new premises are suitable for the provision of healthcare services. The pharmacy's team members have taken steps to help protect people from COVID-19 infection. The pharmacy prevents people accessing its premises when it is closed to keep its medicines and people's information safe.

Inspector's evidence

The registered pharmacy's new premises were bright and secure. Members of the pharmacy team were responsible for keeping it all clean and tidy. And the temperature was controlled to make sure the pharmacy and its team didn’t get too warm. The pharmacy was well lit and there was plenty of natural light. The pharmacy had a retail area, a counter and a reasonably sized dispensary all on the same level. The pharmacy had a spacious consultation room where people could have a private conversation with the pharmacist. It was locked when not in use and entered via keypad access. The dispensary benches provided generous workspace. The pharmacy sink required treatment to remove some limescale.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy displays information about its services so people know what is available. And its working practices are mostly safe and effective. So it generally obtains, stores and supplies its stock satisfactorily. The pharmacy team members make sure people have all the information they need to use their medicines safely. But they could store patient returned medicines more tidily before disposal.

Inspector's evidence

The pharmacy didn't have automated doors but the entrance was level with the outside pavement. This made it easier for people with mobility issues to enter the building. The pharmacy team tried to ensure people could use the pharmacy services. Team members could speak or understand Romanian, Gujarati and Hindi to assist people whose first language was not English, and they could produce large print labels for people who were visually impaired.

The pharmacy displayed a notice reminding people to cover their faces when entering the pharmacy. And available services were listed in its window. The pharmacy had some seating for people to use if they wanted to wait. The RP signposted people to another provider such as the optician, dentist, local surgeries and the nearby branch of the pharmacy, if a service wasn't available at this pharmacy. The pharmacy provided the community pharmacist consultation service (CPCS) when people who had a minor illness or needed an urgent supply of medication had been referred to a community pharmacy usually by NHS 111 or their doctor.

The pharmacy offered a repeat prescription collection service. And people could order their prescriptions through the pharmacy. The pharmacy provided a delivery service to people's homes. 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 even if they didn't have symptoms but may still be infectious.

The pharmacy supplied medicines in multi-compartment compliance packs for people who found it difficult to manage their medicines. This service was mainly on behalf of the nearby branch of the pharmacy because it was quieter at this pharmacy. The pharmacy team members explained the process to patients of the other pharmacy and nomination of their electronic prescribing system (EPS) dispensing tokens was switched to this pharmacy. The pharmacy managed re-ordering of repeat prescriptions which were checked for changes. And depending on the needs of the person and the type of medication, it prepared the compliance aids on a weekly or four-weekly cycle. If the RP received a notification from hospital via the discharge medicines service (DMS), appropriate checks were made, implemented and recorded.

The pharmacy team checked if medicines such as valproates were suitable to be re-packaged. They made sure compliance aids containing CDs were supplied within the 28-day validity of the prescription. And they provided a description of each medicine contained within the compliance packs and patient information leaflets. So, people had the information they needed to take their medicines safely.

Members of the pharmacy team initialled the labels to show who had dispensed a prescription. And they marked some prescriptions to highlight when a pharmacist needed to speak to the person about

the medicines they were collecting such as warfarin or methotrexate or if items needed to be added. They were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed a valproate needed to be counselled on taking it safely. The pharmacy could supply emergency hormonal contraception (EHC) to people within the 18 to 25 year age group via a patient group direction (PGD) if it was appropriate. The PGD and the supply were recorded on PharmOutcomes.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept its medicines and medical devices in their original manufacturer's packaging and marked the date of opening on liquid medicines. The dispensary wasn't as tidy as it could have been. The pharmacy team checked the expiry dates of medicines and kept a record. The pharmacy stored its cold chain stock between two and eight degrees Celsius. The pharmacy's waste medicines including medicines people returned to it were kept separate from stock. But were not placed in one of its pharmaceutical waste bins and required removal by a contractor. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. The SI sent the alert and the pharmacy technician checked stock and annotated the alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. The pharmacy uses its equipment in a way that keeps people's private information safe.

Inspector's evidence

The pharmacy team had access to the BNF and referred to NICE guidance when required. The pharmacy had a plastic screen on its counter to help protect people from infection. The pharmacy had hand sanitisers for people to use if they wanted to. And it had PPE if needed. The pharmacy had glass measures for use with liquids, and some were used only with certain liquids. The pharmacy had a refrigerator to store pharmaceutical stock requiring refrigeration. And the RP demonstrated how she checked the maximum and minimum temperatures of the refrigerator. The pharmacy collected 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. The RP was using another team member's NHS smartcard but gave an assurance that she would only use her own card moving forward.

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.