General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Welfare Pharmacy, Hobson Square, Hobson Avenue, Trumpington, Cambridge, Cambridgeshire, CB2 9FN

Pharmacy reference: 9010866

Type of pharmacy: Community

Date of inspection: 20/02/2024

Pharmacy context

This pharmacy is located in Trumpington, Cambridge. It dispenses NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them take their medicines at the right time. The pharmacy provides other NHS services such as the New Medicine Service, the Community Pharmacy Consultation Service, and the Hypertension Case-Finding service.

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 has written procedures to help its team provide services in a safe and effective manner. Members of the team record their mistakes so that they can learn from them. They largely keep the records they need to by law. They keep people's information safe and are aware of the actions to take to help protect the wellbeing of vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which covered the services that it provided. The superintendent pharmacist (SI) had reviewed them in August 2023. Its team members had read the SOPs and they signed a training record matrix to show this. Individual SOPs did not detail which team members they were directed at based on their roles. So, it may be unclear who is responsible for each part of the process detailed in the SOPs. However, members of the team appeared to be knowledgeable about their roles and when to seek advice from the pharmacist. They were also aware of the activities that could not be completed in the absence of a pharmacist. The SI provided an assurance that the SOPs would be updated to reflect which roles of the pharmacy team they were aimed at.

The pharmacy maintained a record of near misses on a near miss log. This is when a mistake is identified upon completion of an accuracy check in the pharmacy. The mistake was highlighted to the team member involved and they were required to identify the mistake as part of the learning process. They would then correct the mistake and the pharmacist would make a record of the mistake. The SI explained near misses were reviewed each month and the findings were shared verbally so that they could learn from the mistakes that had occurred. Members of the team instilled changes following a review of the near misses to help reduce the reoccurrence of common mistakes. An example of this was the physical separation of amlodipine and amitriptyline. The pharmacy had a process in place for recording dispensing errors. This is when a dispensing mistake occurs but is not identified before the medicine is supplied to a person. A dispensing error report was completed on the pharmacy computer and discussed with members of the team to raise awareness and instil any preventative measures to help try and reduce similar errors reoccurring.

The pharmacy largely maintained the records it needed to by law. Records for controlled drugs (CDs) were kept electronically on the pharmacy computer. The running balances of CDs were recorded and checked against the physical stock regularly. Members of the team made a separate record of patient-returned CDs and signed the record when destruction of these medicines had been completed. A random sample of the recorded balances were checked against the physical CD stock and found to be correct. The pharmacy dispensed private prescriptions and made a record in a prescription register. But the details of the prescriber were missing from most of the entries. The SI provided an assurance that the details of the prescriber would be added to the entries going forwards. Responsible pharmacist (RP) records and records for unlicensed medicines that had been supplied to people were complete and met the requirements.
The pharmacy had professional indemnity insurance which covered the services it provided. And it advertised how people could raise a complaint or provide feedback. Its team members explained they would try and resolve any complaints verbally but would escalate the complaint to the SI when this was

not possible.

Pharmacy team members were aware of how to keep people's information safe, and they had all signed a confidentiality agreement. They used the consultation room to have private conversations with people and separated confidential waste which was shredded by members of the team. Documents that contained people's information were kept secure from unauthorised access. The pharmacy had an SOP about safeguarding vulnerable people which its team members had read. When questioned, team members were able to explain the signs to look out for which may indicate a safeguarding issue. This included physical signs of abuse such as bruising or behaviour changes that may indicate abuse. The details of the local safeguarding contacts were readily available if a concern needed to be raised.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members to safely provide its services. Members of the team feel comfortable about raising concerns and providing feedback.

Inspector's evidence

The pharmacy team consisted of a regular pharmacist, who was the SI, three qualified dispensers and four medicines counter assistants. There was also a foundation trainee pharmacist who was on leave. All team members were qualified for the roles they fulfilled.

Members of the team were aware of their roles to help manage the workload safely and effectively. One team member explained their job was to label prescriptions and assemble medicines for people who received multi-compartment compliance packs. Another team member was helping assemble prescriptions for people who were waiting in the pharmacy to be supplied their medicines. Team members explained the questions they would ask when selling pharmacy medicines. And they identified medicines that are liable to misuse. In such cases, they would refer to the pharmacist if they felt the sale was inappropriate or if repeated requests were made. The pharmacy team members were seen working well together and they supported each other as people entered the pharmacy during busy periods.

There were enough trained team members, and they were seen managing the workload safely. The pharmacy completed annual appraisals with its team members to discuss how they had performed and to help identify any future training needs. But there was no structured ongoing training in place once team members had qualified for their role. This may mean that any new learning opportunities are missed.

Targets were not in place, but one dispenser explained that they sometimes set themselves a personal target to reduce the number of near misses they made. Members of the team also felt comfortable raising concerns or providing feedback to the pharmacy manager. Informal team meetings were held to help members of the team prioritise workload and delegate tasks for the day.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services that the pharmacy provides. And it has a consultation room available for people to have a private conversation with its team members.

Inspector's evidence

The pharmacy was clean and organise. It had adequate lighting and maintained a suitable ambient temperature to provide services in a safe manner. The dispensary area was behind the front counter and unauthorised access was restricted. The pharmacy had adequate bench space to safely assemble prescriptions. A sink with hot and cold water was available. It was clean and suitable for preparing medicines that required mixing before being supplied to people.

A consultation room was available for people to have a private conversation or receive a pharmacy service. It was clean and tidy which helped maintain a professional appearance. It was large enough for the services that the pharmacy offered. Suitable staff facilities were available which included a small kitchen area, washroom and rest area. The pharmacy was secured when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers services that are easily accessible and provides them safely. It obtains its medicines from licensed sources and generally stores them appropriately. Its team members provide advice to people when supplying higher-risk medicines to help make sure they are used correctly.

Inspector's evidence

The pharmacy had a ramp leading to the entrance making it easily accessible for people with a wheelchair or pushchair. The entrance was wide and led into the retail area of the pharmacy which had some seating for people to wait to receive a service. The opening hours of the pharmacy were displayed on the entrance door. A range of health information leaflets were situated in the retail area for people to access if they required additional health related information.

The pharmacy provided some NHS services including the New Medicine Service, the Community Pharmacy Consultation Service, the Hypertension Case-Finding service, and the Pharmacy Contraception service. It was also preparing to offer the new Pharmacy First service, but the SI explained that some of the diagnostic equipment had not arrived. The main workload was dispensing NHS prescriptions. Prescriptions were placed into baskets to prevent them getting mixed up. And different coloured baskets were used to help prioritise the workload and help make it easier to identify medicines that needed to be delivered to people's homes. Team members initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels to help identify who was involved in both processes if a query arose.

Medicines that required special storage conditions, such as fridge items or CDs, were highlighted on prescription bags using stickers so that they could be added before the medicines were supplied. The pharmacist also attached stickers to medicine bags if they needed to provide additional advice to people. This served as a reminder to team members. CD stickers were also used to prompt members of the team to check the prescription for a schedule 2 or 3 CD was still valid at the time of supply.

The pharmacy supplied some people with medicines in multi-compartment compliance packs. It made a record of the medicines that people were supplied with in the packs. And it used the records to check any changes that the prescriber had made. Copies of discharge letters for people leaving hospital were stored so that an audit trail of any changes was maintained. The prescriptions were ordered by the pharmacy team and checked against each person’s record to make sure their medicines had been prescribed correctly. The pharmacist clinically checked the prescriptions before the packs were labelled and assembled. The pharmacist then completed an accuracy check to make sure medicines had been dispensed correctly. Completed packs had the appropriate warning labels printed on them. The description of the medicines supplied were included to make it easier for people to identify the individual medicines. And patient information leaflets were supplied each month so people could access additional information about their medicines.

Education materials were provided to people taking valproate containing medicine to highlight the risks. And the pharmacist was aware of the requirement to supply people with original packs so that the warning card and patient information leaflet were supplied each time. The pharmacist also provided additional advice to people being supplied with methotrexate and warfarin to help make sure the

medicines were being used safely.

The pharmacy obtained its medicines from licensed sources, and it stored them securely to prevent unauthorised access. Its team members checked the expiry dates of medicines every three months and made a record of the area of the dispensary that had been checked and by who. Medicines that were short dated were highlighted with a red sticker. Some liquid medicines that had been opened did not have the date of opening written on the packaging to help team members make sure they were safe to supply to people. The SI separated the affected medicines for disposal as soon as this was pointed out. The expiry dates of some medicines were checked, and none were found to be expired. Medicines with special storage requirements were stored appropriately. CDs were stored in a secure cabinet and date-expired stock and patient returns were clearly marked and separated. Medicines that required cold storage conditions were stored in a suitable fridge. The temperature of the fridge was seen to be in the required range and the pharmacy kept a daily record of the temperatures.

The pharmacy received drug alerts and safety recalls by email and electronically within the pharmacy computer. Its team members checked the pharmacy for any affected stock and made a record of the actions taken. A recent example included a safety recall of Evorel Sequi patches. Members of the team had printed a report from the pharmacy computer to identify people who had been supplied with the patches and contacted them to return the patches back to the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to safely provide its services. And its team members use the equipment appropriately to provide services in an effective manner.

Inspector's evidence

The pharmacy had a selection of clean calibrated glass measures to help its team members measure liquid medicines. And it stored measures that were used for higher risk medicines in the CD cabinet to prevent cross-contamination. Clean counting equipment was also available for tablets and capsules. Electrical equipment was in good working order. The pharmacist explained they use the internet to access resources such as the British National Formulary (BNF).

The pharmacy had three computer terminals installed which held people's clinical records. The screens were not visible to members of the public and the computers were password protected to prevent unauthorised access. Members of the team used cordless phones so they could have conversations without being overheard by people.

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.