General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Medical Hall, 59 High Street, Pendre, CARDIGAN, Dyfed, SA43 1JR

Pharmacy reference: 1043225

Type of pharmacy: Community

Date of inspection: 20/06/2019

Pharmacy context

This is a town centre pharmacy that sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. During the summer months many holidaymakers use the pharmacy as it is in a popular tourist area. The pharmacy provides a wide range of services including emergency hormonal contraception, treatment for minor ailments and a seasonal flu vaccination service for NHS and private patients. Substance misuse services are also available. The pharmacy is open until 5pm on Wednesdays, 5.30pm on other weekdays and 1pm on Saturdays.

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	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
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 make sure the team works safely. But its team members do not always record or review their mistakes. So it is likely that some chances to learn from them might be missed. The pharmacy's team members generally keep the records they need to by law. But sometimes they forget to record information. This means some records may not be reliable or meet legal requirements. The pharmacy asks people to give their views about the services it provides. And it keeps people's private information safe. Its team members understand how to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

The pharmacy had some systems in place to identify and manage risk, including the recording of dispensing errors and near misses. Staff said that the pharmacists tended to discuss near misses with them at the time of each occurrence rather than analyse all incidents on a regular basis to identify patterns and trends.
The branch manager demonstrated that following a recent direction from the superintendent's office to put extra safety measures in place for 'look alike, sound alike' or 'LASA' drugs that were repeatedly the subject of patient safety incidents, they had separated atenolol, allopurinol, amlodipine and amitriptyline tablets on dispensary shelves. A poster listing examples of these drugs and the risks associated with selection errors was displayed in the dispensary.

A range of written standard operating procedures (SOPs) underpinned the services provided; these were regularly reviewed. The pharmacy received regular customer feedback from annual patient satisfaction surveys. The branch manager said the results of the most recent survey were mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in a poster displayed on the consultation room door.

Evidence of current professional indemnity insurance was available. All necessary records were kept and generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, specials procurement and controlled drug (CD) records. However, entries in the RP register for 19 to 21 December 2018, 5 January 2019 and 18 April 2019 were missing. Some recent entries had been made using 'ditto' marks rather than being fully completed by the pharmacist in charge.
CD running balances were typically checked weekly or fortnightly. Running balance checks made for methadone in the recent past sometimes showed small deficits that were accompanied by the explanation 'loss due to measuring'. The branch manager and locum pharmacist explained that until recently the pharmacy did not have a validated 10ml measuring cylinder with which to accurately measure volumes below 10ml and oral syringes had been used. They demonstrated that a validated 10ml measure was now in place and said that loss due to measuring was no longer an issue.

Staff received annual training on the information governance policy and had signed confidentiality agreements as part of this training. They were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. Individual staff members had unique passwords that the system prompted them to change at regular intervals.

The pharmacist and pharmacy technicians had undertaken formal safeguarding training and had access to guidance and local contact details that were available via the internet. Some staff had received in-house training. Three trainee dispensing assistants who had worked at the pharmacy for under three months had not yet received safeguarding training. They were able to identify different types of safeguarding concerns and said they would refer these to the pharmacist, who confirmed that he would report concerns via the appropriate channels where necessary. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough staff to manage its workload safely. But it relies heavily on temporary pharmacists and part-time staff. This lack of continuity means it sometimes cannot provide its services as effectively as usual. The pharmacy's team members complete regular training and have a good understanding about their roles and responsibilities. They feel comfortable about speaking up about the way the pharmacy is managed.

Inspector's evidence

Locum pharmacists oversaw all professional activities. They were assisted in the day-to-day operation of the pharmacy by the branch manager, a qualified dispensing assistant who had worked at the branch for nearly a year on a temporary secondment. The locum pharmacist present said that he worked at the pharmacy from Monday to Wednesday each week.

The staffing level appeared adequate for the services provided. Staff members present were competent and professional and did their best to manage the workload, but it was clear that they were under some pressure as the pharmacy was unexpectedly busy with a backlog of work to deal with. Staff members had the necessary training and qualifications for their roles. Three recently-recruited trainee dispensing assistants worked under the pharmacists' supervision.

Two experienced dispensing assistants were absent on long-term leave and the branch manager said that their roles were being covered by a dispensing assistant who was absent that day and a trainee dispensing assistant. He said that the company were currently trying to recruit a regular pharmacist but had not had any success as yet.

Targets were set for MURs but these were managed appropriately and the regular locum pharmacist said that they did not affect his professional judgement or patient care. Staff worked well together. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists, branch manager, area manager or superintendent's team. A poster advertising a confidential helpline for reporting concerns outside the organisation was displayed in the dispensary.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients and referred to the pharmacist on several occasions for further advice on how to deal with a transaction.

Staff undertook online training provided by the organisation on new products, clinical topics, operational procedures and services. They had recently received training on the Falsified Medicines Directive as well as training provided by NHS Wales on improving the quality of services provided. The pharmacy technician said she understood the revalidation process. She had recently submitted her continuing professional development (CPD) portfolio and based her entries on situations she came across in her day-to-day working environment as well as training provided by the company. The branch manager said that staff had not received formal appraisals for two or three years. He demonstrated that he had begun the process by asking them to complete self-assessment forms and said he was planning to conduct one-to-one appraisals in July. All staff could discuss performance and development

issues informally with him whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean, tidy and secure. It has enough space to allow safe working and its layout protects people's privacy.

Inspector's evidence

The pharmacy was housed in an old building and the décor was in need of refreshment. The branch manager had reported a leak in the stairwell ceiling that appeared to originate from one of four upstairs flats; a contractor arrived during the inspection to investigate and resolve this. The pharmacy was generally clean, tidy and well-organised, although the floor in the pharmacy basement was very untidy. The pharmacy technician was assembling multi-compartment compliance aids on a large table in this area and the floor was littered with empty tablet packaging, leaflets and some loose tablets. The branch manager said that he was aware that the floor needed to be cleaned and staff were planning to do this as soon as the pharmacy was less busy.

There was limited workbench space, and this was quite cluttered, although there was enough space for safe working. Some stock was temporarily stored on the floor in the dispensary and retail area. The branch manager said that there was a plan to relocate the pharmacy to a larger, purpose-built premises in a nearby medical centre in 2020.

The sinks had hot and cold running water and soap and cleaning materials were available; a poster describing hand washing techniques was displayed above the sink. A consultation room was available for private consultations and counselling and its availability was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes the services it provides so that people know about them. If it can't provide a service it directs people to somewhere that can help. The pharmacy's working practices are safe and effective. And it generally manages medicines well. But it doesn't always make sure that people taking high-risk medicines are given additional advice they may need to use their medicines safely.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. Staff said that they would signpost patients requesting services they could not provide to other nearby pharmacies. The pharmacy was located in a Welsh-speaking area. Most staff members were fluent Welsh-speakers and several transactions were observed to take place through the medium of Welsh.

The pharmacy technicians had visited the local district nurses and nearby opticians to discuss and promote services as part of a health board-funded collaborative working initiative. Recent visits had involved discussions around the repeat dispensing service and the common ailments service.

The pharmacy dispensed an average of 9,500 prescription items each month. It supplied medicines in multi-compartment compliance aids for about 110 patients.

Dispensing staff used a colour-coded basket system to ensure that medicines did not get mixed up during dispensing and to differentiate between different prescriptions. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Controlled drugs requiring safe custody, fridge lines and compliancwe aids were dispensed in clear bags to allow staff members to check these items at all points of the dispensing process and reduce the risk of a patient receiving the wrong medicine.

The pharmacy received large numbers of faxed prescriptions due to its rural location and the recent closure of a local surgery. One faxed prescription waiting to be dispensed was unsigned and some others included Schedule 2 and 3 CDs. However, staff said that medicines would not be supplied against unsigned faxes and that schedule 2 or 3 CDs were only ever supplied against the original prescription.

Stickers were used on prescriptions awaiting collection to identify patients eligible for an MUR and to alert staff to the fact that a CD or fridge item was outstanding. The branch manager said that pharmacists attached a note to the prescription bag if they wished to speak to the patient or their representative at the point of handout, although there was no evidence available to reinforce this. Dispensed schedule 3 and 4 CDs awaiting collection were marked with the date after which the prescription was invalid and could no longer be supplied.

Patients prescribed high-risk medicines such as warfarin, lithium or methotrexate were not routinely identified and there was a risk that opportunities for counselling might be missed. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacy carried out regular high-risk medicines audits commissioned by the Local Health Board. Results showed that one patient prescribed valproate who had met the criteria for risk had been counselled and provided with patient information. Steroid cards and warfarin, methotrexate and lithium monitoring booklets were available for provision

to patients.

Prescriptions awaiting collection were marked with five different coloured pens that corresponded to different weeks. They remained on the shelf for four weeks before the patient was contacted and medicines were returned to stock after a further two weeks if not required. The branch manager said that this ensured there was always enough storage space for current prescriptions.

Signatures were obtained for prescription deliveries. Separate signatures were not obtained for CDs, but the delivery sheet was marked if a CD was included and the medicine was packed in a separate clear bag. This allowed the driver to notify the patient that they were receiving a CD. In the event of a missed delivery, the delivery driver put a notification card though the door and brought the prescription back to the pharmacy.

Disposable compliance aids were used to supply medicines to a number of patients. Compliance aids were labelled with descriptions to enable identification of individual medicines. Patient information leaflets were not routinely supplied. This was contrary to legislative requirements and there was a risk that the patient might not have access to all the information they required to make informed decisions about their own treatment. Each patient had a section in a dedicated file that included their personal and medication details, collection or delivery arrangements, details of any messages or queries and any relevant documentation. Medicines were obtained from licensed wholesalers and were generally stored appropriately, including those requiring cold storage.

CDs were stored appropriately in tidy, well-organised CD cabinets and obsolete CDs were clearly segregated from usable stock. One prescription for buprenorphine patches and two prescriptions for tapentadol were no longer valid as more than 28 days had passed since the date on each prescription. A trainee dispensing assistant said that she would always show the pharmacist any prescriptions taken from the CD cabinet before handing them out.

Stock was regularly checked and date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. A scheme run in association with GSK allowed the pharmacy to recycle returned inhalers.
Staff were able to describe how they would deal with medicines or medical devices that had been recalled as unfit for purpose by contacting patients where necessary and returning quarantined stock to the relevant supplier. They explained that the PMR software flashed up a real-time alert on the screen for all drug recalls. Drug recalls were printed, filed and signed to show that they had been actioned.
The pharmacy had the necessary hardware to work in accordance with the Falsified Medicines Directive but the software had not been installed and so the pharmacy was not yet in a position to comply with legal requirements.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services. It makes sure these are always safe and suitable for use. The pharmacy's team members use equipment and facilities in a way that protects people's privacy.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Separate measures were used for CDs. Triangles were used to count tablets and a separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources.

All equipment was in good working order, clean and appropriately managed; evidence showed that it had recently been tested. Equipment and facilities were used to protect the privacy and dignity of patients and the public: for example, the computer was password-protected and the consultation room was used for private consultations and counselling.

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.