General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Wellcare Pharmacy, 2 Castle Avenue, BRIGHOUSE, West Yorkshire, HD6 3HT

Pharmacy reference: 1101446

Type of pharmacy: Community

Date of inspection: 23/05/2019

Pharmacy context

The pharmacy is in a residential area in the village of Rastrick.The pharmacy team mainly dispense NHS prescriptions and sell a range of over-the-counter medicines. Pharmacy team members provide a substance misuse service, including supervised consumption and needle exchange. They supply multi-compartmental compliance packs to people living in their own homes. The pharmacy also provides a minor ailments service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy is cluttered and untidy, and the team has no clear workflow. So, there is a significant risk of mistakes happening in the dispensing process. The pharmacy does not have robust processes to manage the risks of providing multi-compartmental compliance packs. And, pharmacy team members do not always follow standard operating procedures. The pharmacy does not have enough team members to effectively manage risks. So, the pharmacy is creating significant risks to people's safety.
		1.4	Standard not met	The pharmacy has not maintained the standards following feedback from the inspector in the previous inspection in 2017.
		1.7	Standard not met	Pharmacy team members dispose of confidential waste in general waste bins. So, they do not adequately protect people's private information.
2. Staff	Standards not all met	2.1	Standard not met	The pharmacy does not have enough staff to safely organise the workload or effectively manage the risks of providing pharmacy services
3. Premises	Standards not all met	3.1	Standard not met	The pharmacy team do not clean or maintain the pharmacy to make sure it is a suitable environment for the services being provided. And, blocked fire exits and trip hazards means there are risks to the health and safety of staff.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy doesn't have a robust process to supply medicines in multi-compartmental compliance packs. And it doesn't plan its workload well. Pharmacy team members prepare and check multi-compartmental compliance packs without prescriptions. They use records that are unclear and confusing. They prepare the packs under pressure because they don't receive prescriptions on time. And, the area where they dispense the packs is untidy and cluttered. So, there is a significant risk of mistakes being made.

Principle	Principle finding	Exception standard reference	Notable practice	Why
		4.3	Standard not met	Pharmacy team members don’t regularly check the expiry date on medicines. And, there is evidence of out of date medicines on the shelves. They do not monitor temperatures in the medicines' fridge. So, there is a risk they can supply medicines to people that may not be safe to use.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy has written procedures for the team members to follow. But the team members don't always follow them. And this increases risks into ways of working. The pharmacy is cluttered, and so has insufficient space to provide its services safely. And fire exits are blocked putting staff at risk. The pharmacy has no clear or organised workflow. So, there are risks of errors happening. The pharmacy received similar feedback from a previous inspection. And it made changes to its ways of working. But it hasn't fully listened to the feedback as the risks have reoccurred. The pharmacy team members know what to do to protect the welfare of children and vulnerable adults. And they understand the importance of keeping people's private information safe. But they dispose of information with people's private details in the general waste. So, they don't adequately protect people's private details.Systems are in place for the pharmacy team to record mistakes that happen. But, there is no evidence they record their mistakes. And, they don't fully explore and discuss why mistakes happen. So, the team may not always learn from the mistakes and make changes to stop similar errors in the future.

Inspector's evidence

The pharmacy occupied two floors of the same building. Pharmacy team members carried out general dispensing tasks on the ground floor. They prepared multi-compartmental compliance packs on the first floor. The pharmacy had a disorganised workflow. Most of the available bench space was cluttered with stacks of baskets containing prescriptions at different stages of preparation and paperwork. Baskets were also being kept on the floor. Throughout the pharmacy, floors and passageways were cluttered with boxes and wholesaler totes containing large quantities of stock. The landings at the top and bottom of the stairs and the passageway leading to the fire escape were cluttered and blocked, presenting a significant health and safety risk to pharmacy team members. The responsible pharmacist (RP), who was also the superintendent pharmacist (SI) said the boxes and totes of stock were because he had bought medicines in response to recent shortages of medicines and uncertainty over the impact of Brexit on the medicines supply chain. The pharmacy received an action plan in November 2017 following an inspection where concerns were raised about clutter, untidiness and no clear workflow.

The SI was seen frequently during the inspection dispensing and checking his own work. The dispenser was in the first-floor dispensary preparing compliance packs. He said he tried to take a mental break between dispensing and checking. But, he said this usually did not happen, particularly when there were several people waiting for prescriptions. The inspector saw the SI dispense and check several prescriptions without a break during the inspection. The inspector also saw the SI dispense a dose of an 8mg buprenorphine sublingual tablets to a patient that required supervision. But, the SI did not supervise the patient taking the medicine. This was discussed during the inspection.

The pharmacy had a set of standard operating procedures (SOPs) in place. The SI had implemented the procedures in 2017. And had scheduled the next review of the procedures for July 2019. Pharmacy team members had read and signed the SOPs since the last review in 2017. The pharmacy defined the roles of the pharmacy team members each SOP. But pharmacy team members said the SI usually defined their daily tasks verbally.

The SI said near miss errors made by the team during dispensing were recorded and discussed with the dispenser. The dispenser said she recorded her own mistakes. But, she did not discuss with the

pharmacist why a mistake had happened. She said she would usually look at the shelves and try to separate medicines with similar names or packaging and add a sticker to the edge of the shelf to highlight the risks. One example seen was a sticker in front of prednisolone and pizotifen tablets. The SI said he did not analyse mistakes for patterns. But, he said he would be aware of the same or similar mistakes happening frequently and discuss them with staff. The pharmacy had a process for dealing with dispensing errors that had been given out to people. The procedure instructed pharmacy team members to record mistakes using a template reporting form. But, the SI said he only reported dispensing errors to the NHS National Reporting and Learning Service (NRLS) online. This was at odds with the documented procedure. Pharmacy team members could not find any records of near miss or dispensing errors. The SI and the dispenser said they made records but could not find them amongst the clutter and untidiness. And, they could not give any more examples of changes they had made to prevent a mistake happening again. An inspector raised concerns in November 2017 about the pharmacy not following documented procedures in response to mistakes.

At the last inspection in 2017, the pharmacy had received feedback about the standards in the pharmacy. And the report had highlighted where standards needed improvement. After that inspection, the SI gave assurances that the issues identified had been resolved. But, it was clear that the changes made had not been sustained. The pharmacy had a procedure to deal with complaints handling and reporting. But, it did not advertise how people could provide feedback on services in the retail area. So, people may not know how to make a complaint or give the pharmacy feedback. It collected feedback from people by using questionnaires. The SI had published the findings for the last set of questionnaires on the NHS choices website. The only improvement point listed was to provide people with more advice about healthy eating. The SI said he had obtained more information leaflets and placed them in the retail area. But, during the inspection, there were no leaflets available about healthy eating. And, people could not access any leaflets because there were wholesaler totes containing stock in front of them.

The pharmacy had up to date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity when an entry was made in the register. But, CDs that weren't dispensed frequently were not regularly audited. The methadone register was audited every one or two weeks. The pharmacy kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. It maintained a responsible pharmacist record electronically. And it was complete and up to date. The pharmacist clearly displayed their responsible pharmacist notice to people. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy had a shredder to destroy confidential waste. But, discarded dispensing labels were found in the general waste bin, despite pharmacy team members saying they shredded confidential waste. There was no evidence that the pharmacy team had been trained to protect privacy and confidentiality. But, when questioned, pharmacy team members knew how important it was to protect people's privacy.

When asked about safeguarding, the dispenser gave some examples of symptoms that would raise their concerns in both children and adults. They explained how they would refer to the pharmacist. The SI said he would assess the concern. And would refer to local safeguarding teams. He said he had completed training via the Centre for Pharmacy Postgraduate Education (CPPE) but could not remember when. Other staff had not been provided with any training. There was a procedure in place instructing pharmacy team members about what to do if they had a concern.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy does not have enough staff to safely provide pharmacy services and manage tasks. The pharmacist regularly dispenses and checks his own work which increases the risks of mistakes. And, pharmacy team members do not have the opportunity to manage the risks they identify. Pharmacy team members complete training ad-hoc. But, they do not have time to undertake training during the working day. And, they do not regularly reflect on their own performance. So, they may not be keeping their knowledge and skills up to date. The pharmacy team do not always establish and discuss specific causes of mistakes. This means they may miss chances to learn from errors.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the superintendent pharmacist (SI), a dispenser and a medicines counter assistant. The dispenser was employed full time and the medicines counter assistant was part time. The SI admitted that he did not have enough staff to manage the volume of work or to help organise the pharmacy. There was the same concern raised at the last inspection. He said there was currently a vacancy for a qualified dispenser. But, so far there had been no applicants since the advert was placed approximately eight weeks ago. The dispenser said there were several issues to resolve in the pharmacy. But, her and the pharmacist did not have the time to consolidate or make changes. They said they were aware of the risks but were unsure about how to make changes to improve standards. The inspector saw the SI frequently dispensing and checking his own work during the inspection. He said he tried to take a mental break between dispensing and checking his own work, but this frequently did not happen. The dispenser was engaged preparing multi-compartmental compliance packs in the first-floor dispensary. This meant it was difficult for the pharmacist to get her to help with dispensing if needed. The dispenser said she spent at least three days a week upstairs preparing compliance packs.

The dispenser said pharmacy team members completed training ad-hoc. But, she said there was no time during work to complete any training or to read any trade press material received in the post. The pharmacy did not have an appraisal or performance review process. Pharmacy team members said they would ask the pharmacist if there was anything they wanted to learn more about.

The dispenser explained that she would raise professional concerns with the superintendent pharmacist (SI). She said she felt comfortable raising a concern. But, she was unsure about whether her concerns would be considered, or whether changes would be made where they were needed. She did not know where to raise a concern outside of the pharmacy. The pharmacy had a whistleblowing policy. But the information was from November 2011 and was out of date. And, pharmacy team members were not aware of the procedure.

The pharmacy team communicated with an open working dialogue during the inspection. The dispenser said she was told by the pharmacist when he had made a mistake. The discussion that followed did not fully explore why she had made the mistake. But, she said she would always try to move stock on the shelves to prevent the mistake happening again.The SI did not ask the team to achieve any targets.

Principle 3 - Premises Standards not all met

Summary findings

The pharmacy team do not regularly clean the pharmacy to make sure it is a suitable environment for the services provided. The pharmacy appears cluttered and it doesn't have enough space to dispense effectively. And, it doesn't have anywhere suitable for people to speak to pharmacy staff privately.

Inspector's evidence

The pharmacy was generally cluttered and untidy. And, most areas of floor and passageways were obstructed with boxes and baskets, including the fire escape at the back of the premises, the public retail area and the first-floor compliance pack preparation area. It did not have a clear workflow in operation and the only bench space free of clutter was in the compliance pack preparation room. Its shelves were generally untidy and dusty, and the floors were dirty and in need of vacuuming. Concerns were raised with the pharmacy about clutter on benches and floors during their last inspection.

The pharmacy had two private consultation rooms available. But, the rooms could not be used as they were full of stock and clutter. This meant that the pharmacy did not have a suitable space to speak to people privately. There was a clean sink in the ground floor dispensary used for medicines preparation. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The appearance of the retail area and exterior was generally professional.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy's services are accessible to people. The pharmacy sources its medicines from reputable suppliers. But, it doesn’t store or manage its medicines appropriately. The pharmacy doesn’t have a robust process for checking the expiry date on medicines. And, there is evidence of out-of-date medicines on the shelves. Pharmacy team members do not monitor the temperature in the medicine fridge. So, there is a risk the medicines are not safe to supply to people. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. But they don’t have a robust process to adequately manage the risks. They do not provide information leaflets with these devices or include descriptions so people can identify what they look like. The team members take steps to identify people taking some high-risk medicines. And they provide people with advice. But they don’t have any written information for people to take away. So, people may not have correct information they need to help them take their medicines safely.

Inspector's evidence

The pharmacy was accessed by a ramp from the street. It did not have a bell or signs to tell people how to attract staff attention if they needed assistance. But, pharmacy team members said they would see someone at the door and would go and help. The pharmacy had a hearing induction loop. But, pharmacy team members did not know how to use the system. They did not know how to help someone with a visual impairment.

The pharmacy supplied medicines in multi-compartmental compliance packs when requested. Pharmacy team members prepared packs in a room on the first floor. The dispenser and superintendent pharmacist explained that packs were being prepared on the afternoon of the inspection for supply to people the following day. The dispenser said she had a further 22 packs to prepare. Pharmacy team members prepared packs using a hand-written record of what had been prescribed. The records seen were untidy and unclear, many with scribbled changes to medicines, strengths and doses. The record sheets provided the name of the patient. No other information was recorded to confirm the patient’s identity. Pharmacy team members did not have any prescriptions or labels when assembling packs. The dispenser wrote an abbreviated description of each medicine, it’s dose and its strength on the pack’s backing card. The pharmacist then checked the pack against the hand-written sheet and the information provided by the dispenser before sealing the pack. Once packs were sealed, they were stored on shelves unlabelled and without an accompanying prescription until the pack was ready to be supplied. Before supply, the pharmacist took each pack downstairs where he printed the electronic prescriptions and labels. He then attached the labels to the pack and checked that the prescription and the labels matched what had been written on the pack by the dispenser. The pharmacy did not regularly supply people receiving their medicines in packs with patient information leaflets about their medicines. And, packs were not always labelled with description of the medicines to help people identify each item. The pharmacy had no system in place to make sure prescriptions were ordered and received. And, this was contributing to packs being prepared the day before or on the day supply was due.

The pharmacy delivered medicines to people. The SI said that deliveries were signed for. But, there were no records of deliveries available in the pharmacy. He said the delivery driver kept the records and destroyed them after a few weeks. So, the pharmacy did not have an effective audit trail of deliveries

made to people. And it may find it difficult to resolve queries or mistakes. Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up .

The pharmacist said he would question women in the at risk group receiving valproate and provide them with information about the risks of the medicine during pregnancy. But, he said he did not ask them if they were enrolled in a pregnancy prevention programme or if they were using suitable contraception. And, the pharmacy had no printed information to give to people to educate them about the risks.

The pharmacy fridge was very full and cluttered. Pharmacy team members did not store medicines in the fridge in an organised fashion. There was no thermometer available in the fridge. And, temperatures in the fridge were not monitored or recorded. The last available temperature records were from December 2017. The SI admitted that temperatures had not been monitored since the last fridge, with an inbuilt thermometer, had broken down in December 2017. He admitted that he did not know if the fridge was maintaining medicines between the required two and eight degrees Celsius. And, he could not be certain that the medicines were safe to supply to people. There was a discussion about requirements and actions during the inspection.

The pharmacy obtained medicines from five licensed wholesalers. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). The dispenser said she checked the expiry dates of stock when she could. She had made records of checks between November 2018 and April 2019. She said it had taken her that long to check all pharmacy stock. She said that any short-dated items were highlighted with a sticker on the pack four to six months in advance of their expiry. But, the pharmacy did not have a system in place to make sure expiring items were removed before they expired. After a search of shelves, the inspector found eleven packs of expired medicines in different locations around the pharmacy, both in the downstairs dispensary and in the first-floor preparation room.

The pharmacy did not have any systems, software or equipment in place to check for counterfeit medicines. Pharmacy team members had not been trained and were unsure about the new legal requirements.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy mostly has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect confidentiality. But it doesn’t have a thermometer to check the fridge temperature is in range.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy team obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation.

The pharmacy kept sensitive information and materials in restricted areas. It positioned computer terminals away from public view. And they were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view. And, it had a shredder available to destroy confidential waste.

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.