General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Evans Pharmacy – Machynys, 1 The Avenue, Morfa, LLANELLI, Dyfed, SA15 2DP

**Pharmacy reference:** 1043274

**Type of pharmacy:** Community

**Date of inspection:** 10/09/2024

## Pharmacy context

This pharmacy is inside a medical centre in a coastal area of Llanelli. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy offers a range of services including provision of emergency hormonal contraception, treatment for minor ailments and a seasonal influenza vaccination service.

## Overall inspection outcome

**Standards not all met**

**Required Action:** Improvement Action Plan

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 not all met | 1.1 | Standard not met | Some pharmacy team members have not read the standard operating procedures that underpin the services they provide. So they may not be able to demonstrate that they fully understand their role or responsibilities. And there is a risk that they may not be able to provide pharmacy services safely and effectively. There is evidence to show that on some occasions the pharmacy's standard operating procedures are not being followed, which may increase the risk of errors. |
| | | 1.6 | Standard not met | The Responsible Pharmacist record is not properly maintained so it may be difficult to establish who was responsible at any given time. |
| **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 not all met | 4.2 | Standard not met | The pharmacy team routinely delivers some medicines by posting them through people's letterboxes or leaving them in safe places. This practice is not in accordance with the delivery standard operating procedure and it may compromise confidentiality and increase the risk of errors. |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance **Standards not all met**

### Summary findings

The pharmacy has written procedures to help make sure the team works safely. But there is evidence that on some occasions the procedures are not being followed, which may increase the risk of errors. Pharmacy team members take action to help reduce the chance of similar mistakes from happening again. But they do not always record or review all their mistakes, so they may miss some opportunities to learn and improve. The pharmacy generally keeps the records it needs to by law. But the Responsible Pharmacist record is not properly maintained, so it may be difficult to establish who was responsible for the safe and effective running of the pharmacy at any given time. Pharmacy team members know how to keep people's private information safe. And they can recognise and report concerns about vulnerable people to help keep them safe.

### Inspector's evidence

The pharmacy had systems in place to identify and manage risk, including a recording process for dispensing errors and near misses. The most recent near miss records had been made in 2023. However, dispensing team members explained that the pharmacists discussed near misses with them at the time they came to light. And that any patterns or trends that emerged were discussed with the whole team. They agreed to record near misses going forward. Action had been taken to reduce some risks that had been identified. For example, shelf edge stickers had been used to alert team members to the risk of selection errors with amlodipine and amitriptyline tablets following some near misses.

A range of standard operating procedures (SOPs) underpinned the services provided. However, these were overdue for review and so there was a risk that they might not always accurately reflect the activities currently carried out by the pharmacy. Some pharmacy team members had signed SOPs to show that they had read and understood them. But some had not signed any of the SOPs, so it was unclear whether they had been trained to follow the pharmacy's procedures. Team members were observed following most SOPs relevant to their role. However, the SOP for the delivery service was not always followed, which may increase the risk of errors.

A dispensing assistant who worked as an accuracy checker could check most prescription items that had been marked as clinically checked by a pharmacist, except for warfarin and controlled drugs requiring safe custody. However, she explained that she did not use her checking qualification very often as she was usually required to be involved in the dispensing process. A dispensing assistant was able to describe the activities that could not take place in the absence of the responsible pharmacist. The responsible pharmacist notice displayed was incorrect, but the pharmacist remedied this as soon as it was pointed out.

The pharmacy team explained that verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place, although this was not advertised in the retail area. So, people using the pharmacy might not understand the best way to raise concerns.

Evidence of current professional indemnity insurance was available. Most records were up to date, including, private prescription, unlicensed specials, emergency supply and controlled drugs (CD) records. However, the responsible pharmacist (RP) record was not well-maintained. There were many occasions on which the pharmacist had not made an entry in the RP register to show the times during

which they had taken responsibility for the safe and effective running of the pharmacy. So, there was a risk that it might not be possible to identify the pharmacist in charge if something went wrong. The pharmacist understood the risks and agreed to begin completing the record routinely going forward. Electronic emergency supply records did not always include the nature of the emergency. And it was sometimes unclear if an emergency supply had been made at the request of the patient or the prescriber. This meant that it might be difficult for the pharmacy team to fully resolve queries or deal with errors effectively. Running balances of controlled drugs (CDs) were usually checked at the time of dispensing, although medicines that were not frequently supplied were typically checked every three months. Infrequent CD balance checks could lead to concerns such as dispensing errors or diversion being missed. Two private prescriptions for CDs had not been forwarded to the pricing authority for audit purposes. The pharmacist explained that this was an oversight. He gave assurances that the team would send any original private CD prescriptions to the pricing authority in future and retain copies of these in the pharmacy.

Members of the pharmacy team confirmed that they had signed confidentiality agreements, although no evidence of this was available. However, they understood how to protect privacy and confidential information, for example by offering the use of the consultation room for private conversations and by identifying confidential waste and disposing of it appropriately. The pharmacist and one of the dispensing assistants had undertaken advanced formal safeguarding training. Other team members had completed basic formal safeguarding training. They had access to guidance and local safeguarding contact details which were available in a folder in the dispensary. The pharmacy had a chaperone policy, which was available in the SOP file.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are appropriately trained for the jobs they do or are enrolled on a suitable training course for their role. And they feel comfortable speaking up about any concerns they have.

### Inspector's evidence

The pharmacist manager worked at the pharmacy on most days. The pharmacy team consisted of five dispensing assistants (DAs) and a pharmacy student. One of the DAs had an NVQ level three qualification, and another was a qualified accuracy checker. The pharmacy student worked under the supervision of the pharmacist and other trained members of staff. Pharmacy team members were able to safely manage the workload and the staffing level appeared adequate for the services provided.

Members of the pharmacy team working on the medicines counter were observed using appropriate questions when selling over-the-counter medicines to people. And they referred to the pharmacist on several occasions for further advice on how to deal with transactions. Pharmacy team members had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They explained that much of their learning was via informal discussions with the pharmacist. However, the lack of a structured training programme meant that individuals might not keep up to date with current pharmacy practice. There was no formal appraisal system in place, which meant that development needs might not always be identified or addressed. But pharmacy team members explained they were able to informally discuss performance and development issues with the pharmacist whenever the need arose.

There were no specific targets or incentives set for the services provided. Pharmacy team members worked well together and had an obvious rapport with customers. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist and area manager. A whistleblowing policy was available in the dispensary and described the pharmacy’s internal process for raising concerns. On discussion, team members understood that they could contact the GPhC if they wished to raise a concern outside the organisation. Pharmacy team members had access to a support service that offered six free counselling sessions a year.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is clean, tidy and well-organised. It has enough space to allow for safe working and there is a room where people can have conversations with team members in private.

### Inspector's evidence

The pharmacy was clean and well-organised, with enough space to allow for safe working. Some stock medicines and dispensed medicines awaiting collection were being temporarily stored on the floor, but they did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available.

A consultation room was available for private consultations and counselling, and this was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

## Principle 4 - Services **Standards not all met**

### Summary findings

The pharmacy's services are easy for people to access. Its working practices are mostly safe and effective. But some medicines are routinely delivered by posting them through people's letterboxes or leaving them in safe places. This practice may compromise confidentiality and increases the risk of errors. And members of the pharmacy team do not always know when higher-risk medicines are being handed out. So, they might not always be able to check that medicines are still suitable or give people advice about taking them. The pharmacy generally stores medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply.

### Inspector's evidence

The pharmacy team offered a range of services, which were advertised at the pharmacy entrance. There was wheelchair access into the pharmacy and consultation room. The pharmacy team signposted people requesting services they could not provide to other nearby pharmacies. Some health promotional material was displayed in the retail area.

The pharmacy team had a good relationship with local GP surgery teams, which meant that queries and problems were usually dealt with quickly and effectively. Members of the team used colour-coded baskets to ensure that medicines did not get mixed up during the dispensing process and to differentiate between different prescriptions. Dispensing labels were initialled by the dispenser and accuracy checker to provide an audit trail. Bag labels attached to dispensed medicines awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail.

Prescriptions were not always retained for dispensed items awaiting collection. This meant that prescriptions for some Schedule 3 CDs might not be marked with the date of supply at the time the supply was made, as required by law. Most prescriptions were scanned, and the image remained digitally available for reference. However, this was not the case for all prescriptions.

Prescriptions were marked to alert team members to the fact that a CD requiring safe custody or fridge item needed to be added before handout. Prescriptions for schedule 3 or 4 CDs awaiting collection were not routinely identified so there was a risk that these medicines might be supplied past the 28-day validity period. However, all pharmacy team members were suitably trained and those present said that they recognised prescriptions for Schedule 3 or 4 CDs and checked that they were still valid before handing them out.

Prescriptions for higher-risk medicines such as warfarin, lithium and methotrexate were not routinely highlighted, so there was a risk that counselling opportunities could be missed. The pharmacist explained that he asked people about relevant blood tests and dose changes but did not record these conversations. Pharmacy team members were aware of the risks of valproate use during pregnancy. They were also aware of the requirement to supply valproate products in original packs. They confirmed that anyone prescribed valproate who met the risk criteria would be counselled and provided with educational information at each time of dispensing.

The pharmacy provided medicines in disposable multi-compartment compliance packs to a large number of people in the community. People requesting the service were risk-assessed for suitability.

Compliance packs were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied. A list of people receiving their medicines in compliance packs with their collection or delivery details was displayed in the dispensary for reference. Details of any messages or queries were recorded in a diary for communication purposes. An original pack and medication administration record (MAR) dispensing service was provided to some care home residents.

Uptake of the pharmacy's common ailments service was high, as it was an established service and the pharmacy also received frequent referrals from the local GP surgery. The regular pharmacist was an independent prescriber and was able to provide the extended common ailments service. Demand for the emergency supply of prescribed medicines service was also high, as local surgeries often referred people to the pharmacy if they were unable to provide them with a valid prescription in an emergency. There was a low uptake of the EHC (emergency hormonal contraception) and bridging contraception service as the pharmacy was not open at weekends. The pharmacy team also provided a smoking cessation (supply only) service, a seasonal influenza vaccination service and a free blood pressure measurement service.

The pharmacy provided a regular prescription collection service from four local surgeries and an occasional collection service from two other surgeries in the area. It also offered a free medicines delivery service. The delivery driver used a delivery sheet to record the time that each delivery was made. Signatures were obtained for deliveries of controlled drugs. In the event of a missed delivery, the delivery driver usually put a notification card though the door and brought the medication back to the pharmacy. However, the pharmacy team explained that some people's medicines were routinely delivered by posting them through letterboxes or leaving them in safe places, contrary to the pharmacy's delivery SOP. They gave assurances that this was only done with the person's consent after discussion with the pharmacist. But they could not produce any evidence to show that consent had been provided, as the signed forms were stored at another branch. And there was no evidence to show that a risk assessment had been carried out to ensure that the process was safe.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in two well-organised medical fridges. The larger of the two fridges was used to store stock medicines and another smaller fridge was used to store dispensed medicines awaiting collection. Maximum and minimum temperatures were recorded daily for the large fridge, and these were consistently within the required range. There were no recent temperature records available for the smaller fridge. However, temperatures for this fridge were within the required range, and the pharmacy team gave assurances that they checked the temperatures each day. On discussion, the pharmacy team agreed to record fridge temperatures for the small fridge going forward. CDs were stored in two well-organised CD cabinets and obsolete CDs were kept separately from usable stock. The pharmacy team also stored some cash in the CD cabinet. On discussion, they understood that accessing the cabinet to retrieve this could increase the risk of accidental loss or diversion of CDs. They agreed to review the pharmacy's procedures for storing cash going forward.

The pharmacy team provided assurances that regular expiry date checks were carried out. However, the frequency of these checks had not been documented since June 2023. This created a risk that out-of-date medicines might be overlooked, although none were found. On discussion, the pharmacy team understood the risks and agreed to review their date-checking processes going forward. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received safety alerts and medicine recalls via its NHS email account. These were printed out and filed for reference. The pharmacy team were able to describe how they would deal with a medicine recall by contacting patients where necessary, quarantining affected stock, and returning it to the supplier.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy team has the equipment and facilities it needs to provide the services they offer. And it makes sure that these are 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. Triangles were used to count loose tablets. The triangles were dusty, but the dispensing team confirmed that they were washed before each use. A separate triangle was available for use with cytotoxic medicines to prevent cross-contamination. 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 electrical equipment had recently been tested. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the consultation room was used for private conversations and counselling. The pharmacy software system was protected with a password and computer screens were not visible to people using the pharmacy.

## 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. |