General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Welch Pharmacy, 64 St Matthews Street, IPSWICH, Suffolk, IP1 3EP

Pharmacy reference: 1037180

Type of pharmacy: Community

Date of inspection: 15/11/2022

Pharmacy context

The pharmacy is located on a busy main road in a town centre in a largely residential area. It receives most of its prescriptions electronically. And it provides a range of services, including the New Medicine Service and flu vaccination service. It also offers the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to one person who lives in their own homes to help them manage their medicines.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It learns from mistakes that happen during the dispensing process to help make its services safer. And it protects people's personal information well. People can feedback any concerns about the pharmacy or its services. The pharmacy keeps its records up to date and these are largely accurate.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs), and reporting and reviewing of dispensing mistakes. And team members had signed to show that they had read, understood, and agreed to follow them. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The mistakes were discussed openly at the time they happened. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The pharmacist was not aware of any recent dispensing errors.

The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks. Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription.

Team members knew which tasks should not be undertaken if the pharmacist had not turned up in the morning. A notice was available to inform people that team members sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. Team members' roles and responsibilities were specified in the SOPs.

The pharmacy had current professional indemnity and public liability insurance. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Liquid overage was recorded in the registers. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly. The private prescription records were mostly completed correctly, but the prescriber details were not usually recorded. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. Team members said that they would ensure that the private prescription record and emergency supply record were completed correctly in future.

Confidential waste was taken to another pharmacy within the company to be shredded. Computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members

used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed and details about how people could complain were available in the pharmacy leaflet. The pharmacist said that there had not been any recent complaints.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And the pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The dispenser could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. Team members can raise any concerns or make suggestions and have regular meetings. And they can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist, one trained dispenser, one apprentice and one trainee medicines counter assistant (MCA) working in the pharmacy on the day of the inspection. Team members wore smart uniforms with name badges displaying their role. They communicated effectively during the inspection and they worked well together to ensure that tasks were prioritised, and the workload was well managed. The apprentice had been enrolled on an accredited course for her role and the trainee MCA had worked at the pharmacy for less than three months. The pharmacist said that the trainee MCA would be enrolled on an accredited course within the required timeframe.

The trainee MCA appeared confident when speaking with people. She said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. Or if someone asked to purchase more than one box of an over-the-counter medicine.

Team members were in the process of completing training modules for the Pharmacy Quality Scheme. The training matrix was displayed in the dispensary to show which modules had been completed. The pharmacy joined together with another pharmacy in the company to undertake weekly face-to-face training. The dispenser said that team members could access online training modules at work during quieter times. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. He felt able to take professional decisions. And he said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. He had recently completed online training about the flu vaccination service.

The pharmacist explained that he was in the process of carrying out the yearly performance reviews for team members. There were also ongoing informal performance reviews and the pharmacist said that he would address any issues with someone directly at the time it happened. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. And there were regular informal meetings to ensure that tasks were allocated to appropriately trained people. The dispenser explained that he had created the delivery log on the pharmacy's computer to keep track of deliveries. And this had helped team members manage the deliveries.

Targets were set for the New Medicine Service. The pharmacist said that he did not feel under pressure to achieve the targets and carried out the service for the benefit of the people taking the medicines. He mentioned that the pharmacy usually met its targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Air conditioning was available and the room temperature was suitable for storing medicines. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. The pharmacist could hear conversations at the counter and could intervene when needed.

There were a few seats in the shop area for people to use while they waited. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was accessible to wheelchair users and was accessible from the shop area and the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. And separate hand washing facilities were available.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. Overall, the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and largely stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. And there was step-free access to the pharmacy through a wide entrance. An alarm sounded when the door was opened which helped team members to know that there was someone in the shop area. Services and opening times were clearly advertised and a variety of health information leaflets was available.

Dispensed medicines were only handed out by either the pharmacist or dispenser. So that gave them the opportunity to speak with a person about their medicines. The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But he did not keep a record of blood test results. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. The pharmacy used a prescription retrieval system which was checked weekly. The dispenser explained that people were contacted if they had not collected their medicines after around three weeks. And items remaining uncollected after four weeks were returned to dispensing stock where possible and the prescriptions were returned to the NHS spine or to the prescriber. Any expired prescriptions were flagged on the pharmacy's computer and these were kept separated from those still waiting collection. The dispenser said CDs and fridge items were checked with people when handing them out. The dispenser said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant patient information leaflets and additional warning cards available. But it did not have spare warning stickers for use with split packs. The dispenser said that he would order these from the manufacturer.

Stock was stored in an organised manner in the dispensary. The dispenser said that a full expiry date check had been carried out a few months ago. The trainee MCA said that she had checked some recently and found some short-dated items. She had removed these from dispensing stock and stored them separately so that they could be used first if possible. Short-dated items were not highlighted and there were several medicines found with dispensing stock which were out of date. The pharmacist said that he would ensure that a more reliable system was used in future. Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for the multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. The

dispenser said that the pharmacy was contacted if people needed these medicines were needed when the packs were due. The pharmacy kept a record which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled but the backing sheets were not attached to the trays. This could increase the chance of them being misplaced. Patient information leaflets were not routinely supplied. This could make it harder for people to have up-to-date information about how to take their medicines safely. The packs were assembled and checked by the pharmacist.

CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and separated from stock. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible and these were recorded in a way so that another person's information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. Drug alerts and recalls were received from the NHS and the MHRA. The dispenser explained the action the pharmacy took in response to any alerts or recalls. These were kept on the pharmacy's email system but a record of the action taken was not kept, which could make it harder for the pharmacy to show what it had done in response. The dispenser said that he would do this in future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available and separate liquid measures were used to measure marked for certain medicines only. Triangle tablet counters were available and clean. And a separate counter was marked for cytotoxic use only to help avoid any cross-contamination.

There were up-to-date reference sources available in the pharmacy and online. The blood pressure monitor had been in use for around six months. The dispenser said that this would be replaced in line with the manufacturer’s recommendations. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.