General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Wellbeing Pharmacy, Portakabin, Princess Of Wales Hospital, Lynn Road, ELY, Cambridgeshire, CB6 1DN

Pharmacy reference: 1089227

Type of pharmacy: Community

Date of inspection: 14/03/2023

Pharmacy context

This pharmacy is set within the grounds of a hospital but provides community pharmacy services mainly to patients of two GP surgeries located close by. It changed ownership in November 2022 and most of the current team members worked for the previous owners. Its main activity is dispensing NHS prescriptions, some of which it delivers to people. And it supplies some people with medicines in multi-compartment compliance packs to help these people take their medicines at the right times. It offers seasonal flu vaccinations, and it provides the Community Pharmacist Consultation Service.

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 manages the risks associated with its services effectively. It generally makes the records it needs to by law within the required timescales. And it protects people's information. The pharmacy team members learn from their mistakes so they can make their services safer. It has up-to-date procedures which tell staff how to work safely. But its team members have not read these yet, so may not always be aware of best practice.

Inspector's evidence

The pharmacy manager provided most of the responsible pharmacist (RP) cover at the pharmacy and was on duty during the inspection. The pharmacy team members had received new written standard operating procedures (SOPs) following the change of ownership though the pharmacy team had not yet managed to read through these. The pharmacy manager agreed to make sure team members read these new procedures.

When asked, team members were aware of when they needed to refer queries to the RP. They understood what they could and couldn't do if there was no RP at the pharmacy. And they could explain the restrictions on sales of some products, including medicines containing codeine.

The pharmacy had adopted a new process to reduce risks during the dispensing process. A new patient medication record system had been installed and this also used barcode scanning during the dispensing process to make sure the correct item was being dispensed. The pharmacist carried out an initial clinical screen of all electronic NHS prescriptions and then released these for dispensing on the system. For prescriptions involving part packs, parallel imported medicines, and controlled drugs, or for paper prescriptions, the system required greater intervention by the pharmacist to allow the dispensing process to continue. The pharmacy kept a record about mistakes made and corrected during the dispensing process (known as near misses). The team commented that the upgraded IT system had greatly reduced the numbers of dispensing mistakes that were being made. The near misses that were made and recorded included some information about why mistakes had happened and what the dispenser should do to try to prevent similar events happening again. Since the change of ownership, the pharmacy said there had been no dispensing mistakes which had reached patients. But there was a process to deal with these appropriately and to report them. To prevent common selection errors of medicines which sounded or looked similar, for example amitriptyline and amlodipine, storage locations were separated and highlighted. Staff were able to explain how a complaint should be handled and would refer to the pharmacist on duty when needed.

The pharmacy had professional indemnity and public liability insurance in place. There was a notice displayed for the public showing details of the current RP on duty. The record about the RP was available; this was kept electronically. When checked, records had been made for most days but not every day the pharmacy had been open. The pharmacy manager explained the team was still getting used to the new IT system which was used to record this information. But he would check how to make sure the records were made correctly in future. Records viewed about controlled drugs (CDs) were up to date. These were also kept electronically. Running balances were recorded and checked regularly. The pharmacy manager explained how balance checks had been made when the ownership changed to

ensure the records were correct. And how he completed interim balance checks when items were dispensed. The recorded stock of three items chosen at random agreed with physical stock. CDs returned by people for destruction would be recorded in a designated book; there were no patient-returned CDs awaiting destruction.

When asked, staff could describe the need to keep people's information private. And experienced members of staff had evidence of the training they had completed previously. There were procedures to protect people's information. Computer screens containing patient information could not be seen by the public. Confidential waste was separated from normal waste and disposed of securely by shredding. The pharmacy manager had completed level 3 safeguarding training. And some of the other members of staff had completed level two.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload effectively. Its team members work well together, and they feel well supported by the new owners. They have also completed or are enrolled on the right training for the roles they undertake. The pharmacy doesn't yet have a formal training plan in place. This could mean that the pharmacy isn't always able to identify and address any ongoing learning needs to help keep the team members skills and knowledge up to date.

Inspector's evidence

At the time of the inspection, the pharmacy team was made up of the pharmacy manager (the RP), two trained dispensers, and two trainee dispensers. One of the trained dispensers had completed a pharmacy technician's course but had not yet registered. A further member of staff was off work. The team was able to cope with the workload during the visit though one surgery was issuing double prescriptions as it was due to close, and this had increased the pharmacy's workload somewhat.

Members of staff had completed or were enrolled on the right training for their roles. There was evidence seen of on-the-job coaching being given by more experienced members of staff and the pharmacy manager to newer staff members throughout the inspection. The pharmacy manager could show evidence of formal training that some of the team had completed under the previous ownership to keep their skills and knowledge up to date. This included training about infection prevention, antimicrobial stewardship, and safeguarding. However, the pharmacy didn't currently have a formal training plan to identify and address ongoing learning needs of all the team.

Members of the team worked closely together and were seen helping each other during the inspection. When asked, team members said they felt well supported by the new owners and could contact them for help if they had any queries or issues that needed to be resolved. They said the team members got on well with each other and could share ideas about how to make the pharmacy work more efficiently and these would be listened to. To make sure information was shared with team members who were not in at the same time, the team used a communications book. This meant that prescriptions that needed ordering or queries that needed to be followed up were dealt with appropriately.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are small but are adequate to provide the pharmacy’s services safely.

Inspector's evidence

The pharmacy was in a portacabin located in the grounds of a hospital. It had its own hygiene facilities. And separate sinks for handwashing and for preparing medicines; these had hot and cold running water. The premises were small and had limited storage space, but the team was trying to keep working areas as tidy as possible. There was a limited range of health information about self-care displayed in the retail area. There was a small room to one side of the dispensary that staff used for rest breaks. This area also had a bench where multi-compartment compliance packs were prepared, away from distractions in the main dispensary.

The lighting and ambient temperatures during the visit were suitable for the activities undertaken and for storing medicines. The pharmacy was reasonably clean; the team members carried out cleaning tasks themselves. There was limited space for people waiting for services but the waiting area had chairs and was kept clear of clutter. Medicines were stored behind the medicines counter and in the dispensary and could not be reached by members of the public.

There was ramped and stepped access to the portacabin and the doors were wide enough to accommodate wheelchairs or prams. The premises could be secured against unauthorised access. Lighting outside the premises had been upgraded to help make entry and egress from the premises safe and secure. A private consultation room was available and was large enough for the services provided. Conversations inside the room would not be easily overheard by other people in the pharmacy. It too could accommodate a wheelchair. There was no confidential paperwork left on display in the room.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy manages its services effectively. The pharmacy's team members prepare compliance packs safely. And the pharmacy stores and manages its medicines appropriately. It works closely with other healthcare providers to help make sure people get the medicines they need. And the pharmacy tries to make sure that people who receive prescriptions for higher-risk medicines get all the information and advice they need to take their medicines safely.

Inspector's evidence

The pharmacy was open Monday to Friday 9am to 6.30pm; it did not open at weekends. The pharmacy manager explained that the prescription volume had risen since the change of ownership and the pharmacy was getting very positive reviews. Some of this he felt was down to the way the pharmacy had been able to source antibiotics to meet the demand posed by increased Strep A infections. And he had worked closely with the local surgery to obtain alternative prescriptions where needed to tackle stock shortages.

The pharmacy delivered medicines to some people; the provision of this service had increased more recently. There was an electronic audit trail for this service to show that medicines had reached the right people. And the pharmacy could track and keep in touch with the delivery driver when he was mid-delivery if there were queries from people about their delivery. People who collected their prescriptions from the pharmacy were sent a text informing them that their prescription was ready. This had reduced phone calls to the pharmacy. The system also assigned a shelf location for the dispensed items which made it easier to find them when the person came to collect.

During the dispensing process, baskets were used to keep prescriptions for different people separate. Picked items were scanned as part of the dispensing process to check the correct item had been selected. Prescriptions that were not urgent were separated so they could be processed at quieter times.

The pharmacy supplied medicines in multi-compartment compliance packs to a small number of people who lived in their own homes. The dispensers prepared these packs on a separate workbench, away from other dispensing activities. The pharmacy had individual records for the people receiving these packs and added notes to these records when there were changes or other interventions. The pharmacy also ordered prescriptions on the person's behalf. As none of the previous electronic patient medication records had transferred to the new system, the team had created a tracker to make sure all the necessary information was transcribed on to the new system. The packs were labelled with the dose and a description of the medicines in the pack. All packs were sealed as soon as dispensed except for one set which contained a large number of different medicines. With these packs, the dispenser confirmed that the pharmacist was able to check the packs as soon as they were dispensed and would only start to prepare them if that was possible. These packs were left unsealed to help with the checking process. And would then be sealed as soon as they were checked. Patient information leaflets were supplied every four weeks.

The pharmacy had the current safety literature about pregnancy prevention to provide to people when

supplying valproate. The team was aware of the updated guidance about supplying this medicine safely. However, a recent audit had found that the pharmacy didn't currently supply to anyone in the at-risk group. The pharmacy highlighted prescriptions for CDs so that members of staff could check they were still valid when handing the medicines out. The pharmacy manager could explain the types of checks that he made when supplying higher-risk medicines such as methotrexate so that people were given advice about possible side-effects. There were stickers available to highlight prescriptions for higher-risk medicines or prescriptions where the pharmacist wanted to speak with the person when they collected their medicines. This was to ensure people received the information they needed to take their medicines safely.

The pharmacy got its medicines from several licensed suppliers. Medicines were generally stored in an organised manner on shelves in the dispensary though storage space was limited, making it harder to keep some medicines clearly separated. Back-up stocks for fast-moving lines were stored separately and the team knew to rotate stock to reduce the risk of supplying date-expired medicines to people. Waste medicines were stored in designated bins. The pharmacy had not created a date-checking matrix since the change of ownership. However, staff commented that all medicines had been date checked as part of a recent stock take. And when stock was checked during the visit, there were no out-of-date medicines found. There was also some evidence that medicines with short shelf-lives were highlighted. Liquid medicines had the date of opening added to the container when needed so dispensers could assess if the medicines were still safe to use.

Medicines that required refrigerated storage were kept in the pharmacy fridge. Maximum and minimum fridge temperatures were monitored, and the electronic records seen were largely within the required range. As was the temperature during the inspection. But there were some dates where a record had not been made. The pharmacy manager felt this was due to a lack of familiarity with the new IT system and agreed to follow this up to make sure a record was made daily. There was enough storage capacity in the fridge and no evidence of ice build-up.

The pharmacy received safety alerts about medicine recalls via email and kept an audit trail to show that stock medicines were checked to see if any were affected by the alerts. When asked, team members could correctly explain the process they followed about these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs to provide its services safely. And, on the whole, it keeps its equipment clean, and it makes sure its equipment is working correctly.

Inspector's evidence

The pharmacy had a range of validated glass measures for dispensing liquid medicines and these were clean. It also had a number of counting triangles, some of which were reserved for cytotoxic preparations to reduce the risk of cross-contamination though these weren't always cleaned after use. The team members agreed to do this in the future to reduce handling risks. Computer screens containing patient information could not be seen by members of the public and the pharmacy team had cordless phones so could hold private conversations out of earshot of the public. The blood pressure meter had been replaced recently and looked in good working order. The patient medication record system was password protected. The pharmacy fridge was of a suitable size for the volume of medicines that needed refrigeration. The fridge temperature at the time of the visit was within the required range. The CD cabinet had sufficient space and was kept secure. The pharmacy did not currently have an induction hearing loop but a notice suggesting they did was displayed. The pharmacy manager said the pharmacy was looking to get a new loop installed but understood the notice could be misleading and would address this.

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.