General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Wanstead Pharmacy, 75-77 High Street, Wanstead, LONDON, E11 2AE

Pharmacy reference: 1040130

Type of pharmacy: Community

Date of inspection: 05/10/2021

Pharmacy context

The pharmacy is co-located with a Post Office on a high street in a residential area. As well as dispensing NHS prescriptions the pharmacy supplies medicines in multi-compartment compliance packs to some people who need help managing their medicines. The inspection was undertaken during the Covid-19 pandemic. The pharmacy also provides a Covid vaccination service.

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. People who use the pharmacy can give feedback on its services. The pharmacy generally keeps the records it needs to by law so that medicines are supplied safely and legally. And the pharmacy team knows how to help protect the welfare of vulnerable people. Team members respond appropriately when mistakes happen during the dispensing process.

Inspector's evidence

Standard operating procedures (SOPs) were available and team members had read and signed SOPs which were relevant to their roles. Team roles were defined within the SOPs. The team had been routinely ensuring infection control measures were in place. Team members had been provided with personal protective equipment (PPE). The superintendent pharmacist (SI) who was also the responsible pharmacist (RP) explained that the necessary risk assessments to help manage Covid-19 had been completed and this included occupational ones for the staff. Information was displayed at the entrance asking people to wear a mask upon entering.

The pharmacy recorded dispensing mistakes which were identified before the medicine was handed out (near misses) and those where the medicine was handed to a person (dispensing errors). Near misses were said to be recorded as they occurred; however, the book could not be located during the inspection. Near misses were discussed at the weekly team meeting to encourage an open and honest working environment and share learning. As a result of past near misses medicines which sounded similar had been highlighted on the shelves with warning labels. Medicines with similar packaging were also stored in separate drawers. Dispensing errors were investigated and a record was made. A root-cause analysis was completed to identify how the error had occurred. Following a past error the RP tried to ensure that another team member double checked his work or if he had to self-check, he ensured to take a mental break between dispensing and checking. The pharmacy had also created an allocated checking bench to help distinguish between the different steps. The SI had identified that in most cases errors occurred due to an operator error which would then result in training needs to be identified.

A correct RP notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaint procedure. Prior to the pandemic the team had also carried out annual patient satisfaction surveys.

Records for private prescriptions, controlled drug (CD) registers and RP records were well maintained. CDs that people had returned were recorded in a register as they were received. A random check of a CD medicine quantity complied with the balance recorded in the register. Emergency supplies were not given routinely and there were no records. The pharmacy had not dispensed unlicensed medicines but the SI was able to describe the records that would be kept.

Assembled prescriptions were stored on the side of the medicines counter and people's private information was not visible to others using the pharmacy. An information governance policy was available. Relevant team members who accessed NHS systems had smartcards. The SI had access to

Summary Care Records (SCR) and consent to access these was gained verbally.

Pharmacists had completed level two safeguarding training and team members had also completed level one training. One of the pharmacists had completed the level 3 safeguarding course for the covid vaccination service. Contact details for safeguarding boards were available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to dispense and supply its medicines safely, and they work effectively together and are supportive of one another. Team members are given some ongoing training to keep their knowledge and skills up to date. Where relevant, the pharmacy generally enrols staff on a suitable accredited training course for their role. But it does not always do this in a timely manner.

Inspector's evidence

On the day of the inspection the pharmacy team comprised of the SI, a second pharmacist who was also the clinical lead for the Covid vaccination service and a trained medicines counter assistant (MCA). Another MCA who was due to work that day was attending a training programme. The SI explained that the team were short staffed and he was in the process of recruiting a trained dispenser. The team members were up to date with their dispensing. Most of medicines the pharmacy dispensed were supplied in compliance packs. Additional team members who were not working on the day of the inspection included part-time team members who helped with cleaning and a part-time dispenser who helped with the multi-compartment packs. The vaccination service had a separate team.

The MCA was observed to counsel people on the use of over-the-counter medicines and ask appropriate questions before recommending treatment. Expiry date checks were carried out on a regular basis by a team member who had worked at the pharmacy for 12 years but not completed any training. Following the inspection, the SI informed the inspector that date checking would be carried out by a pharmacy student.

The SI held regular reviews with team members which was also linked to pay. The SI also used this opportunity to discuss training needs. Team members were enrolled on training courses as needs were identified. The pharmacy team held weekly meetings as part of which team members were provided with training. Various companies also offered training which the SI enrolled team members on. Team members were also provided with training by the local emergency hormonal contraception and smoking cessation teams. There were no targets set for team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was clean and largely organised. Some shelves were untidy and the SI gave an assurance that this would be organised. There was ample workspace. Cleaning was carried out by team members. A clean sink was available for the preparation of medicines. Team members were observed to use face masks. Screens had also been fitted at the counter. Hand sanitiser was also available for team members to use. The pharmacy had a large clean consultation room which was easily accessible. The room allowed a conversation at a normal level of volume to take place inside and not be overheard. The door leading into the room had a large glass window from which people outside could see into the room. The SI gave an assurance that he would look into obtaining blinds or frosting for this.

The pharmacy was also a Covid vaccination site. People were directed to the right-hand side of the premises to access this service. There was a large room which was used for the preparation and administration of the vaccine. The room was clean. A post-observation area had been created with screens placed in between chairs to ensure social distancing could be maintained.

The room temperature was adequate for the provision of pharmacy services and the safe storage of medicines. Air conditioning was available to help regulate the temperature. The premises were secure from unauthorised access. The pharmacy was open for longer hours than the Post Office. Post Office staff did not have access to the dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy largely provides its services safely. It obtains its medicines from reputable sources and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

The pharmacy was easily accessible, it was co-located with a Post Office at street level and had double doors. Aisles were wide and allowed easy access to the pharmacy. Services were appropriately advertised to patients. Team members knew what services were available. A delivery service was offered to those people who were unable to access the pharmacy.

The majority of prescriptions were received electronically, these were clinically checked by the pharmacist, processed, and dispensed by the team. Dispensing was carried out in the evening when it was quieter. It was very rare that pharmacists self-checked. In the event that the SI had to self-check he would take a mental break in between each step. Medicines were removed from the bag and shown to people at the point of handout which enabled the team to carry out a third check. Dispensed and checked-by boxes were available on labels and these were routinely used. Baskets were used to separate prescriptions, preventing transfer of items between people.

Some people's medicines were supplied in multi-compartment compliance packs. The service was managed by the pharmacists. Prescriptions were clinically checked by one of the pharmacists when they were received. Changes were queried with the prescribers. Individual records were kept for each person. Mandatory warning labels were included however, product descriptions of the medicines inside the packs were not recorded. This could make it difficult for people to identify their medication. Patient information leaflets (PILs) were also not routinely supplied. The SI assured that future packs would include product descriptions and PILs would be supplied monthly.

The SI was aware of the change in guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme. Booklets and warning labels were available but the pharmacy supplied sodium valproate in original packs majority of the time. For medicines which required ongoing monitoring, the RP checked if people were having regular blood tests and counselled them on the use of their medicines. The pharmacy did not routinely dispense warfarin as a nearby pharmacy provided the anticoagulation clinic.

The SI was an independent prescriber. The pharmacy's indemnity insurance covered any prescribing activity. The SI said he prescribed very occasionally in emergency situations where people had run out of their medicines. This was mainly for salbutamol when the surgery was closed. The SI checked summary care records, made a note on the person's electronic record and a record of what was prescribed was also sent to the person's regular GP.

The pharmacy provided the Covid vaccination service. Team members had completed paediatric life support training. There was one chair in the waiting area and other people were asked to queue outside. The pharmacy had a gazebo available which would be used in the event of adverse weather

conditions. People were checked-in using an electronic tablet device. The pharmacy had a designated room which was used for vaccinations and the preparation area was also in this room. Vaccinations were provided by a nurse. One of the regular pharmacists was the clinical lead of the service. The observation area was situated outside the room. Screens were fitted in between chairs to ensure social distancing could be maintained. The pharmacy had noticed an increased number of fainting cases amongst the younger cohorts. The pharmacy provided a delivery service, the driver had been provided with PPE. Signatures were no longer obtained when medicines were delivered and this was to help infection control. In the event that someone was not available medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers. The SI reported that there had been stock shortages and it had been difficult to get hold of some items. As the pharmacy had accounts with various wholesalers, they were able to obtain stock. Fridge temperatures were monitored using a USB logger. Records seen showed that the temperature were within the required range for the storage of medicines. CDs were held securely.

No date-expired medicines were found on the shelves checked. Out-of-date and other waste medicines were kept separate from stock, stored securely and then collected by licensed waste collectors. Drug recalls were received via email from the MHRA, emails were retained once they were actioned.

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

The pharmacy had a calibrated glass measure, and tablet counting equipment. A replacement measure had been ordered for one which had broken. An electronic tablet counting machine was available, this was calibrated by the SI each morning. The cholesterol monitor was provided by Redbridge Council and they provided calibration fluid. Equipment was clean and ready for use. The pharmacy had two medical fridges of adequate size available. Up-to-date reference sources were available including access to the internet. The pharmacy’s computers were password protected and screens faced away from people using the pharmacy. A shredder was also available.

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.