General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Waterton Pharmacy, Framfield Medical Centre, Ipswich Road, WOODBRIDGE, Suffolk, IP12 4FD

Pharmacy reference: 1093702

Type of pharmacy: Community

Date of inspection: 16/11/2022

Pharmacy context

The pharmacy is next to a medical centre in a largely residential area. It provides a range of services, the New Medicine Service. And it also provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy receives around 90% of its prescriptions electronically. And it supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their 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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And people can feedback about the pharmacy's services. The pharmacy keeps most of its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) and team members had signed to show that they had read, understood, and agreed to follow them. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. The team said that there were very few near misses and these were usually mistakes where the prescription was for a box of 28 and the pack size had 30. A team member explained that she had recently reconstituted the wrong antibiotic so she now checked with the pharmacist that she had selected the correct one before adding the water to it. The pharmacy had made records of its near misses prior to February 2022 but not since. Team members said that they would start using it again to help them identify patterns. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that he was not aware of any dispensing errors having happened since he took over the pharmacy around three years ago.

There was ample workspace in the dispensary and this was kept free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members could not access the pharmacy if the pharmacist had not turned up in the morning. The trainee medicines counter assistant (MCA) knew that he should not sell pharmacy-only medicines or hand out dispensed medicines if the pharmacist was not in the pharmacy. Team members' roles and responsibilities were specified in the SOPs. The accuracy checking technician (ACT) explained that the pharmacist initialled prescriptions which he had clinically checked. She knew that she could check those once another team member had dispensed the items. And she knew that she should not check any items if she had been involved in the dispensing process.

Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The right responsible pharmacist (RP) notice was clearly displayed and the RP record was completed correctly. The pharmacy had current professional indemnity and public liability insurance. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The private prescription record was mostly completed correctly, but there were some prescriber's details

mossing from the veterinary prescription record. The record was kept on the pharmacy's computer system and the pharmacist said that he had reported the issue but the system provider could not find a solution. He said that he would speak with them again about it.

Team members had completed training about protecting people's information. Bagged items waiting collection could not be viewed by people using the pharmacy. Confidential waste was shredded in the pharmacy, computers were password protected and the people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection.

The pharmacy's complaints procedure was available for team members to follow if needed and details about it were available in the pharmacy's leaflet. The pharmacist said that there had not been any recent complaints. A QR code was displayed at the medicines counter for people to use to provide feedback about the pharmacy to Suffolk County Council. And any feedback received by the Council would be sent to the pharmacy.

The pharmacist and ACT had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. The ACT described some potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And the pharmacist said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training to support their learning needs and maintain their knowledge and skills. They can discuss any concerns or make suggestions openly.

Inspector's evidence

There was the pharmacist (who was the owner), one ACT, one dispenser and one trainee MCA working at the start of the inspection. The trainee MCA finished his shift at lunch time and another ACT started their shift in the afternoon. Most team members had completed an accredited course for their role and the rest were undertaking training. Team members wore smart uniforms with name badges displaying their role. The team were up to date with the pharmacy's dispensing tasks and they prioritised tasks to ensure that the workload was well managed.

The trainee MCA appeared confident when speaking with people. He was aware of the restrictions on sales of pseudoephedrine containing products. And he knew which medicines could be abused or may require additional care. He said that he would refer to the pharmacist if a person regularly requested to purchase one of these medicines. And he knew which questions to ask to establish whether the medicines were suitable for the person.

The dispenser said that she had recently returned to working in a pharmacy and said that she wanted to gain a little more experience before enrolling for further training courses. The pharmacist said that team members were not provided with ongoing training on a regular basis, but they did receive some. He said that he read pharmacy-related magazines and passed on important information to the team. The pharmacist and ACT were aware of the continuing professional development requirement for the professional revalidation process. The ACT said that she had recently undertaken some training about the Discharge Medicine Summary.

The pharmacist felt able to take professional decisions. He said that team members had ongoing appraisals and performance reviews. Team members felt comfortable about discussing any issues with the pharmacist or making any suggestions. Targets were not set for team members. The pharmacist said that he provided the services for the benefit of the people using the services.

Principle 3 - Premises ✔ Standards met

Summary findings

People can have a conversation with a team member in a private area in the pharmacy. And the premises provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was bright, clean, and tidy throughout which presented a professional image. And it was secured from unauthorised access. Pharmacy-only medicines were kept behind the counter. And there was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available and the room temperature was suitable for storing medicines.

There were several chairs in the shop area and some had arms to aid standing. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. There was a large consultation room which was accessible to wheelchair users. It was accessible from the shop area and the dispensary. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. People with a range of needs can access the pharmacy's services.

Inspector's evidence

Services and opening times were clearly advertised and a variety of health information leaflets was available. There was step-free access to the pharmacy through a wide entrance with an automatically opening door. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed.

The pharmacist said that the surgery would not issue a prescription for a higher-risk medicine if the person was not up to date with their relevant blood tests. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said they checked CDs and fridge items with people when handing them out. Prescriptions for Schedule 3 CDs were highlighted, but not prescriptions for schedule 4 CDs. This could increase the chance of these medicines being supplied when the prescription is no longer valid. The pharmacist said that he would ensure that these were highlighted in future. The pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant patient information leaflets and warning cards available. But it did not have spare warning stickers for use with split packs. The pharmacist said that he would order some from the manufacturer.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next six months were marked. There were no date-expired items found in with dispensing stock. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked. CDs were stored in accordance with legal requirements and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned and expired CDs were clearly marked and kept separated from the stock. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full and people were kept informed about supply issues. Prescriptions for alternate medicines were requested from prescribers where needed and prescriptions were kept at the pharmacy until the remainder was dispensed and collected. There were very few part dispensed prescriptions at the pharmacy. The pharmacist said that he had a good working relationship with the surgery. He explained that he would inform the surgery about any stock issues so that alternate items could be prescribed and help minimise the waiting time for the patient to get a suitable medicine. The pharmacist said that uncollected prescriptions were checked monthly, and people were contacted if they had not collected their items after around five weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing

stock where possible.

The pharmacist said that people had assessments carried out by their GP to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. The pharmacist said that people ordered prescriptions for these items from the surgery directly when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Team members wore gloves when handling medicines that were placed in these packs. The ACTs were responsible for checking the packs after one of the dispensers had assembled them.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of the infection. A cool box was used for transporting fridge items. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. But the pharmacy did not always keep a record of any action taken, which could make it harder for the pharmacy to show what it had done in response. He said that he would keep a record in future.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules. Up-to-date reference sources were available in the pharmacy and online. The shredder was in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.