General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Welcome Health Pharmacies Limited, The Library Site, Glebe Road, Bedlington, Northumberland, NE22 6JX

Pharmacy reference: 9010570

Type of pharmacy: Community

Date of inspection: 16/08/2023

Pharmacy context

This is a busy pharmacy located next to a doctor's surgery in Bedlington, Northumberland. Its main activities are dispensing NHS prescriptions and providing people with their medicines in multi-compartment compliance packs to help them take their medicines correctly. It provides NHS services including the hypertension case finding service and supervises the administration of medicines to some people. This pharmacy recently changed ownership, but the same team members work in the pharmacy as before.

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 team follows written procedures to help ensure it delivers its services safely and effectively. It keeps the records required by law. Team members discuss their mistakes and record them so that they can learn from them. They keep people's private information secure, and they know how to protect vulnerable people and children.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) that were relevant to its practice. These included controlled drug (CD) and responsible pharmacist (RP) SOPS. And it had SOPs for the patient medication record (PMR) system, which used barcode scanning technology and supported the accuracy check of dispensed medication. The SOPs helped inform team members how to complete tasks safely and effectively and they were available in paper form for easy referencing. They had been written and authorised by the superintendent pharmacist (SI) and the pharmacist owner, except for the SOPs for the automated PMR system which were provided by the PMR company. The pharmacy's main SOPs were annotated with the date of first use and date of planned review. But the automated PMR SOPs did not have this information. The SOPs had been entirely replaced when the pharmacy recently changed ownership and team members were progressing through reading and signing the new SOPs to confirm their understanding and compliance with them.

The pharmacy recorded errors identified during the dispensing process so that the team could learn from them. The team member who made the error was responsible for recording the details of the error when it was identified by the pharmacist. The errors were recorded on paper and the records showed that entries had been recorded each month since the takeover. The volume of near misses recorded was low. The pharmacist explained that the automated technology within the PMR system helped reduce the number of near misses produced, as the system identified near misses, such as when an incorrect medicine had been scanned, and alerted the dispenser by sounding a warning. Every two weeks the pharmacist used the information from the near miss log to identify trends. She explained the automated technology did not identify errors involving incorrect quantities, and it was mostly errors of this type that had been recorded. The team members informally discussed the errors in daily 'huddles' and made suggestions for change. For example, medicines that looked-alike or sounded-alike were separated on the storage shelves to help prevent future incorrect selection. And when medicines were prescribed in quantities different from the original pack size, a second quantity check was completed by an experienced dispenser before the final accuracy check by the pharmacist. There was also a procedure in place to record dispensing errors that were not identified until after a person had received their medication. The SI confirmed the process was to investigate the error and report the incident to the relevant authorities, including the NHS and the person's GP. There had been no such dispensing errors recorded since the pharmacy had changed ownership.

Team members were experienced in their roles and were able to describe the tasks that they were responsible for. The pharmacy had an SOP that detailed the roles and responsibilities for each person. The RP notice was prominently displayed in the retail area and reflected the details of the pharmacist on duty. The pharmacy did not have a complaints policy displayed to advise people how they could make complaints or give feedback. However, the supervisor explained how she would attempt to resolve any complaints and, if unresolved, that she was able to escalate to the SI, who worked

frequently in the pharmacy, or contact the owner. She confirmed this process had not needed to be engaged since the takeover and that feedback received had been positive. For example, people using the pharmacy had given positive feedback regarding the implementation of a free delivery service. Current professional indemnity insurance was in place.

The pharmacy used mostly electronic records, except for the records of CDs that had been returned by people who no longer needed them, which were kept on paper. The electronic CD register recorded all required details. Running balances were recorded and team members checked CD stock against the running balances weekly, and every time a medicine was received or supplied. A check of two randomly selected CDs matched the recorded balance. Records of patient returned CDs showed they were destroyed in a timely manner. Records of the RP on duty and records of the supply of unlicensed medicines were in order. Team members were unable to access the correct private prescription register during the inspection, but the owner subsequently explained that entries were automatically recorded in the PMR system when dispensed.

Team members were aware of their responsibilities to ensure that people's private information was kept secure. There was an SOP for staff to refer to regarding the requirements of information governance (IG) and General Data Protection Regulation (GDPR), and there was a privacy policy on display in the consultation room. Confidential waste was separated for destruction by a third-party company.

Team members were aware of their responsibilities for safeguarding vulnerable adults and children. The pharmacy had a policy which had been reviewed and updated by the SI in May 2023. And team members had signed to say they had read it. The delivery driver explained he understood his responsibility to report to the pharmacist any concerns regarding people he was delivering medicines to. There was a chaperone policy on display in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably trained team members to manage the workload and deliver its services safely and effectively. There is an open and honest culture within the team, and they feel comfortable raising concerns if they need to.

Inspector's evidence

At the time of the inspection there was a pharmacist, who was the RP and SI, four trained dispensers and two trainee dispensers. Additionally, there were two trained dispensers not present. There was a part-time delivery driver who the supervisor thought had been trained for his role under the previous employer but was aware of the requirement to enrol the driver on a course if this was not the case. All team members had been employed by the previous owners, with some having worked in the pharmacy for many years and some who had joined just prior to the takeover. They were observed working well together to manage the workload. The SI explained that a relief pharmacist covered her absences and provided consistency of cover. And staff from other branches covered dispenser absences if needed. Team members were encouraged to complete ongoing training and the SI explained the current focus for the team was fully implementing the SOPs. Team members had been trained to take people's blood pressure, and their competency was assessed by the pharmacist. The supervisor was due to be enrolled on an accuracy checking course.

A dispenser described the questions she asked people before selling over-the-counter medicines to make sure they were suitable. And team members knew to be vigilant for repeated requests for medicines liable to misuse, and referred these to the pharmacist. Team members felt able to discuss their mistakes openly and felt comfortable to raise concerns. They knew who to raise concerns with and had direct access to the SI and owner if needed. But they were not aware whether a whistleblowing policy was in place. Team members received monthly performance reviews from the relief pharmacist and these were recorded.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and provides suitable space for the services it delivers. It has an appropriately soundproofed room where people can access services and have private conversations with team members.

Inspector's evidence

The pharmacy was clean, tidy, and free from clutter. And it portrayed a professional appearance. The retail area and dispensary were spacious. Team members had rearranged medicines since the takeover, and these were stored neatly and alphabetically on shelves. There was a good workflow with different benches for team members to complete different tasks. Dispensing of multi-compartment compliance packs was completed on a small bench space in the staff room, which was kept clean. But this only happened outside break times and the pharmacist intended to move this activity to a more appropriate space. The medicines counter acted as a barrier between the retail area and the dispensary to prevent unauthorised access. The dispensary was not in view of people in the retail area so dispensing tasks could take place without distraction. And the pharmacist's checking area was situated in the dispensary behind the medicines counter so that they were able to intervene in conversations at the medicines counter if necessary.

The pharmacy had a soundproofed consultation room where people could have private conversations with team members. The room had a desk, two chairs and various lockable cupboards. There was appropriate space in the room to allow services to be provided safely. There was a sink in the consultation room which provided cold water only. The consultation room was not lockable, and it was situated so that pharmacy staff may not notice anyone entering. The pharmacist agreed to ensure that equipment such as sharps bins were kept locked in the consultation room cupboards when not in use to prevent unauthorised access. The pharmacy had a cleaning rota displayed on a wall in the dispensary which detailed which areas of the pharmacy were to be cleaned. There was a sink in the dispensary for professional use and for handwashing. And the toilet facilities were clean, hygienic, and provided hot and cold water and soap for handwashing. The lighting was bright throughout the dispensary and the temperature was comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally manages the delivery of its services well. And it has suitable procedures to ensure people receive their medicines when they need them. But when the pharmacy supplies valproate medicines, team members do not always provide people with important information about the risks. Team members store and manage medicines as they should. And they carry out checks to make sure medicines are kept in good condition and suitable to supply.

Inspector's evidence

The pharmacy had level access from outside. There was a ramp and an automatic door which helped provide access to people with limited mobility or with pushchairs. The pharmacy delivered some people's medicines to their homes. People's names and addresses were put on a sheet which the driver used to confirm deliveries for the day. And the sheet was annotated to highlight any fridge or CD items present. The supervisor explained the team used an electronic device to take a picture of the delivery sheet so they could answer any queries from people about whether their medication was out for delivery. The driver confirmed that fridge items were prioritised for delivery and that people were asked to sign for their CD deliveries.

The pharmacy provided a range of services including the hypertension case finding service, smoking cessation, Community Pharmacy Consultation Service (CPCS) and treatment and advice for urinary tract infections. Appropriate records were kept.

When dispensing, team members kept people's prescription forms and medicines together in baskets to help prevent errors. An electronic audit trail was kept on the automated PMR system that indicated who had dispensed a medication and who had checked it. The pharmacy normally dispensed valproate in original manufacturer's packs, but also supplied it for a few people re-packaged into compliance aids. When questioned, some team members were aware of the risks associated with the use of valproate during pregnancy and knew they were supposed to supply information about this when valproate was dispensed. The pharmacist admitted she was unaware of the requirements of valproate pregnancy prevention programme. All original packs of valproate that the pharmacy had in stock included appropriate information and warnings about the risks. But some team members were unaware that they needed to be careful not to cover the perforated cards included with the manufacturer's packs when they were attaching dispensing labels. So there was a risk that important information could be covered up. And the team did not have any spare warning cards or educational material so could not provide this information when they supplied the medicines in compliance aids. But they subsequently confirmed that the pharmacy did not currently supply any patients who met the risk criteria.

The pharmacy dispensed some medicines into multi-compartment compliance packs to help people take them at the right times. A dispenser was the main person responsible for managing the service, alongside the RP. Each team member was trained to dispense the packs so that holidays and absences could be covered. The dispenser explained that prescriptions were ordered a week in advance so any queries could be resolved with the GP. Each person had a record of their medicines to be supplied in the packs and the times of day each medicine should be taken. And communications regarding changes to medication were kept within the record. Packs that included CDs were made up weekly due to lack of storage within the CD cabinets. Some compliance pack patients received medicines that may lose stability when removed from their original packs. The pharmacy team had spoken to the patients or

their carers about whether these medicines could be supplied separately. But if they needed to be dispensed in the compliance pack, they were not added to the pack until the day they were due to be supplied. And a note was added to the patient medication record to show that the patient had been counselled and had given consent. The pharmacy provided patient information leaflets with the packs, so people had the necessary information to take their medicines. And they included descriptions on the labels to help people identify the individual medicines.

Team members completed monthly expiry date checks of stock medicines. They highlighted medicines that were going out of date in six months with a 'short dated' sticker and recorded these in a diary. They removed medicines with an expiry date of three months or less. Liquid medicines with a short expiry date on opening were marked with the date of opening. A random sample of dispensary stock was checked, and the medicines were all found to be in date. The pharmacist confirmed that packs were scanned by the automated PMR system during the dispensing process and any out of dates would be highlighted by the system. Medicines in the fridge were kept neatly and well organised. Team members recorded daily fridge temperatures electronically and these were in order. Patient returned medicines were kept separately for destruction and pharmacy medicines were stored either behind the medicines counter or within clear plastic boxes with a notice that instructed people to ask for assistance. Team members understood the process for managing drug alerts and medicines recalls. These were received by email or via the wholesaler. And the team kept records to show what action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses the equipment and facilities in a way that protects people's private information.

Inspector's evidence

The pharmacy had access to paper copies of the British National Formulary (BNF) and British National Formulary for children (BNFc). It used stamped measuring cylinders that were marked for measuring water and liquid medicines. A blood pressure machine was marked with the date of first use. This date was more than two years previous and there was no record of it being checked or calibrated in the meantime. The pharmacist ordered a new machine to provide assurance that any future readings would be reliable.

Team members used a cordless telephone so that conversations could be kept private. Computers were protected against unauthorised access as they were password protected. Each staff member had their own smartcards, but two team members were unable to use theirs. Screens were positioned so that only team members could see them. Prescription forms were stored within the dispensary in a way that prevented people in the retail area from seeing any private information.

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.