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: 13/02/2024

Pharmacy context

The pharmacy is situated in the village of Wilstead. It mainly dispenses NHS and private prescriptions to people in the local community and to some care home residents. It also supplies some people with medicines in multi-compartment compliance packs to help them take their medicines correctly. The pharmacy provides NHS services such as the Pharmacy First service, New Medicine Service and vaccination services including COVID-19 and seasonal influenza.

Overall inspection outcome

✔ **Standards met**

Required Action: None

Follow this link to find out what the inspections possible outcomes mean

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 identifies the risks associated with its services and manages them appropriately. Its team members follow written procedures and know their role in safeguarding the wellbeing of vulnerable people. They largely keep records in line with their legal requirements. When a dispensing mistake happens, team members respond well and discuss any learnings. The pharmacy team appropriately protects people's personal information.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which covered all the services that the team was providing. The superintendent pharmacist (SI) had last reviewed them in March 2023 and training records were available to show all team members had read the SOPs that were relevant to their role. The pharmacy had current indemnity insurance which covered the services it provided.

Members of the pharmacy team were aware of the tasks that could and could not be carried out if the responsible pharmacist (RP) took a short leave of absence from the pharmacy. Members of the team explained they sought advice from the pharmacist when a clinical query arose or if they were unsure when selling a pharmacy medicine (P-med) to help make sure any medicines were sold safely.

The pharmacy had a process to support the team with learning from mistakes that were identified during the final check by the pharmacist, also known as near misses. The pharmacist would ask the team member involved to identify the mistake and make a record on a near miss log after it had been corrected. The SI explained near misses were reviewed each month, but they did not document the review. Instead, a verbal conversation took place with team members to highlight any common mistakes and they discussed the action needed to reduce the chance of similar mistakes happening again. A recent example included the physical separation of lisinopril 10mg and 20mg tablets. A shelf edge warning label was also placed under atenolol tablets to make sure the strength was checked during the dispensing process. The pharmacy did not have any recent dispensing errors, this is when a mistake is identified after medicines had been handed out. When questioned one of the dispensers explained that any dispensing errors were recorded; these were discussed with the SI and the rest of the team to help reduce the risk of similar mistakes happening again.

The pharmacy's RP record and private prescription register were kept in line with requirements. But in some cases, it did not always keep an accurate record of when unlicensed medicines were supplied to people. The pharmacy kept a copy of the certificate of conformity but omitted both the patient and prescriber's details. The SI provided an assurance that the record will be maintained as per the requirements going forwards. Electronic controlled drug (CD) registers had been filled in correctly and running balances were maintained. Running balances for two CDs were checked and found to match the physical quantities that were being held in the cabinet. CDs that were returned to the pharmacy were recorded in an electronic patient returns register and the entries were updated when the medicines were destroyed to clearly show this had been completed.

The pharmacy had a process for managing complaints and the team was aware of the steps to follow if a complaint needed to be escalated. In the first instance, team members would try to resolve a complaint verbally but would refer to the SI if it required escalation. Confidentiality agreements for all

team members were in place and the team members were aware of the importance of maintaining patient confidentiality. They were aware not to share people's private information. And they separated confidential waste which was then collected by an authorised waste carrier. Members of the team also took appropriate steps to have private conversations about people's medicines as the retail area overlooked the dispensary due to its open plan style. This included using a quiet corner of the dispensary and not raising their voices to be overheard.

Members of the pharmacy team described the safeguarding procedures that were in place as per the SOP and explained they would refer any concerns to the pharmacist on duty to help support the wellbeing of anyone vulnerable. Details of the local safeguarding contacts were easily accessible.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to effectively manage the workload. And they feel comfortable about raising any concerns and making suggestions to improve the way they work. The pharmacy adequately supports its team members who are undertaking training.

Inspector's evidence

The pharmacy team comprised of the SI, a regular pharmacist, two part-time trainee dispensing assistants, one qualified dispensing assistant, one trainee pharmacy technician, one qualified medicines counter assistant (MCA), one trainee MCA and a delivery driver. The SI did not regularly work at the pharmacy but oversaw the operations of the pharmacy and management of its team members.

The trainees present said that adequate time was given to them to complete their training and the SI and pharmacist provided them with support when needed. Training was provided by a recognised provider but once the course was completed there was no formalised ongoing training in place. The SI explained that any changes to or new processes or guidance were verbally shared with members of the team.

Members of the team received an annual appraisal which was led by the SI. During these meetings, team members raised any concerns and provided feedback. There was also a discussion about their performance and if any additional training was required. The pharmacy team started each day with a brief conversation, known as a team huddle, to help them prioritise and manage the workload effectively. And they were seen working well together to serve people that entered the pharmacy to collect their medicines or receive a service. The pharmacy team had a process in place to cover for holidays and periods of absence to make sure the level of service it provided remained consistent. The pharmacy team members were aware of the process to follow if they had multiple requests from the same person for medicines that were liable to abuse. And they knew the correct questions to ask when selling medicines over the counter. There was also an acknowledgement that some medicines, or cohorts of people, may require additional advice when buying medicines. Team members had adequate signposting information available in the form of leaflets to help them with their roles.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises clean and tidy. And it is large enough to support the level of workload that the pharmacy processes. People who need to have a private conversation can do so in a suitable consultation room.

Inspector's evidence

The pharmacy was clean and tidy. The fixtures and fittings were well maintained, and cleaning was done by the pharmacy team members. The dispensary area was large enough to safely manage the workload. A room on the second floor was used to assemble multi-compartment compliance packs and dispense medicines that were supplied to care homes in the local area. An appropriate temperature was maintained across the premises and the lighting was suitable to provide services safely. A sink with running hot and cold water was available for hand washing and making medicines that were required to be mixed before handing out.

A consultation room was available with good access for people to have a private conversation if needed. The room was tidy and clean which allowed the provision of the pharmacy services on offer. The premises were secured overnight.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from licensed sources and stores them appropriately. It highlights higher-risk medicines to team members to help them provide people with additional information about these medicines. And it takes the right action if medicines or devices are not safe to use. It delivers medicines to some people in their own homes effectively and safely. Members of team are adequately trained to provide the services that are on offer.

Inspector's evidence

Access to the pharmacy was step-free with an automatic door at the entrance which made it easy for someone using a wheelchair or a pram to access the pharmacy. The opening hours and services on offer were clearly advertised in the shop window.

The pharmacy received prescriptions electronically which were clinically checked by the pharmacist before being processed for assembly. Once the clinical check was completed, the prescription was processed by a dispenser. They generated the dispensing labels according to the prescription and medicine stock was picked from the dispensary shelves. Once the dispensing labels were attached to the medicine boxes, team members scanned a barcode on the medicine box and label which allowed the pharmacy computer to complete an accuracy check. If there was a mismatch between the dispensed medicine and the prescription, a warning box would appear on the computer to prompt the team member to double check the medicine and the pharmacist would complete a final accuracy check to help make sure it was corrected. The SI explained that a pharmacist would always complete an accuracy check on any new medicines that had been prescribed to people or if the medicine was a CD or fridge item. And they would accuracy check any medicines that had to be split from their original pack to help make sure the correct quantity had been dispensed.

Dispensing baskets were being used to separate different people's prescriptions and helped prioritise workload and identified when medicines needed to be delivered to people's homes. A dispensing audit trail was in place which included the use of 'dispensed-by' and 'checked-by' boxes to clearly identify who had done the dispensing and checking processes. Prescriptions for Schedule 2, 3, and 4 CDs were highlighted to help the pharmacy team members make sure they were not handed out beyond the prescription's legal validity. And team members also highlighted prescriptions which required a fridge item to be added before being supplied to people. The pharmacy team explained that they use a variety of stickers to highlight any medicines that may require the pharmacist to counsel the patient or ask additional questions. The pharmacist was aware of the additional counselling about pregnancy prevention required with sodium valproate products and the steps to take for people in the at risk-group. This also included providing valproate containing medicines in their original container so that the patient warning card and patient information leaflet were provided with each supply. A medicine delivery service was provided to those who preferred to have the medicines sent to their home. The delivery service was completed by a delivery driver and an audit trail of successful deliveries were kept.

Some people in the local area and those residing in care homes were supplied their medicines in multi-compartment compliance packs to support them with managing their medicines. Records were maintained to help make sure the packs were dispensed accurately each month and provided in a timely manner. A few packs were checked and found to contain an accurate description of the

medication making it easier to identify the medicines that were being supplied. An audit trail of the team members involved in the dispensing and checking process were available. Patient information leaflets were being supplied with the packs, making it easier for people to access additional information if needed. Communication sheets were available for each patient that received the packs which the pharmacy team members used to record any changes initiated by the doctor or hospital.

Medicines and medical devices were obtained from a range of licensed wholesalers and were stored appropriately in the original packs. Access to prescription medicines and medicines awaiting collection was restricted. The expiry dates of medicines were checked each month by members of the team, and they attached a coloured round dot sticker on any short-dated medicines. But they did not make a record of completed checks so it may make it harder to identify which areas of the pharmacy have been checked and by who. However, team members recorded short-dated medicines in a diary under the month it was due to expire. They would then remove these from the shelf at the beginning of each month if they had not been supplied. A selection of medicines stored on the shelves were checked, and none were found to be out of date. And liquid medicines had a date of opening written on them. The pharmacy had a suitable fridge available, which was within the appropriate temperature range for medicines that required cold storage. A daily record of the fridge temperatures was stored electronically. The pharmacy had a secure CD cabinet available to use. CDs that had been returned to the pharmacy were clearly marked and separated from stock CDs. The pharmacy received drug alerts and safety recalls by email. Its team members checked the pharmacy for any affected stock but did not make a record of the actions taken. This may make it harder for them to respond to any queries following a safety alert.

The pharmacy provided some NHS and some private services. Members of the team were briefed about the services so they could explain to people what the service was for and how the service worked. The pharmacist and SI had completed some training to help make sure they provided the services safely. Signed copies of patient group directions (PGDs) were available and in use. The pharmacy had just started to offer the new Pharmacy First service but had not received any referrals. It also provided COVID-19 and seasonal flu vaccinations, but this had stopped as the season was coming to an end.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has all the necessary equipment that it needs to provide its services. And it uses its equipment in a way which helps protect people's personal information.

Inspector's evidence

The pharmacy used suitably calibrated and clean conical measures during the dispensing process. And its team members used separate counting triangles for medicines deemed higher risk when counting out medication.

Resources such as the BNF were accessed online when needed. The pharmacy team members were aware of when the consultation room should be used to help protect the privacy of people that accessed the pharmacy services or require advice.

Cordless phones were in use to help staff have a private conversation if needed. Electrical equipment had not been tested but appeared to be in good working order. Pharmacy computers which held people's medicine history were password protected and screens were not visible to people using the pharmacy.

The pharmacy had some specialised equipment including an otoscope and ear micro suction equipment which were regularly cleaned and maintained each month. A blood pressure monitor was also available and was calibrated every three months.

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.