

# Registered pharmacy inspection report

**Pharmacy Name:** Well, Primary Health Care Centre, Bradbury Road,  
Wharton, WINSFORD, Cheshire, CW7 3GY

**Pharmacy reference:** 1085467

**Type of pharmacy:** Community

**Date of inspection:** 10/10/2024

## Pharmacy context

This community pharmacy is located in a health centre in Winsford, Cheshire. Its main activity is dispensing NHS prescriptions, and the pharmacy also provides several other services and sells a range of over-the-counter medicines. It supplies some people with medicines in multi-compartment compliance packs to help them take their medicines correctly. Some NHS prescriptions supplied from the pharmacy are assembled at an off-site dispensing hub within the same company.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy identifies and manages the risks associated with its services to help provide them safely. It records and regularly reviews any mistakes that happen during the dispensing process. And it uses this information to decide what changes may be needed to help make its services safer and reduce any future risk. It protects people's personal information well. And people can provide feedback about the pharmacy. The pharmacy keeps its records up to date and accurate.

### Inspector's evidence

The pharmacy had a full set of electronic standard operating procedures (SOPs). The SOPs were reviewed and updated regularly by the superintendent pharmacist's (SI) team. Each member of the pharmacy team had an electronic training record showing that they had read and understood the SOPs. The training records were monitored by head office and any overdue training was chased up. The responsible pharmacist (RP) confirmed that all SOP training was up to date.

Dispensing mistakes which were identified before a medicine was supplied to people (near misses) were highlighted to the team member involved in the dispensing process were recorded on a log and an action plan was discussed to avoid the error from reoccurring. The near miss was also recorded on Datix, and a patient safety review was completed each month. As a result of past reviews team members were briefed on the different inhaler formulations and different types of insulins. Medicines that 'looked-alike' or 'sounded-alike' were separated and hazard stickers were attached to the shelves where some medicines were kept. Any instances where a dispensing mistake had happened, and the medicine had been supplied (dispensing errors) was investigated, the team was briefed, and a record was made. As a result of a past error, apixaban 2.5mg tablets and alfuzosin 2.5mg tablets had been separated on the shelves.

A correct Responsible Pharmacist (RP) notice was displayed. When questioned, 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. A complaints procedure was in place and team members tried to resolve complaints in the pharmacy where possible.

Private prescription, emergency supply, RP records, controlled drug (CD) registers and records of unlicensed medicines supplied were well maintained. Running balances for CDs were recorded and regularly checked against physical stock held in the pharmacy. A random balance was checked and found to be correct. CDs that people had returned to the pharmacy were recorded in a register and appropriately destroyed.

An information governance (IG) policy was in place and all staff received IG training once a year. Confidential waste was collected separately and disposed of in a dedicated bin for destruction by a specialist contractor. A safeguarding policy was in place and all team members had completed relevant training. The RP was aware of where the contact numbers required for raising safeguarding concerns could be found but would contact the SI in the first instance.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

There are enough team members to manage the pharmacy's workload effectively and they receive appropriate training to carry out their roles safely. Team members get regular feedback, and they are supported to keep their knowledge and skills up to date. Team members can provide feedback and concerns relating to the pharmacy's services.

### Inspector's evidence

The pharmacy team consisted of a regular pharmacist, who was also the pharmacy manager, a pharmacy technician, five dispensing assistants and two trainee dispensing assistants. Annual leave and absences were covered by members of the team. The pharmacy also had a team of delivery drivers to deliver medicines to people's homes. They were not assigned to a specific branch and supported multiple pharmacy branches within the same company. The team appeared to manage the workload effectively but the RP said there were times when it felt like there were not enough staff. The staffing levels were due to be reviewed. Two of the team members were also in the process of completing the training to become accuracy checkers. The RP had returned from long term leave but during their absence, the pharmacy did not have regular pharmacist cover and relied on different locum pharmacists. Regular and consistent pharmacist cover had only been arranged in the middle of August.

Members of the team were regularly provided with ongoing training. This was normally in the form of electronic training packages. The trainees felt well supported by colleagues. The pharmacy team asked questions when selling medicines to check they were suitable. A pharmacy assistant was aware of the medicines that were liable to misuse and confirmed they refused sales if they didn't feel it was appropriate.

The team leader held appraisals with team members on an annual basis. Team members were also provided with ongoing feedback. Team members felt able to raise concerns and feedback to the manager and area manager. Head office set targets for the services provided by the pharmacist, although there was some pressure to meet these the RP confirmed that they did not allow the targets to compromise their professional judgement.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises are clean, secure and provide a safe environment to deliver its services. People using the pharmacy can have a conversation with its team members in a private area.

### Inspector's evidence

The pharmacy was clean and tidy. The dispensary was generally large enough for workload undertaken and cleaning was done on a daily basis. Some work bench space was taken by a number of stacked baskets with dispensed prescriptions but there was sufficient clear space which helped to make sure prescriptions were assembled safely. A clean sink was available to prepare medicines that required mixing before being supplied to people. Lighting and the ambient temperature of the pharmacy were adequately controlled and maintained.

The premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for private conversations.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy offers a range of service which are accessible. It provides its services safely and manages them well. The pharmacy gets its medicines from licensed suppliers and 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

There was step-free access into the pharmacy from the car park and medical centre. Services and opening times were clearly advertised, and a variety of health information leaflets were available. A hearing loop was available. The team were aware of services that were offered locally and also used the internet to find out the details of local services so that they could signpost people who needed services that the pharmacy did not provide. In some cases, translation applications were used if someone did not speak English.

The RP felt that the NHS Pharmacy First service had the most impact on the local population as people did not have to wait for appointments with their doctor. The team contacted people when referrals were received on PharmaOutcomes. The RP had planned a meeting with the surgery to provide them with more information on the service and exclusion criteria.

There was an established workflow within the dispensary and prescriptions were dispensed by one of the dispensers and checked by the RP. 'Dispensed-by' and 'checked-by' boxes were routinely signed on dispensing labels, to create an audit trail showing who had carried out each of these tasks. Colour coded baskets were used to separate prescriptions, preventing the transfer of medicines between different people and to help manage the workload.

Team members were aware of the guidance when supplying sodium valproate and that the original pack could not be split and made sure warnings were not covered when attaching the dispensing label. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring and people were provided with additional counselling.

Some of NHS prescriptions were dispensed off-site at the company's hub pharmacy. The pharmacy team inputted the information from the prescription into the patient medication record (PMR) system and this was accuracy checked by the RP before being transmitting to the hub. The medicines were then dispensed at the hub in accordance with the transmitted information and returned to the pharmacy in sealed bags to be handed out to the patients. Prescriptions for fridge items, some CDs and split packs of medicines could not be sent to the hub. These prescriptions continued to be dispensed in the pharmacy. As part of a quality assurance check, one bag received from the hub was checked manually in store per day. If there were any errors, these were reported on Datix. The RP explained this was uncommon.

Some people's medicines were supplied in multi-compartment compliance packs. Record sheets were kept for all the people who received a pack, showing their current medication and dosage times. This information was checked against repeat prescriptions and any discrepancies would be checked with the surgery. Assembled packs were labelled with product descriptions and the mandatory warnings. There

was an audit trail to show who had prepared and checked the packs. Patient information leaflets were routinely handed out. Backing sheets were placed loosely in the packs so there was a risk that these could be lost. Team members provided an assurance that they would ensure these were securely affixed in the future. The pharmacy was supposed to be working a week ahead with the compliance packs but at the time of the inspection they were only two days ahead. Team members explained that people were not left without medication, but the team were working hard to keep up to date.

The pharmacy supplied medicines to some people who resided in assisted living accommodation. Prescriptions were ordered by the administration team at the accommodation. In the past there had been issues with missing items, but it transpired that the medicines had not been ordered with the respective GP practices. Medicines were supplied in original packs. The pharmacy delivered to the accommodation once a week and a representative would come in and collect any acute prescriptions that were received on days other than that of the scheduled delivery.

The COVID-19 and flu vaccination services were provided by two of the team members under the National Protocol. Both had completed face to face training before providing the service. The RP had completed inhouse training for the NHS Pharmacy First service. Signed PGDs were in place for the service.

An electronic system was used for managing deliveries. People receiving a delivery were sent a text message to inform them that the driver was due to deliver their medicines on the same day. In the event that someone was not home, medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and unlicensed specials were ordered from a specials manufacturer. Stock medicines were stored tidily, and expiry date checks were carried out on a three-month cycle. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of cold chain medicines. CDs were kept securely. Waste medicines were disposed of in dedicated bins that were collected periodically by a specialist waste contractor. Drug alerts and recalls were received electronically, and records were kept showing what action had been taken.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide its services. Equipment is kept clean and is ready to use.

### Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment was also available. Equipment was clean and ready for use. Three medical grade fridges were available. A blood pressure monitor, otoscope and ambulatory blood pressure monitor (ABPM) were available and used for some of the services provided. The ABPM was shared with another branch and people were signposted there when the monitor wasn't available. The head office team arranged for annual calibration tests. Up-to-date reference sources were available.

The pharmacy's computers were password protected and screens faced away from people using the pharmacy. A cordless telephone was also available to ensure conversations could not be overheard.

### 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.