General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Wilstead Pharmacy, 1 Crossroads, Church Road, Wilstead, BEDFORD, Bedfordshire, MK45 3HJ

Pharmacy reference: 1093200

Type of pharmacy: Community

Date of inspection: 27/12/2019

Pharmacy context

The pharmacy is situated in a village on a main road. It provides NHS and private prescription dispensing mainly to local residents. The team also dispenses medicines in multi-compartment compliance packs for some people in their own homes and medicines to a large number of residential care homes. They also offer flu vaccinations and smoking cessation. The pharmacy only occupies part of the shop floor.

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

Members of the pharmacy team generally work to professional standards and try to identify and manage risks effectively. They are clear about their roles and responsibilities. The pharmacy keeps its records up to date which show that it is providing safe services. It manages and protects information well. The team members also understand how they can help to protect the welfare of vulnerable people. They discuss any mistakes they make during the dispensing process. But they do not always record these. So they may find it harder to learn from these events to avoid problems being repeated.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were issued by the company. The SOPs covered the services that were offered by the pharmacy. A sample of SOPs was chosen at random and had been reviewed within the last two years. The SOPs were signed by the pharmacy's team members to indicate they had been read. The written procedures said the team members should log any mistakes they made in the dispensing process in order to learn from them. They occasionally logged issues but the team reported that the pharmacist would highlight to them when they had made a mistake, so that they could correct it.

The pharmacy conspicuously displayed the responsible pharmacist notice. The responsible pharmacist record required by law was up to date and filled in correctly. The pharmacy team members were aware of their roles and they were observed asking the pharmacist for advice when needed.

Feedback from customers was sought in an annual survey, which was published on the NHS web-site. No areas for improvement had been highlighted in the most recent survey completed. The team was in the process of reviewing whether or not the care homes could be supplied with manufacturers' patient packs, so feedback was being sought from the homes' staff about their needs. The pharmacy had professional indemnity and public liability insurances in place.

The pharmacy team recorded private prescriptions and emergency supplies on the computer but the details of the prescriber and the date of the prescription were not always accurately recorded. The controlled drugs registers were up to date and legally compliant. The team did regular checks on the recorded balance and actual stock of controlled drugs to ensure that there were no missing entries. Fridge temperatures were recorded daily and were usually recorded as within the recommended range. Some patient-returned controlled drugs had not been recorded on receipt

Confidential waste was segregated and was disposed of using a licensed waste contractor. NHS smartcards used to access electronic prescriptions were not shared. There was a company policy about Information Governance which had been read by the staff and the pharmacist knew what to do if there was a data breach.

The pharmacists had undertaken the appropriate level of safeguarding training and also helped to train some of the staff in the care homes about this. The dispensing staff and delivery drivers had received training about safeguarding and were able to give examples of when they had asked the pharmacist for more advice about possible safeguarding concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide safe services. Its staff are relatively inexperienced, but they are completing the right training for their roles. The pharmacy's staffing rotas enable it to have good handover arrangements and effective staff communication.

Inspector's evidence

The superintendent pharmacist and a regular pharmacist was present during the inspection. There was also a pre-registration pharmacy graduate, two trainee dispensers, a part time counter assistant and two new starters who were dispensing for the care homes. There was also a delivery driver.

The non-pharmacist staff were all trainees. There were plans to use a Numark training package in the future for on-going training, but at the time of the inspection there was none in place as the staff were still to complete the basic training for their roles.

The staff said that they had opportunities to suggest changes to the way the pharmacy was run, and that the superintendent pharmacist was receptive to suggestions. Having a lot of new staff was proving challenging for the business. However, with two pharmacists present it usually allowed one upstairs in the homes dispensary and the second in the shop dealing with the public so that all the staff's work could be supervised.

The pharmacist said that the superintendent pharmacist did not set targets which affected his professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe and secure for people to receive healthcare.

Inspector's evidence

The premises contained the registered pharmacy, plus some other shelving which was not part of the premises. There were two tills, one of which was used to sell the goods from the non-registered part (including cigarettes and alcohol) and was not on the registered premises. The shop had the same hours as the pharmacy, and the premises were secure from unauthorised access. The areas outside the building were also secure.

The dispensary was situated to the right of the shop door, and had its own till, with pharmacy-only (P) medicines displayed on the wall behind it (on the right). Dispensed medicines were stored near the stairs, also on registered premises. The non-pharmacy till was straight ahead of the door, with the cigarette cabinet behind it. To the left of this was a small consultation room. The rest of the shop was not registered. It was not clear to the public which areas formed part of the pharmacy and which were the convenience store.

The consultation room was very basic and did not have a great deal so space, meaning that if a person fainted following an injection, access to them would be difficult. The room had a table and two chairs.

Upstairs there were four rooms and a bathroom. The bathroom was used for storing returned medicines awaiting destruction. The two front rooms were used for dispensing and assembling medicines for care homes. The rooms to the rear were used for storage of stock and as an office.

The dispensary area was clean and relatively tidy, although the area near where dispensed medicines were kept could be tidier. The upper rooms were quite cluttered with lots of small rubbish, bits and pieces of medicines packaging from the trays dispensing process being left about.

Outside the building there was also a shed used to store waste medicines ready for collection.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective, and it gets its medicines from reputable sources. The pharmacy doesn't have a complete audit trail to show who has dispensed each medicine. So, it may be harder for individuals to learn from their mistakes or to investigate any issues at a later date. Pharmacy team members do not always ask about test results or current doses when supplying higher-risk medicines. So some people may not get the advice they need to take their medicines safely. And the pharmacy could do more to make sure all medicines are stored in line with legal requirements.

Inspector's evidence

Access to the pharmacy was level from the road and services were advertised on a board on the window of the shop.

The pharmacy usually used a dispensing audit trail to identify who had dispensed and checked each item although this was not consistently done. Given that the staff were mostly trainees this meant that learning from mistakes was harder to do. The use of baskets helped to ensure that prescription items were kept together and were easy to move from one area of the dispensary to another.

In the downstairs dispensary walk-in and repeat prescriptions for Schedule 4 controlled drugs were not always highlighted to staff who were to hand them. Access to the pharmacy was level from the road and services were advertised on a board on the window of the shop.

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In the downstairs dispensary, walk-in and repeat prescriptions for Schedule 4 controlled drugs were not always highlighted to staff who were to hand them out. This could increase the chance of these items being supplied more than 28 days after the date on the prescription. People taking warfarin, lithium or methotrexate were also not always asked about any recent blood tests or their current dose. So, the pharmacy could not show that it was monitoring these people in accordance with good practice. People in the at-risk group who were receiving prescriptions for valproate were routinely counselled about pregnancy prevention and appropriate warnings stickers were available for use if the manufacturer's packaging could not be used.

The pharmacy supplied medicines to approximately 600 people living in care and nursing homes. The prescriptions for these people were dispensed in the upstairs dispensary where there was a different way of working. Staff in the care homes were reminded that their prescriptions were due, and the care homes staff ordered the prescriptions themselves. The pharmacy team members then matched the prescription against what they expected to have been ordered and queried any changes with the homes. There were no checks made about high-risk medicines to ensure that the people on these medicines were receiving appropriate monitoring by the homes, or surgeries. The prescriptions were usually dispensed into single medicine trays, these were then labelled and checked against the prescription. Once the whole home, or section of it, had been prepared the items would be placed on

racks, putting each person's medicines in the correct order for handing out at the different times of day. This activity was done in a separate room and acted as another check that all the items were present. Items which were not placed on racks were supplied separately for each person. Patient information leaflets were supplied.

Medicines which had been put into trays but were not required (and so had not left the pharmacy) were left in alphabetical order in a box. However, some of these trays did not have dates of dispensing on, and so the staff had no idea when they had been removed from the manufacturer's packaging. There were some which had been dated the earliest of which read February 2018. Some of the trays were not adequately labelled with the details needed for safe dispensing. These trays were removed for destruction following the inspection.

More than 200 flu vaccinations had been done in the 2019 to 2020 season. Patient group diretions (PGDs) were present and in date and relevant staff had done the appropriate training for a safe service. The pharmacy participated in the Community Pharmacy Consultation Service which they reported had been used on a few occasions.

The pharmacy got its medicines from licensed wholesalers, and stored them on shelves in a tidy way. But some medicines were not stored in line with legal requirements. There were 'use first' stickers on the shelves and boxes to indicate items which were short dated. Regular date checking was done. Drug alerts were received, actioned and filed appropriately to ensure that recalled medicines did not find their way to people who used the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the right equipment for its services. It makes sure its equipment is safe to use.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. The pharmacy had access to up-to-date reference sources. This meant that people could receive information which reflected current practice. The pharmacy had a separate triangle marked for use with methotrexate tablets ensuring that dust from them did not cross contaminate other tablets.

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.