General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Wellbeing Pharmacy, 2 Parsons Lane, Littleport, ELY, Cambridgeshire, CB6 1JU

Pharmacy reference: 1125445

Type of pharmacy: Community

Date of inspection: 20/08/2019

Pharmacy context

This community pharmacy is set close to a medical centre in a largely residential area of the village. It is open for 100 hours each week. Its main service is dispensing NHS prescriptions. It also supplies some medicines in multi-compartment compliance packs to people living at home and to residents in several care homes. Other services provided include Medicines Use Reviews (MURs) and a small number of New Medicine Service (NMS) checks.

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

The pharmacy identifies and manages risks adequately and it protects people's personal information. It has a process to respond to complaints. But it doesn't display information about its complaints process in the pharmacy. So, it may be harder for people to know how to raise concerns. Its team members take steps to learn from their mistakes to help prevent them from happening again. But they don't always keep a record of these, so they may miss opportunities to spot any patterns or trends and make further improvements. The pharmacy could do more to make sure all the records it needs to keep are complete.

Inspector's evidence

A new set of standard operating procedures (SOPs) had been put in place when the business changed ownership, in 2018. These included SOPs about the management of controlled drugs (CDs), dispensing prescriptions, procedures covering handover of responsible pharmacist (RP) and absence of the RP, the supply of some higher-risk medicines including methotrexate, and oral anti-cancer medicines, but there was no SOP for the supply of oral anticoagulant medicines. Most of the SOPs had been signed by the pharmacists and regular staff to show they had been read. The RP at the time of the inspection was satisfied that the SOPs reflected the activities in the pharmacy. The responsibilities of staff were set out in the procedures.

Pharmacy staff could describe what to do when handing out medicines, checking that the prescription medicines were given to the right person. Higher-risk medicines including CDs were not highlighted to staff. This could make it harder for staff to make checks about blood tests, possible side-effects, or that the prescription was still valid. For example, a prescription for pregabalin was found in the retrieval system which had not been highlighted. The prescription was still valid, but the assistant didn't know how long the prescription would be valid for. Staff were aware of when they needed to refer queries to the RP and were seen doing so during the inspection.

There were SOPs about dealing with errors, near misses and complaints. Near misses were said to be discussed with individuals and amongst the team but were not recorded routinely. The pharmacist said they would tell the dispenser about any patterns in the mistakes they found. The pharmacist provided evidence of responding to a recent dispensing error and how the pharmacy had recorded the incident and had reviewed it to identify how it had happened and any improvements the pharmacy could make to prevent similar happening again. The pharmacist explained that errors were reported to the National Reporting and Learning System by the superintendent (SI). Several improvements had been made in the pharmacy following previous mistakes or identified risks. These included separating sound-alike and look-alike medicines more clearly, for example, amitriptyline and amlodipine. And making sure that part-used packs were marked to prevent the supply of the wrong amount of a medicine.

The pharmacist was aware of the potential risks associated with self-checking and explained how they took a mental break between dispensing and checking prescriptions. There were several dispensed prescriptions that had been prepared by the pharmacist which had been set aside to be accuracy checked later. Prescriptions were assembled in one part of the dispensary then moved to a different

area for accuracy checking, to create separation of these tasks. Baskets were used to keep prescriptions for different people clearly separated.

Staff were able to explain how a complaint should be handled and would refer to the pharmacist on duty when needed. Some information about the complaints process was available on the pharmacy's website. But there was no information on display in the pharmacy which could mean people using the pharmacy are not aware of what to do if they have concerns about the pharmacy.

The pharmacy had current professional indemnity and public liability insurance. There was a notice displayed for the public showing who the RP on duty was. The electronic record about the RP was available but it hadn't been completed fully. There were several days in August and July 2019 without entries for the RP. The SI said that locum pharmacists had worked on the days, providing holiday cover, and said he would remind them of the need to make the appropriate records in future.

Records about the supply of unlicensed medicines were complete. Emergency supplies and private prescriptions were recorded electronically. Few of the occasional emergency supplies included information about the nature of the emergency. Private prescription records did not always include the correct information. For example, the prescriber's details were sometimes incorrect. The SI said the pharmacy would be more careful to make accurate and complete records for these in future. Records about CDs were generally complete. Running balances were recorded and checked. The recorded stock of an item chosen at random agreed with physical stock.

There was a SOP about protecting people's confidentiality. The new member of staff and a dispenser had not signed this yet. The pharmacist was aware of the General Data Protection Regulation but had yet to complete any training on it. One of the two regular pharmacists was using their own NHS Smartcard to access electronic prescriptions. But said they sometimes used their colleague's card as well so they could dispense and order medicines using the two computer terminals in the dispensary at the same time. They were reminded about keeping these cards and passwords secure. Confidential waste was separated from normal waste and was shredded on site. There was no private information on show to the public.

To help ensure vulnerable people could be protected, the pharmacy had a SOP for safeguarding. The RP had completed level 2 safeguarding training. They were not aware of any concerns the pharmacy had encountered about safeguarding matters and knew where to find current contact details for safeguarding agencies if they did have a concern that needed reporting.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members manage their workload appropriately, using quieter times to complete tasks which need particular care. The pharmacy has processes to assure itself that new starters have the right qualifications for their roles. Pharmacy professionals can act in the best interests of the people who use the pharmacy, and this is not affected by any targets.

Inspector's evidence

There were two pharmacists on duty during the inspection, one of whom was the SI. These pharmacists split most of the RP cover between them. The pharmacists tried to have overlap each day to enable them to have breaks and to support good handover processes. They were coping with the workload during the visit and said that some of the dispensing and checking activity, particularly the compliance packs, could be done in the evenings when it was quieter and there was less walk-in trade.

A dispenser was said to be on holiday and another was on long term absence. A student new to the pharmacy was working on the counter and in the dispensary under close supervision of the RP. The SI was made aware of the minimum training requirements for pharmacy support staff. The pharmacy had recruited a full-time dispenser who was due to start the following month. The SI had requested to see their accredited training certificate. The delivery driver was on holiday so one of the pharmacists was doing medicine deliveries in the meantime.

When asked, the student assistant was able to describe what he could and could not do if there was no pharmacist present. He was observed referring all queries including requests for over-the-counter medicines to a pharmacist during the visit.

The staff were said to have annual performance reviews. The pharmacist explained how these reviews were used to identify skills and knowledge gaps which would then be supported through ongoing training. Promotional literature about new products was shared with staff. And there were said to be informal team discussions about issues or incidents that had occurred and to provide updates to the team. Details about these weren’t recorded. The pharmacists said that targets for some services were set by the company but there was no undue pressure to achieve these. And these did not affect their ability to exercise their judgement to act in the best interests of people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, safe, and well-maintained. And they provide a suitable environment for the services it provides.

Inspector's evidence

There was ramped access to the front entrance of the pharmacy and the door was wide enough to accommodate prams or wheelchairs. The shop floor area was kept clear of clutter or trip hazards. Medicines stock was kept off the floor. Access to the dispensary was restricted. Members of staff had good visibility of the medicine counter and pharmacy-only medicines were stored out of reach of the public. The premises were generally clean, bright and well-maintained. They had been refitted in recent years. The room temperature was appropriate for storing medicines and could be controlled. Lighting was adequate for safe dispensing.

There was a small consultation room, accessed from the shop floor, and this was clean and well-screened. It was accessible to people with wheelchairs. There was no sink or access to patient medication records in this room.

The pharmacy could be secured against unauthorised access. There were handwashing facilities available for staff though one of the sinks needed cleaning. Soap and hot and cold running water were available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's services are managed appropriately, and it gets its medicines from reliable sources so they are safe to use. The pharmacy makes its services available to people over extended hours. It gets its medicines from reputable suppliers. But the lack of records for date checks could increase the chance of some stock being missed. And because it doesn't always provide people with the leaflets that come with their medicines, some people may not get all the information they need about their medicines.

Inspector's evidence

The pharmacy's opening hours were displayed at the entrance. The extended opening hours meant that people in the local area could access pharmacy services at this location when other providers were closed. There was a limited range of health leaflets about self-care displayed in the retail area. There was no practice leaflet displayed which could mean that people don't know about all the services the pharmacy provides. But there was some information about the services provided and opening hours on the company's website.

The pharmacy delivered medicines to some people. There was an audit trail for this service to show that medicines had reached the right people. Medicines were not posted through letterboxes or left unattended.

There was evidence seen which showed the responsible pharmacist had completed appropriate training about supervised consumption. Prescriptions for this service were annotated when doses were not collected, and the prescribers were contacted when consecutive doses were missed. The pharmacy separated prescriptions that should have been sent elsewhere and kept these secure. The pharmacist was advised to let the clinic know when this happened in future, so all prescriptions could be accounted for.

The pharmacy supplied some medicines to residents in care homes. Care home staff ordered the prescriptions and the pharmacy were kept informed about any changes to people's medication. If there were unexpected changes, the pharmacist contacted the care home to query these. The medication record system used provided barcoded labels and enabled the care home to readily scan medicines and record when medicines were issued. It also captured a screenshot of the prescription for reference by the pharmacy and the care home. Most of the medicines taken regularly were supplied in multi-compartment compliance packs. These packs were sealed in the pharmacy as soon after dispensing as possible to reduce the risk of mistakes or contamination. The pharmacist was aware of issues regarding covert administration and would only provide advice about this where there was evidence that a prescriber had authorised its use. The pharmacy didn't routinely provide care homes with patient information leaflets but the pharmacist said they would do so in future.

The pharmacy also supplied medicines in compliance packs to some people who lived in their own homes. The packs seen were labelled with the dose and a description of the medicines added. There was an audit trail on the packs to show who had dispensed and checked each pack. The pharmacist explained how any mid-cycle changes were handled; packs were retrieved from people, the changes

made, and then redelivered. Patient information leaflets were not generally supplied beyond first issue. The pharmacist said they would do so routinely in future. There was no automatic process to inform prescribers if packs intended for weekly supply were not collected. Doing so might help to identify any compliance issues that needed further support.

The pharmacy had the current safety literature about pregnancy prevention to provide to people when supplying valproate. When discussed during the inspection, the pharmacist was not fully aware of all the updated guidance about supplying this medicine safely and said they would do further reading on the subject.

The pharmacy got its medicines from several licensed suppliers. Medicines were generally stored in an organised manner on shelves in the dispensary. But storage space was limited, and some medicines were not clearly separated which could increase the chance of selection errors. A small number of tablets in unmarked containers were found amongst dispensing stock. These were said to have been mistakenly removed from blister strips when preparing compliance packs. They were removed from stock during the inspection and an assurance given that containers would be fully labelled if the same happened in future. There were no out-of-date medicines found amongst dispensing stock and waste medicines were stored in designated bins. The pharmacy did not keep records of date-checks undertaken but said this was done regularly. Keeping a record of checks would make it easier for the pharmacy to be sure that all parts of the dispensary were checked. Most liquid medicines had the date of opening added to the container when needed so dispensers could assess that the medicines were still safe to use.

Medicines that required refrigerated storage were kept in the pharmacy fridge. Maximum and minimum fridge temperatures were monitored but not always recorded every day. There was sufficient storage capacity in the fridge and no evidence of ice build-up. The records viewed showed the temperatures had remained within the required range and the thermometer showed that the temperature at the time of the inspection was within this range.

The pharmacy received alerts about medicine recalls and safety alerts and the pharmacist was aware of the most recent notification. The pharmacist explained how they responded to drug recalls by checking stocks and quarantining any affected medicines, if needed. The pharmacy staff didn’t keep a record of any follow up actions they took but said they would do so in future. The pharmacy had the scanning equipment it needed to comply with the Falsified Medicines Directive. Staff had yet to be trained in its use and SOPs were still to be developed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And these are generally well maintained.

Inspector's evidence

The electronic patient medication record system was only accessible to pharmacy staff and computer screens could not be viewed by the public. The pharmacy had cordless phones, so staff could move to private areas to hold phone conversations out of earshot of the public. The premises could be secured against unauthorised access.

Staff had access to a range of reference sources, so the advice provided to people was based on up-to-date information. The equipment used for measuring liquids was of an appropriate standard and was clean though required some descaling. Some measures were used solely for measuring CDs to prevent cross-contamination. There were denaturing kits available to ensure medicines were destroyed safely.

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.