General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Werrington Pharmacy, 97 Church Street, Werrington, PETERBOROUGH, Cambridgeshire, PE4 6QF

Pharmacy reference: 1089933

Type of pharmacy: Community

Date of inspection: 26/06/2019

Pharmacy context

This community pharmacy is in a building that includes a dental surgery, dispensing opticians and an osteopath. It is being extended to add a GP surgery and additional consultation rooms for private healthcare. The pharmacy is in a residential area and dispenses prescriptions that it receives from several local GP surgeries. It provides some medicines in multi-compartment compliance aids to help people take their medicines safely. It uses a robot to help dispense some medicines.

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 its risks well. The pharmacy reviews dispensing incidents to make improvements to its processes. It keeps the legal records that it needs to, and it generally makes sure that these are accurate. The pharmacy's team members manage people's personal information appropriately. And they know how to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which covered its services. The SOPs been recently updated and had been signed by team members to confirm their understanding. The responsible pharmacist's name and registration number was displayed on a notice that was visible from the medicines counter.

The pharmacy's team members made records about near misses in the dispensing process. Records included the medicine name, the error description and team members involved. The records were analysed and reviewed by the pharmacist. Actions to improve safety were recorded. Team members had been encouraged to use the dispensing robot more often to reduce the chance of picking the wrong product for storage shelves. Team members had also been reminded not to cover important information on medicine packaging with dispensing labels.

Certificates were displayed which indicated that there were current arrangements for employer's liability, public liability and professional indemnity insurance. The pharmacy kept the controlled drug (CD) records that were required. It kept records about CD running balances to keep track of its stock. Expired stock was not always clearly recorded in CD registers which meant that checking the balances of some CDs was sometimes more difficult. There were several registers for different medicine brands and they weren't always clearly organised which increased the risk of entries being made in the wrong place. Two controlled drugs were checked, and the physical stock matched the recorded balances. Records about the responsible pharmacist, returned CDs, unlicensed medicines and private prescriptions were kept and maintained adequately.

The pharmacy provided surveys to people using the pharmacy, so they could give their feedback. Most respondents in the recent survey rated the pharmacy as 'excellent.' The pharmacy's team members said that people also provided their verbal feedback about the pharmacy and its services. The pharmacy had a SOP about managing complaints. The pharmacy's practice leaflet provided information about the complaints and feedback process.

Team members had been trained about safeguarding vulnerable people. The team had received information in the pharmacy's SOPs and some team members had completed training from the Centre for Pharmacy Postgraduate Education (CPPE). The pharmacy had contact details for local safeguarding organisations. The pharmacist described previous incidents that had been raised as concerns with the appropriate organisation.

The pharmacy team had read SOPs about correctly managing people's personal information. The team segregated confidential waste so that it could be appropriately destroyed by a third-party company. Dispensers used their own NHS Smartcards to access electronic prescriptions. A statement that the

pharmacy complied with the Data Protection Act and NHS Code of Conduct on Confidentiality was in the pharmacy's practice leaflet.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to safely dispense people's medicines. But the staff sometimes struggle to keep up to date with other tasks. The pharmacy's team members receive appropriate training to make sure they perform their roles competently. And they know when it is appropriate to refer to the pharmacist.

Inspector's evidence

At the time of the inspection there was the responsible pharmacist (superintendent pharmacist), two dispensers and two medicines counter assistants present. The pharmacist said that he used part-time staff and overtime to provide cover for absences. The staffing level was appropriate to safely and efficiently serve people visiting the pharmacy. However, there was a build-up of medicines to check and stock orders to put away. Several workbenches were cluttered, and the team did not have much time to carry out tasks other than dispensing medicines.

The team used informal discussions to share messages. Some team members had recently joined the pharmacy and described situations that they needed to refer to a more experienced team member or the pharmacist. The pharmacist supervised team members that were less experienced and provided feedback when needed.

Team members described training that they received when they were employed at the pharmacy, to make sure they could complete tasks competently. There were certificates displayed which showed that the dispensers had completed appropriate pharmacy qualifications. Team members said that they sometimes received additional training to keep them up to date. This included information that was provided by pharmaceutical companies. The pharmacist said that there wasn't always enough time to provide ongoing training during work hours. He said that there were no formal targets and the team concentrated on managing its daily workload.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy safely provides its services from suitable premises. The pharmacy has enough space to help its team members efficiently provide its services.

Inspector's evidence

The pharmacy was generally clean and tidy. It had a large retail area which comfortably accommodated people waiting for their medicines. Several workbenches in the dispensary were cluttered which reduced the available space for dispensing and other work. Prescriptions and dispensed medicines were organised. Team members located people’s medicines and prescriptions efficiently.

There was adequate heating and lighting throughout the pharmacy. And there was hot and cold running water available. The pharmacy had two consultation rooms which were suitably sized and were appropriate for confidential discussions. Team members said that there had been no recent security incidents or break-ins. The pharmacy had appropriate security arrangements for its premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages its services well. It generally stores its medicines appropriately so that people can use them safely. The pharmacy's team members identify higher-risk medicines and provide appropriate advice to help people use their medicines effectively.

Inspector's evidence

The pharmacy's layout and step-free access meant it was wheelchair accessible. Leaflets in the retail area provided information about the pharmacy and its services. The pharmacy mostly received prescriptions from two local GP surgeries. It kept records about ordered prescriptions to make sure that all prescription items were received.

Multi-compartment compliance aids were supplied to around 120 people to help them take their medicines safely. The workload was organised across four weeks so that it was more manageable. The pharmacist said that the compliance aids were generally assembled one week prior to supply. The compliance aids included descriptions to help people identify individual medicines. The pharmacy provided patient information leaflets (PILs) with compliance aids. It kept records about the medicines that were included in the compliance aids to make sure the compliance aids were assembled correctly.

Dispensers used baskets to make sure prescriptions were prioritised and medicines remained organised. Computer-generated labels contained relevant warnings and were initialled by the dispenser and checker to provide an audit trail. The pharmacy's dispensing software highlighted interactions between medicines. Team members said that they verbally informed the pharmacist about these interactions. They said that these warnings could also be printed.

The pharmacy kept records about relevant blood tests when people were supplied with warfarin. It had access to appropriate guidance materials about pregnancy prevention advice to supply to people in the at-risk group who were supplied with sodium valproate. The pharmacy delivered medicines to some people. It kept records about the deliveries that had been completed. Most records did not include the recipient signature, so it would have been more difficult for the pharmacy to prove these deliveries had been completed correctly.

The pharmacy used a robot to help dispense some medicines. A dispenser described the training that she had been given by the pharmacist to use the robot properly. She said that she could refer to the pharmacist or another colleague if there were any issues with the robot. Medicines were scanned into the robot to help make sure that they were in date and stored in the correct place. The robot picked the medicine that was selected by team members when they entered prescriptions on the computer. Medicines arrived via a chute to the dispenser so a dispensing label could be attached. The pharmacist encouraged the team to use the robot where possible because he said that it reduced the risk of the incorrect medicine being dispensed. The robot was regularly maintained to make sure it was working adequately. The pharmacist had contact details of people who could repair the robot if it wasn't working. The robot was large and had an entry point to allow team members to manually remove medicines from the robot if it wasn't working.

The pharmacy had invoices that showed medicines were obtained from licensed wholesalers. Two

fridges were used to store medicines that needed cold storage. The pharmacy kept fridge temperature records to help make sure these medicines were stored at the right temperature. Templates were used to record the temperatures every day, but there were some days in the past month where the temperatures had not been recorded. The thermometers were checked during the inspection and showed appropriate temperatures.

CDs were stored according to requirements. However, the CDs were not stored in an organised way. Different medicines were not clearly separated which may have increased the risk of the team members picking the wrong item. Expired CDs were clearly marked so that they weren't used for dispensing.

The expiry dates of medicines were generally checked every six months. The pharmacy kept records about the medicines that were approaching their expiry dates, so they could be removed from stock when they expired. Several medicines were chosen at random and seen to be in date. The pharmacy generally marked the date onto bottles of liquid medicines when they were first opened. This was so that its team members knew if the medicines were safe to use for dispensing again. There were some bottles which had not been marked with the date. This included cetirizine liquid. The bottles were highlighted to the pharmacist so that they could be appropriately managed. Expired and returned medicines were separated from other stock and placed into pharmaceutical waste bins to be destroyed.

The pharmacy did not have scanners to help verify the authenticity of their medicines in line with the Falsified Medicines Directive. The pharmacist said that he had ordered the scanners so that they could be used in the pharmacy. The superintendent pharmacist received information about medicine recalls and made sure that affected medicines were removed from stock. The pharmacist had records about the recent recalls he had received. This included a recent recall about co-amoxiclav.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the right equipment and facilities to safely provide its services. It makes sure that its equipment and facilities are appropriately maintained.

Inspector's evidence

The pharmacy's equipment appeared in good working order and was maintained adequately. Maintenance issues were referred to the superintendent pharmacist, so he could appropriately manage them. Confidential information was not visible to people using the pharmacy. Computers were password protected to prevent unauthorised access to people's medication records.

Sinks had hot and cold running water. Crown-stamped measures were available in the pharmacy to accurately measure liquids. The pharmacy had internet access to up-to-date reference sources.

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.