General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Welch Stoke Park Pharmacy, 51 Stoke Park Drive, IPSWICH, Suffolk, IP2 9TH

Pharmacy reference: 1086916

Type of pharmacy: Community

Date of inspection: 04/07/2023

Pharmacy context

The pharmacy is next to a dental surgery on a small parade of shops in a largely residential area. It provides NHS dispensing services, the New Medicine Service, the flu vaccination service and blood pressure checks. It also provides medicines as part of the Community Pharmacist Consultation Service. And it provides substance misuse medications to a small number of people. The pharmacy receives most of its prescriptions electronically.

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. It records and regularly reviews any mistakes that happen during the dispensing process. It uses this information to help make its services safer. The pharmacy protects people's personal information. And team members understand their role in protecting vulnerable people. People can provide feedback about the pharmacy's services. The pharmacy keeps its records up to date and largely accurate.

Inspector's evidence

Team members had signed to show that they had read, understood, and agreed to follow the SOPs. 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 separately for each team member and these were reviewed regularly for any patterns. And the outcomes from the reviews were discussed openly during the regular team meetings. And learning points were also shared with other pharmacies in the group. Following a recent review of the near misses, different strengths of naproxen were now kept separated. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The pharmacist said that the superintendent (SI) pharmacist would be informed about any dispensing errors, where a dispensing mistake had reached a person. And he would fill out an incident report form and undertake a root cause analysis. The complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy leaflet. The pharmacist said that he would pass on any complaints to the pharmacy's superintendent pharmacist. There had not been any recent complaints received.

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

Team members' roles and responsibilities were specified in the SOPs. The trainee dispenser said that the pharmacy would remain closed until the pharmacist had turned up. Team members knew that they should not sell pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Any liquid overage was recorded in the register. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were largely completed correctly, but the prescriber's details were not usually recorded or the date the prescription was written. 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. The pharmacist said that he would ensure that the private prescription records and emergency supply records were completed correctly in future.

Confidential waste was shredded or taken to the pharmacy's head office for appropriate disposal. People using the pharmacy could not see information on the computer screens and the computers were password protected. and the Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. He said that other team members had completed some safeguarding training provided by the pharmacy. The team 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. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough 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. The team discusses adverse incidents and uses these to learn and improve. And it has regular meetings and can raise any concerns to do with the pharmacy. Team members can take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one regular locum pharmacist, one trainee dispenser and one trainee medicines counter assistant (MCA) working during the inspection. The trainee MCA had been enrolled on a course and the trainee dispenser had worked at the pharmacy for around one month. The pharmacist said that the pharmacy had been experiencing staffing issues recently and one team member had been on planned leave. But, despite this, the pharmacy was relatively up to date with its dispensing.

The trainee MCA appeared confident when speaking with people. She asked people relevant questions to establish whether an over-the-counter medicine was suitable for a person. She was aware of the restrictions on sales of pseudoephedrine-containing products. And she was aware which medicines could be abused or may require additional care. She referred any queries to the pharmacist during the inspection.

The pharmacist was aware of the continuing professional development requirement for professional revalidation. He said that he had recently completed some online training about the flu vaccination service. The pharmacist said that the SI provided team members with ongoing training. He said that they could complete this during the day during quieter times. And team members kept their training certificates at the pharmacy. The trainee MCA said that she completed most of her training at home but could ask for help with this during the day if needed. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training. And he felt able to make professional decisions.

The pharmacist said that there were regular staff meetings to discuss any ongoing issues, near misses and dispensing errors. And he could contact the SI if there were any issues that arose during the day. Team members had yearly performance reviews carried out by the SI. And they felt that they could provide feedback to the pharmacist or SI. Targets were not set for team members.

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 and this presented a professional image. Pharmacy-only medicines were kept behind the counter. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There was seating available in the shop area for people to use. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. The consultation room was to the rear of the dispensary up a couple of steps. It was suitably equipped and well-screened, but the room was not accessible to wheelchair users. The pharmacist said that he would signpost people to another local pharmacy or their GP if they needed a service which required access to a consultation room. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

Toilet facilities were clean and there were separate hand washing facilities available. Some in use pharmaceutical waste bins were stored in the toilet area. This made it harder for the pharmacy to show that these medicines were being kept securely. The pharmacist said that he would ensure that medicines were not kept in the toilet area in future.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and largely stores them properly. It responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services.

Inspector's evidence

Services and opening times were clearly advertised and a variety of health information leaflets was available. There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed.

The pharmacist said that he highlighted prescriptions for higher-risk medicines, so there was the opportunity to speak with these people when they collected their medicines. He said that he would check with a person's GP if he had any concerns about their blood test results. Some bags containing Schedule 3 and 4 CDs were highlighted with the date the medicines were not to be handed out after. But the bags were not always highlighted. The pharmacist said that he would remind team members to do this for all CDs. Team members said that they checked CDs and fridge items with people when handing them out. The pharmacist 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 (PPP). The pharmacist said that people would be signposted to their GP if they needed to be on a PPP and were not on one. The pharmacy ensured that people were provided with the relevant information.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The pharmacist explained the action the pharmacy took in response to any alerts or recalls received. But a record of any action taken was not always kept, which could make it harder for the pharmacy to show what it had done in response. The pharmacist said that he would keep a record of these in future. 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 segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months was marked. And medicines were kept in their original packaging. The pharmacist said that fridge temperatures were checked daily, and records indicated that the temperatures were consistently within the recommended range. The pharmacy had two fridges; a larger medical fridge used for stock. And a smaller fridge which was used for a shorter time for medicines awaiting collection. The minimum and current temperatures for both fridges were seen to be within range on the say of the inspection. But the maximum temperatures for both fridges were seen to be several degrees over the recommended range. The pharmacist said that the fridge temperatures were checked daily, and the records seen showed that previously the fridge temperatures had been within the appropriate range. The locum was unsure how to reset the thermometer and contacted the SI during the inspection. The thermometer for the smaller fridge was reset during the inspection. But the temperatures were seen to slightly go out of the

appropriate range. Following the inspection, the SI confirmed that all the medicines inside the smaller fridge had been moved to the larger one. And a suitable fridge had been ordered in to replace the smaller one.

Part-dispensed prescriptions were kept at the pharmacy until the remainder was collected. Team members checked them frequently and contacted suppliers for updates about any supply issues. Prescriptions for alternative medicines were requested from prescribers where needed. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Uncollected prescriptions were checked monthly. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. 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.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

Equipment for measuring liquids was available but the pharmacy was using plastic ones sometimes and the glass ones were not clean. The pharmacist said that he would order some suitable glass measures. Separate liquid measures were marked for use with certain medicines only. Triangle tablet counters were available, the pharmacist said that these were cleaned before each use. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination.

Up-to-date reference sources were available in the pharmacy and online. The pharmacist said that the blood pressure monitor would be replaced in line with the manufacturer's guidance. The weighing scales and the shredder were in good working order. 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.