General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Health Centre, 53 Leckie Road, WALSALL, West Midlands, WS2 8DA

Pharmacy reference: 1038506

Type of pharmacy: Community

Date of inspection: 30/07/2024

Pharmacy context

This is a traditional community pharmacy located next to a medical centre in a residential area, not far from Walsall town centre. People who use the pharmacy are from the local community and a home delivery service is available. The pharmacy primarily dispenses NHS prescriptions, and it provides some other NHS funded services. Some prescriptions are assembled at the company's central dispensing hub and delivered to the pharmacy for onward supply. The pharmacy team dispenses some medicines into multi-compartment compliance packs for people to help make sure they remember to take them.

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 generally manages the risks associated with its services to make sure people receive appropriate care. It is responsive to feedback and uses this to make improvements. The pharmacy has written procedures to make sure the pharmacy team work safely, but key members of the team have not read these in a timely manner which means they might not know what is expected of them. Pharmacy team members record their mistakes so that they can learn from them. And they generally make changes to stop the same sort of mistakes from happening again.

Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the operational activities of the pharmacy and the services provided. SOPs were available electronically on the pharmacy's intranet system. Team members had a personalised electronic learning (eLearning) library which could be accessed from the pharmacy computers or on their own devices, which allowed them to undertake training at home. SOPs that were relevant to the individuals job role were uploaded to the individual eLearning library. Each SOPs had a 'test your understanding' style quiz at the end so team members could demonstrate that they had understood the content. Online SOPs allowed the pharmacist manager and head office to track when training had been completed and address any outstanding training requirements. The pharmacist manager, who had been worked for the company for around five months, had not read all of the SOPs relevant to her job role. This meant that she might not always know the correct way of working or be able to assess whether the pharmacy was operating according to the SOPs. The area manager and pharmacist manager had agreed a date for which the training was required to have been completed by.

Near misses and dispensing incidents were recorded using an online system. Near misses were initially recorded on a paper log and then transferred on to the online system. The near miss was discussed with the dispenser at the time of the incident to see if there were any learning points and the dispenser involved recorded it on the near miss log themselves. The near miss report contained notes about each near miss to aid the review process. The pharmacist manager completed a monthly near miss review and shared the learning with pharmacy team members. But not all near misses were recorded on the electronic system which limited the information available to the superintendent's team.

Dispensing incidents were recorded using the online system and printed off and stored in an incident file, together with any associated paperwork or emails. An example of a dispensing error was discussed, and the steps taken to prevent a similar incident occurring. The error had been investigated by the pharmacist manager and a root cause analysis completed. The investigation had been submitted to the pharmacy superintendent's team, together with other documentation that they had requested, for example, a copy of the persons prescription. The pharmacy superintendent's team had made some additional suggestions. However, these had not been fully implemented and there was no evidence that the SOP has been read or re-read as recommended.

The pharmacist manager had joined the team after an extended period of the pharmacy operating with locum and relief pharmacists and having difficulty recruiting and retaining support staff. The team gave several examples of positive changes that had been made since she had started in her role and spoke

highly of the benefits of having a regular pharmacist manager. Some ‘quick win’ changes included the introduction of a cleaning schedule ensuring all areas of the pharmacy were cleaned regularly, reducing stock holding to create more shelf space, creating a system to organise and prioritise prescriptions to be dispensed, organising the multi-compartment compliance pack process, and providing direction to the team members so that they knew what the priorities for the day were. The team said that the feedback from people using the pharmacy was positive in response to these changes. People had mentioned differences such as reduced waiting times, prescriptions being ready when people came to collect them, and the pharmacy appearing brighter and cleaner.

The company used a hub and spoke model for dispensing repeat prescriptions. The team called the hub ‘Central Fulfilment’ (CF). All prescriptions were entered onto the patient medication record system at the pharmacy and as part of the process they were identified as being suitable to be sent for CF. The pharmacist completed an accuracy check and clinical check on the computer system before releasing the labelling information for CF. Dispensed medicines were then returned in barcoded bags to be reconciled with the prescription form and put into the pharmacy’s retrieval system. There was a contingency process for people that came to collect their prescription before it had been received from CF and for medicines out of stock at CF. The pharmacist manager audited a number of CF prescriptions per day for accuracy and recorded this on a log.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A member of the team answered hypothetical questions related to requests for over-the-counter high-risk medicines, such as co-codamol correctly.

People could give feedback to the pharmacy team verbally, in writing or by contacting the customer services department at head office. The pharmacy team tried to resolve issues that were within their control and would involve the area manager or pharmacy superintendent’s team if they could not reach a solution.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist (RP) notice was clearly displayed, and the RP log met requirements. Controlled drug (CD) registers were in order and a random balance check matched the balance recorded in the register. Patient returned CDs were recorded. Private prescription records were generally seen to comply with requirements with some minor technical errors that the pharmacist manager agreed to review.

Confidential waste was stored separately from general waste and destroyed securely offsite. The pharmacy team had their own NHS Smartcards and confirmed that passcodes were not shared. The pharmacist manager had completed level three training on safeguarding and the details of local safeguarding bodies were available. Members of the team completed annual training on safeguarding and data protection, and completion was monitored by head office.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload and the services that it provides. The team members plan absences in advance, so the pharmacy has enough cover to provide the services. They work well together, and they know who to speak to if they need to raise concerns or make suggestions.

Inspector's evidence

The pharmacy team comprised of the pharmacist manager (RP during the inspection), a trained dispensing assistant, two trainee dispensing assistants and a pharmacy student. A home delivery driver was available and shared with the other Well pharmacies in the area. One of the team members was leaving the company and a vacancy for a replacement had been advertised locally and on the Well website. Holidays were discussed with other team members to ensure no-one else had already booked the same week and requests approved by the pharmacist manager. There was a relief dispenser available in the area to provide cover.

Staff members had access to a range of different learning opportunities and could complete them at work, or at home. Due to workload pressures, training was done at home and there was no protected training time available during the working week. This was not convenient for some of the team members and meant that they had not completed all of the mandatory training modules that were required of them. All members of staff had to complete yearly mandatory e-learning based training on topics such as health and safety, safeguarding and information governance. This was audited by head office and the pharmacist manager was accountable for ensuring the training was up to date.

Team members appeared to work well together during the inspection and were observed helping each other and moving onto the medicines counter when people came into the pharmacy. Team members said that they could raise any concerns or suggestions with the pharmacist manager, the area manager or the superintendent’s office. There was a company whistleblowing policy, and the details were available on the intranet.

The pharmacist manager was observed making herself available throughout the inspection to discuss queries with people and giving advice. Some targets for professional services were set by head office. The pharmacist manager felt that most of the targets were realistic and achievable, and that her line manager would discuss the reasons if targets were not met.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy, and it provides a suitable environment for the delivery of healthcare services. It has a consultation room, so that people can speak to the pharmacy team in private when needed.

Inspector's evidence

The premises were smart in appearance and appeared to be well maintained. Any maintenance issues were reported to head office. The dispensary was an adequate size for the services provided and an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate areas of the worktops and there was ample space to store completed prescriptions.

There was a private soundproof consultation room which was used by the pharmacist during the inspection. The consultation room was professional in appearance. Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter. The dispensary was clean and tidy with no slip or trip hazards evident.

The temperature in the dispensary felt comfortable and lighting was adequate for the services provided. The pharmacy was cleaned by the staff. The sinks in the dispensary and staff areas had hot and cold running water, hand towels and hand soap were available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are accessible. It manages its services and supplies medicines safely. The pharmacy obtains its medicines from licensed suppliers, and stores them securely and at the correct temperature, so they are safe to use. People receive appropriate advice about their medicines when collecting their prescriptions.

Inspector's evidence

The pharmacy had step free access from the car park. A limited home delivery service was available and intended for patients who could not access the pharmacy. A range of health promotion leaflets were available, and pharmacy staff used local knowledge and the internet to support signposting. Pharmacy staff could speak to people in English, Urdu and Mirpuri. The pharmacy had several tools to ensure they remembered to complete various tasks. They had an online task tracker which was used by head office to send updates such as medicine recalls. Daily, weekly and monthly tasks list were printed and displayed, and the pharmacist manager wrote a 'to-do' list for the pharmacy team to follow on her day off.

Items were dispensed into baskets to ensure prescriptions were not mixed up together. Staff signed the dispensed and checked boxes on medicine labels, so there was a dispensing audit trail for prescriptions. Stickers and notes were attached to completed prescriptions to highlight people suitable for certain services or that needed fridge or CD items adding. The team had a clear understanding of the risks associated with the use of valproate containing medicines during pregnancy, and the need for additional counselling. They knew to supply valproate containing medicines in original containers. A prescription for sodium valproate had been dispensed, but not checked by the pharmacist and the dispensing labels had been placed on top of the printed valproate warning. The pharmacist manager agreed to remind the dispensers that the warnings should not be covered under any circumstances.

The pharmacy offered the NHS Pharmacy First service. The service was clearly advertised to people using the pharmacy. The team had undergone training and had read training materials. They had quick reference guides and the NHS PGDs (patient group directions) and supporting documentation were available for reference.

Medicines were supplied in multi-compartment compliance packs for some people. Prescriptions were ordered in advance to allow for any missing items to be queried with the surgery ahead of the intended date of supply. Each patient had a record sheet showing the dosage time and which external items they required. A sample of dispensed compliance packs were seen to have been labelled with descriptions of medication and an audit trail identifying who had been involved in the dispensing and checking process. Patient information leaflets (PILs) were included with each monthly supply. A 'Community Monitored Dosage System Suitability Assessment' was available on the intranet, but it was not used routinely as the team were unaware of it.

A prescription collection service was in operation. The type preferred by the pharmacy was the 'FRPS' service. This was the company name for the managed collection service as this gave the pharmacy enough time to send the prescriptions to CF for assembly. The dispensers had a list of all of the items

that the patient had ordered so they could chase any missing items. This meant the patient had everything they needed. Each patient had a FRPS sheet which contained their contact details, consent for the collection service, details of medication and dates of the next prescription. The team also recorded the date that the next prescription was due on the patient medication record so that they could respond to queries quickly.

A random sample of dispensary stock was checked, and all medicines were found to be in date. Date checking records were maintained and short dated medicines were clearly marked as a visual reminder. Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being stored in their original packaging. Split liquid medicines with limited stability were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in a designated area. Medicines were obtained from a range of licenced wholesalers. Drug recalls were received electronically and marked when they were actioned.

The CD cabinets were secure and a suitable size for the amount of stock held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridges were working within the required temperature range of 2°C and 8°Celsius.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF) and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough computer terminals for the workload currently undertaken. A range of clean, crown stamped measures and counting triangles were available. Equipment for clinical consultations had been suitably procured and was stored appropriately. Some of the equipment was single use, and ample consumables were available.

Computer screens were not visible to members of the public. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

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.