General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 147 - 151 Wood Street, Walthamstow, LONDON, E17 3LX

Pharmacy reference: 1091596

Type of pharmacy: Community

Date of inspection: 04/10/2024

Pharmacy context

This is a branch of the Well pharmacy chain located in Walthamstow in a parade of shops. It dispenses people's prescriptions, sells over-the-counter medicines, and provides health advice. It offers the New Medicine Service (NMS), blood pressure checks and some medicines through the Pharmacy First service. And it also offers flu vaccinations during the autumn and winter seasons. It prepares medicines in multi-compartment compliance packs for people who have difficulty remembering to take their medicines. And offers a delivery 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

The pharmacy uses written procedures to ensure that team members understand their responsibilities and how to carry out activities. It generally manages and protects confidential information well. People using the pharmacy's services can easily provide feedback. Team members have the relevant training to safeguard the welfare of people using their services. But they do not always record their mistakes, which could make it harder to review them and identify any patterns or trends.

Inspector's evidence

The responsible pharmacist (RP) sign was incorrect and not visible to the public at the time of inspection. This was rectified immediately when highlighted to the RP. The RP record was held electronically, and it was mostly completed correctly. Private prescription records were held electronically, however, the sample of records for private prescriptions inspected were not complete with the prescriber and corresponding address. This may mean that this information is harder to find out if there was a query. Team members were not able to access records for emergency supplies and were not aware of any unlicenced medicines that may have been supplied. The required entries had been made in controlled drug (CD) registers that were seen and a random physical check of two CD medicines matched the balance recorded in the register. CD balances were checked regularly as stated in the SOP.

The pharmacy's standard operating procedures (SOPs) were stored online in a central learning system which staff had access to through individual login details. There was a quiz and declaration for each SOP, which had to be successfully completed before the individual team member would be signed off to carry out the task(s) associated with each procedure. The SOPs were regularly reviewed and updated by the pharmacy's head office. And team members present on the day of inspection had read the SOPs relevant to their roles. Team members were able to describe what action they would take if they did not have an RP present. They could explain what activities they could and could not do.

The pharmacy had a platform to record dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes which had reached the person (errors). However, no recent entries were seen on the Datix platform. The trainee pharmacy technician said that team members were encouraged to record their own mistakes on the system to promote learning, and they would have an informal discussion surrounding the mistake. However, due to recent changes in staffing, the recording of near misses was not always completed, although some near misses had occurred. There were some posters in the dispensary that highlighted some common medicines which sounded alike or looked alike. Team members could not recall any dispensing errors but said that they would refer a person to the RP if this occurred.

Feedback or complaints from people using the pharmacy's services could be received verbally in person or by telephone. If a complaint was received, team members said they would refer to the RP and they had an SOP to refer to if required. The pharmacy had appropriate indemnity insurance.

Computers were password protected meaning that confidential electronic information was stored securely. Confidential paper waste was destroyed appropriately using an external contractor. And patient-returned medicines that were to be sent for destruction had patient details removed. Checked

medications that were awaiting collection were stored appropriately to ensure that people's information was not visible from the counter. Team members said that they had completed General Data Protection Regulation (GDPR) and information governance training through the company learning portal.

Team members had completed safeguarding training and were able to describe some of the signs to look for. They were aware they could use the consultation room for private discussions if necessary and knew when to refer to the pharmacist. The trainee pharmacy technician knew of the local safeguarding boards and said that there was a safeguarding lead within the organisation that they could also escalate concerns to if needed. 'Safe space' posters were displayed in the shop area to highlight to people that they can ask for information or support if required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The team has the appropriate skill mix to ensure safe practice, and team members can raise concerns if needed, in an open and honest environment. Team members get protected time to do ongoing learning to keep their knowledge and skills up to date.

Inspector's evidence

The team on the day of the inspection included a locum pharmacist, a trainee technician and a trainee dispenser. Team members took turns in covering the front counter as there was not a designated member of staff for this task. They commented that this interrupted dispensing activities, but the backlog of work was small. The dispenser was able to demonstrate an awareness of medicines with the potential for abuse and could identify people making repeat purchases. They reported feeling comfortable to refuse a sale where necessary and gave an example of where they have had to do this in the past. Team members were observed serving people and seen asking appropriate questions when responding to requests or selling medicines.

Both trainee team members were undergoing training with an accredited provider. They used the company's online learning system to complete mandatory training, and there was designated training time for this in work hours. Staff felt that service targets put extra pressure on the team, but they would not let the targets affect their professional judgement. The trainee pharmacy technician said that they had a formal appraisal and felt able to raise concerns with the RP. The team described an open and honest workplace and had informal discussions around concerns and feedback. They said that they used messaging platforms to communicate operational information as different team members worked at the weekend.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe and people visiting the pharmacy can have a conversation with a team member in private. The premises are secure from unauthorised access when closed. The pharmacy is clean and generally tidy, but the team could do more do make sure that unnecessary clutter is removed promptly.

Inspector's evidence

Pharmacy-only medicines were kept behind the counter and in glass cabinets, and people had to ask for assistance when making a purchase. Medications awaiting collection were kept in the dispensary to ensure that patient identifiable information could not be seen by people in the shop area. There was a consultation room, which allowed for conversations at a normal level of volume to be private. The room was accessible from the shop floor and was suitable for the provision of services.

There was an area in the dispensary where the team had space to dispense multi-compartment compliance packs without distractions. The premises were clean and generally tidy with some boxes of medication to the back of the dispensary that were waiting to be unpacked. And some bags of general waste which were blocking the fire exit, which were moved immediately when highlighted to the dispenser. There was bright lighting, and the pharmacy was kept secure from unauthorised access. Air conditioning was available to maintain suitable medicines storage temperature. There were handwashing facilities available in the dispensary and staff kitchenette. The pharmacy had a toilet for staff with separate handwashing facilities. Team members cleaned high-touch areas during quieter times.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people with differing needs and overall, it delivers its services in a safe and effective manner. It obtains its medicines from reputable sources and generally manages them appropriately so that they are safe for people to use. The pharmacy does not routinely highlight prescriptions for higher-risk medicines. So, it may be missing out on opportunities to provide additional counselling information to people taking these medicines.

Inspector's evidence

The pharmacy had signs in the window to tell people what services it provided, and health information leaflets were available outside the consultation room. Step free access made it accessible to a wide range of people. Large-print labels were available to people on request. The main entrance to the pharmacy was through a single door and down some steps. However, there was also double door access large enough for people with wheelchairs or pushchairs. This was kept locked, but the staff opened the doors for people upon request. Some seating for people waiting for services was available in front of the medicines counter.

Medicines were sourced from licensed suppliers. A random spot check of stock revealed no expired medicines. ‘Use first’ stickers were used to highlight short-dated items on the shelves. Returned medicines were collected by a waste contractor. CDs were stored securely. Dispensed CDs were stored separately from stock and expired medicines were segregated in clearly marked bags while awaiting destruction. Destruction kits were available for patient returns or expired medicines.

Records for the pharmaceutical fridges were completed daily and showed no deviations in temperature outside of the required range of between 2 and 8 degrees Celsius. However, some records showed the same readings for several days in row. When asked, a team member said that they do not routinely reset the thermometer and were unsure of how to do this. This may mean that maximum and minimum recorded temperatures do not accurately reflect the temperature in the fridges and staff may not know if the temperature goes out of range. Also, a few Flu vaccinations were seen to be stored at the back of one of the fridges against a build-up of ice. This may mean that there is a risk of medicines being exposed to temperatures outside of the manufacturer’s recommended range. Vaccinations were not seen to be damaged, and the team member said they would discuss improvements needed for the fridge storage with the regular pharmacist.

The pharmacy received safety alerts and drug recalls, or information about other problems with medicines or medical devices, through the pharmacy system. The dispenser said that they checked these daily and discussed all alerts with the RP before documenting the action taken in response.

There were controls in place to help minimise errors, such as using baskets for each prescription so that their contents were kept separate from other prescriptions. Dispensing labels included ‘dispensed by’ and ‘checked by’ boxes to indicate who had carried out those tasks. The pharmacy dispensed some medicines in multi-compartment compliance packs for people who needed help to manage their medicines. Packs were assembled in a designated area of the dispensary to avoid distractions. The pharmacy used information sheets to keep track of regular medications and any changes. The dispenser used the information sheets to order repeat prescriptions for these people to help ensure they were

ordered in a timely manner for dispensing. They said that they used the NHS summary care record or contacted the surgery if there are any items missed or any changes made to a person's regular prescription. Medicine warnings and descriptions of each of the medicines were printed on the backing sheets inside of the packs. Patient information leaflets were routinely provided.

When asked, the dispenser was aware of the risks involved when supplying valproate products to people who could become pregnant. They also knew about the guidance to supply these products in complete original manufacturer's packs, and to ensure they didn't cover any of the warnings with dispensing labels. There was a poster in the dispensary to remind staff of the guidance when dispensing these medicines. The importance of undertaking individual risk assessments if valproate was not dispensed in the original manufacturer's pack was discussed with a team member who said that they would feed this back to the regular pharmacist. Prescriptions for other higher-risk medicines were not usually highlighted to remind the team to refer to the pharmacist when handing out these medicines. 'Pharmacist advice' stickers were available in the pharmacy but were not in use. This may mean that opportunities to provide counselling to people about these medicines would be missed. CD medicines were not highlighted to encourage the team to check the validity before handing out, and this may mean that medicines could be given to people past the 28-day period that the prescription is valid.

Uncollected prescriptions were removed from the shelf periodically. Once removed, medicines were returned to stock where possible and the prescription was marked as not dispensed or partially dispensed before being returned to the NHS spine or claimed for. PGDs for the Pharmacy First service were available for reference in the dispensary. The RP confirmed they had completed the training to provide the service.

The pharmacy offered a delivery service and had an area in the pharmacy to store the deliveries that needed to be taken. The delivery driver would scan the bags of medicines and a barcode in the dispensary with a handheld device before taking them. All deliveries were made within the pharmacy's opening hours. Medicines were returned to the pharmacy if people were not home, and the pharmacy had contact numbers for people receiving deliveries and would reschedule where necessary. The dispenser was able to access a log of the deliveries, however this did not show any recent deliveries that had been made. This may mean that information is harder to find out if there was a query.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use and uses it to help protect people's personal information.

Inspector's evidence

The pharmacy used suitable standardised conical measures for measuring liquids, and clean tablet triangle counters were available for dispensing loose medication. A separate conical measure was available for certain liquids and a separate tablet counter for cytotoxic medication. A sharps bin and an in-date anaphylaxis kit were available in the consultation room for when vaccinations were administered. There was a blood pressure monitor in the consultation room however the RP was not sure if this was calibrated or replaced to ensure accurate readings. Team members had their own NHS smartcards, for accessing electronic prescriptions, and all computers were password protected to safeguard information. A portable telephone enabled the team to ensure conversations were kept private were necessary. Fire extinguishers were available in the dispensary.

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.