

Registered pharmacy inspection report

Pharmacy Name: Wellbeing Pharmacy, Richmond Surgery, Richmond Close, FLEET, Hampshire, GU52 7US

Pharmacy reference: 1119591

Type of pharmacy: Community

Date of inspection: 30/09/2020

Pharmacy context

This is an independently owned community pharmacy. It is one of two owned by the same owner. The pharmacy is in Fleet. And is joined to a medical centre. The pharmacy is open extended hours. It dispenses prescriptions and sells over-the-counter medicines. And it supplies medicines in multi-compartment compliance packs (blister packs) to some people who may have difficulty managing their medicines. The inspection was conducted during the COVID-19 pandemic. The pharmacy had limited its range of services during the pandemic.

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 its risks well. And its team members have adapted their working practices suitably to minimise risks to people's safety during the COVID-19 pandemic. Team members record their errors and review them to identify the cause so that changes can be made to stop mistakes from happening again. The pharmacy has written procedures in place to help ensure that its team members work safely. The pharmacy has insurance to cover its services. Team members know how to protect people's private information and know how to protect the safety of vulnerable people. And they generally respond well to feedback.

Inspector's evidence

The pharmacy team had introduced measures to help reduce the risk of transmitting the virus in the pharmacy. It had closed off its entrance from the surgery. And instead served people through an open window. The team had also placed a plastic screen behind the window to provide a protective barrier between themselves and people on the other side of it who were standing outside. It had put builders' tape on the floor inside. The tape marked out areas for staff to stand to help them to socially distance from one another. Team members had access to PPE although chose not to wear it most of the time. They washed or sanitised their hands periodically and cleaned surfaces and equipment at the end or beginning of each day. In addition, they cleaned the card machine after every use and washed or sanitised their hands after handling money or prescription forms received from people. The number of cases of COVID-19 in the area was lower than the national average for England as published for the previous week. But the number of infections had also risen week from the week prior to that and the previous month. The inspector reminded the responsible pharmacist (RP) of the pharmacy's responsibilities to report cases of Covid-19 transmission which happened in the workplace, to the appropriate authorities.

The pharmacy had procedures for managing risks in the dispensing process. Team members discussed every incident, including their near miss mistakes, as soon as they were discovered. And they recorded them and reviewed them regularly. They did this to help prevent the same or similar, mistakes from happening again. The inspector and RP discussed the benefits of recording each near miss mistake and also the importance of recording the learnings and actions arising from them. They agreed that records should show what staff could do differently to help prevent similar mistakes in future. Including the series of checks which they should conduct while dispensing. Team members made each other aware of similarly packaged items and look-alike-sound-alike drugs (LASAs), to help prevent them from picking the wrong item. And they had separated higher risk items to separate shelves to prompt an awareness and additional checks. They had separated warfarin tablets in this way. The pharmacist also described how she spoke the name of certain medicines out loud as an additional check when dispensing them. She often did this when dispensing or checking similar medicines such as simvastatin and atorvastatin.

Team members worked under the supervision of the responsible pharmacist (RP). The RP had a notice, showing her registration details, which she displayed at the pharmacy window for people to see. The team had access to a set of documented standard operating procedures (SOPs) to refer to. Team members had read the SOPs relevant to their roles. They were observed consulting the RP when appropriate. The RP described how each team member was given responsibility for a part of the dispensing process. So that one person produced labels, another assembled the medicines, another

ordered medicines and another served on the counter. This was done so that there were several people involved in the dispensing process, providing more opportunities to spot any mistakes.

The pharmacy team responded positively to people's feedback. Team members described how they had received many positive comments from people throughout the pandemic. Particularly when the surgery next door had been closed and was providing a skeleton service only. People had expressed their gratitude to the team for helping them to manage their prescriptions and for providing them with advice. Pressure had eased in more recent weeks with a gradual opening up of GP services. But some people had been difficult to deal with and had raised their voices to staff over matters out with their control such as medicines availability. Or when, at very busy times, prescriptions were not ready as quickly as people wanted them. Whilst the team had found people's behaviour upsetting at times, they had understood the importance of staying focussed on the task in hand to ensure that the service was delivered safely. In recent weeks team had reviewed its procedures for bagging dispensed prescriptions to make them safer.

The pharmacy had a complaints' handling procedure. And it generally kept records of any complaints or dispensing incidents. But it did not receive many formal complaints. And the team preferred to deal with any customer concerns at the time. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for people and its services. Insurance arrangements were in place until 29 September 2021 when they would be renewed for the following year. The pharmacy team could access details for the local NHS complaints advocacy service and the Patient Advice and Liaison service (PALS) if necessary.

The pharmacy kept all its essential records and, in general, kept them in the way it needed to. But it still needed to ensure that its records for unlicensed 'specials' contained all the details required by the MHRA. And its emergency supply records needed a clearer description of the nature of the emergency. The pharmacy's team members understood the need to protect people's confidentiality. They discarded any unused labels and old prescription tokens into confidential waste baskets which had been placed on each dispensing bench. The contents of the baskets were shredded daily using the surgery's shredder. The pharmacy stored its completed prescriptions in the dispensary where they were out of people's view. All team members had completed appropriate safeguarding training. And could describe what they would do if they had a concern. Team members could access details for the relevant safeguarding authorities online. They had not had any specific safeguarding concerns to report.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team manages the workload safely and effectively. And team members work well together. They are comfortable about providing feedback to one another, so that they can maintain the quality of the pharmacy's services.

Inspector's evidence

This was a busy health centre pharmacy. And it had two regular pharmacists. The rest of the team consisted of a pre-reg, a pharmacy student about to begin her second year and two dispensing assistants. The RP had completed risk assessments with individual team members. And had established that they felt safe working at the pharmacy. This was confirmed by team members when asked by the inspector. Team members worked effectively together. They worked at their assigned tasks and assisted each other when required. The team was up to date with the workload of prescriptions and it attended to its customers promptly. Pharmacists could make their own professional decisions in the interest of patients. They did not have any specific targets other than to manage the daily workload while keeping each other, and people using the pharmacy, safe.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. They are sufficiently clean and secure. But they would benefit from having a greater amount of work surface and storage space. The pharmacy has made some sensible adjustments to help keep people safe during the pandemic.

Inspector's evidence

The pharmacy occupied the same building as a doctors' surgery. And the premises were small for the number of prescriptions dispensed. But the RP had organised the workflow to make the best use of space. She did this by leaving the dispensing of multi-compartment compliance aids and medicines for care homes to the weekends when it was quieter. And she managed staff rotas to ensure there were not too many team members in at any one time. The premises consisted of a small retail space with a narrow walkway into the dispensary. The dispensary was slightly bigger than the retail space with four distinct workstations for labelling, dispensing and accuracy checking. Work surfaces were well used but overall, dispensing areas were tidy and organised. The dispensary had a door which connected it with the surgery. The door was generally kept closed.

The pharmacy had a consultation room which had been clearly signposted. But the room was not being used for consultations at the time of the inspection due to the restrictions on public access to the premises. But the room was suitable for providing services and holding confidential conversations. The consultation room had two entrances one from the dispensary which was kept open when not in use. And one from the retail space which was generally kept locked. It was usually locked to prevent unauthorised access. As the room was occasionally used for dispensing work and from time to time contained patient confidential material. Confidential information would be removed or concealed before a consultation with someone.

The RP described the owner's plans to seal off the pharmacy's entrance from within the surgery and create double doors to the front from the car park, where the window was. The owner was doing this after consulting with the team about how best to reduce interaction with people using the surgery. This was part of the team's longer-term strategy towards managing the risks associated with the coronavirus. This would also involve improving the slightly raised and uneven surface on which people currently had to stand when waiting to be served at the window. These changes would also allow people to enter the pharmacy and wait undercover in poor weather.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides its services safely. The pharmacy team gets its medicines and medical devices from appropriate sources. And it stores them appropriately. Team members make the necessary checks to ensure that the pharmacy's medicines and devices are safe to use to protect people's health and wellbeing.

Inspector's evidence

At the time of the inspection, during the COVID-19 pandemic, the pharmacy had closed off physical access into the premises for people. But people could still access its services via the front window. And as described elsewhere in the report, the owner had plans to create an improved entrance to the front of the building in the following months. In the mean-time staff provided a delivery service for anyone who found it difficult to make the step up to the window or a member of the team would attend to them outside. The shop floor area was generally uncluttered although was being used to store stock in the absence of people inside the premises. When needed, the consultation room was also suitable for wheelchair access. The pharmacy had a 100-hour contract. And in general, it delivered its services in accordance with its SOPs. The pharmacy worked closely with its other branches, on which it could rely on for team support and items of stock when needed. It also had contingency plans in place, where it would work with the pharmacy close-by to ensure people got their medicines, if either pharmacy had to close or was unable to manage the workload. The pharmacy had a prescription ordering service which had seen an increase during the pandemic when the surgery had closed.

The pharmacy provided multi-compartment compliance packs for people who needed them. Team members labelled compliance packs with a description of each medicine, including colour and shape, to help people to identify them. And they included patient information leaflets (PILs) with new medicines and on a regular basis. The labelling directions on compliance packs gave the required advisory information to help people take their medicines properly. Medicines summary sheets were created for each person and checked against their prescriptions each time. Pharmacists gave advice on a range of matters. They were aware of the guidance about pregnancy prevention to be given to people in the at-risk group who took sodium valproate. And would give appropriate advice to anyone taking other high-risk medicines.

The pharmacy had introduced a new electronic patient medication record (PMR) system in recent weeks. The new system allowed staff to scan a unique barcode relating to each prescription and item dispensed. This helped to minimise picking errors or handing out errors. The system also provided a robust audit trail and could identify the stage at which a prescription was in the process and who had been involved at each stage. The system also highlighted prescriptions for high risk medicines, fridge items and CDs. This included schedule 4 CDs which, once dispensed, were generally stored along with the other dispensed prescriptions. But because they were highlighted staff could identify them more easily. This helped to ensure that they were not handed out after their 28-day expiry.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team stored its medicines, appropriately and in their original containers. And stock on the shelves was tidy. This helped the team's efficiency and made it easier for team members to find and select the item they were looking for. Since the previous inspection the pharmacy team had improved

the pharmacy's storage capacity through improved stock management and the removal of uncollected prescription items. The pharmacy team date-checked its stock regularly. It stored items in a CD cabinet and fridge as appropriate. And it monitored its fridge temperatures daily to ensure that the medication inside was kept within the correct temperature range. In general, short-dated stock was identified and highlighted. The pharmacy responded promptly to drug recalls and safety alerts and kept appropriate records. The pharmacy team had not been scanning products with a unique barcode in accordance with the European Falsified Medicines Directive (FMD). But were awaiting further instruction from the superintendent.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. And, it keeps them clean. The team uses its facilities and equipment to keep people's private information safe. But some storage facilities require maintenance so that the medicines they contain can be kept in the way the law requires.

Inspector's evidence

The pharmacy had a range of appropriate, current reference sources. And the team had access to relevant equipment to provide pharmacy services. This included counting triangles, a separate one for cytotoxic medicines and clean, crown stamped, conical measures for liquid medicines. The pharmacy had hot and cold running water with hand wash and hand sanitisers. The dispensary sink used to reconstitute medicines was clean. And computer terminals were positioned so that they could not be viewed by people. The pharmacy also had cordless phones to enable further privacy. The team used their own individual NHS Smart cards to access electronic prescriptions.

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.