General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Old Doctors Surgery, 5 Vauxhall, LLANELLI, Carmarthenshire, SA15 3BD

Pharmacy reference: 1043277

Type of pharmacy: Community

Date of inspection: 07/02/2024

Pharmacy context

This pharmacy is near a medical practice in Llanelli town centre. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. Some NHS prescriptions are assembled off-site at another pharmacy owned by the company. The pharmacy offers a range of services including provision of emergency hormonal contraception, treatment for minor ailments and a smoking cessation service. It also provides substance misuse services.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 met	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	Staff have the appropriate skills, qualifications and competence for their roles, and are supported to address their learning and development needs
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 make sure the team works safely. Its team members record their mistakes so they can learn from them. And they take some action to help stop mistakes from happening again. The pharmacy keeps the records it needs to by law. It keeps people's private information safe. And its team members understand how to 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 the electronic recording and monthly analysis of dispensing errors and near misses. Some action had been taken to reduce risks that had been identified. For example, shelf edge stickers had been used to alert staff to the risk of selection errors with tramadol and trazodone, and these two products had been distinctly separated on dispensary shelves. Different forms of pregabalin had also been separated and highlighted in this way after near misses with these items. Chloramphenicol ear drops had been clearly separated from chloramphenicol eye drops in the drug fridge as a proactive measure to reduce selection errors.

A range of standard operating procedures (SOPs) underpinned the services provided. Members of the pharmacy team were currently in the process of being trained on a new version of the stock management SOP, following a change in the organisation's unlicensed medicines supplier. The responsible pharmacist notice on display was incorrect, but the pharmacist remedied this as soon as it was pointed out. The pharmacy team were able to describe the activities that could and could not take place in the absence of the responsible pharmacist.

Verbal feedback from people using the pharmacy was mostly positive. But some people had been unhappy about having to wait longer than they wanted to for their prescriptions when the pharmacy was short-staffed. The pharmacy team gave assurances that the situation was improving. A formal complaints procedure was in place and was advertised in a poster displayed in the retail area. Leaflets that gave details of the NHS complaints procedure 'Putting Things Right' were available in the consultation room.

Evidence of current professional indemnity insurance was available. All necessary records were up to date, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed medicines and controlled drug (CD) records. CD running balances were typically checked weekly by a regular relief pharmacist.

Staff received annual training on the information governance policy and had signed confidentiality agreements. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. Privacy notices displayed near the medicines counter and on the consultation room door signposted people to the company's website for information about the way in which their personal data was used and managed.

The pharmacist and pharmacy technician had undertaken advanced formal safeguarding training. All other team members had undertaken basic formal safeguarding training. They had access to guidance and local safeguarding contact details that were available in a folder in the dispensary. Leaflets that

included information and advice for carers were available in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members complete regular training and have a good understanding about their roles and responsibilities. They feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacy was operated by several different pharmacists. The pharmacist present worked at the pharmacy on Wednesdays and Thursdays. Another regular pharmacist worked on Tuesdays. There was no regular pharmacist on Mondays or Fridays and these days were covered by relief or locum pharmacists. A part-time dispensing assistant (DA) was employed as the team leader and oversaw the operational running of the branch. She was assisted by a full-time pharmacy technician. Another part-time DA who usually worked at a different branch provided cover for a few hours once a week. A relief accuracy checking technician (ACT) was also used to cover absences, or to support the team during busy periods. The pharmacy was quiet, and the staffing level appeared adequate for the services provided.

All staff were trained to work on the medicines counter. One member of the pharmacy team described how she would use the WWHAM questioning technique when selling medicines and gave appropriate examples of situations she would refer to the pharmacist. She said that she would feel confident refusing a sale and had done so in the past when dealing with what she considered to be an inappropriate request for a product containing codeine. Pharmacy team members undertook regular online training provided by the organisation on clinical topics, operational procedures and services. They had recently completed some mandatory training provided by NHS Wales on mental health awareness. The pharmacy technician understood the revalidation process and based her continuing professional development entries on training modules as well as on situations she came across in her day-to-day working environment. Team members were subject to six-monthly performance and development reviews and could discuss issues informally with the pharmacists or area manager whenever the need arose.

Targets were set for some services, but these were managed appropriately, and the pharmacist explained that they did not affect her professional judgement or compromise patient care. 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 pharmacists, the area and regional managers and the superintendent’s team. A whistleblowing policy was available on the pharmacy’s intranet system. It included details of organisations that could be contacted if team members wished to raise a concern outside the organisation. The pharmacist agreed to print the policy out and display it in the dispensary for easy reference.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is 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 clean, tidy and well-organised. The dispensary was small but there was enough clear bench space for safe working. Some stock items and prescriptions awaiting collection were being temporarily stored on the floor, but these did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff and customer use. 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's services are easy for people to access. If it can't provide a service, it directs people to somewhere that can help. The pharmacy's working practices are generally safe and effective. It stores medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply. But 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.

Inspector's evidence

The pharmacy team offered a range of services, most of which were appropriately advertised. A needle and syringe provision scheme was not advertised, and the pharmacy team arranged to obtain a service logo to display in the pharmacy window as soon as this was pointed out. 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.

About 70% of the pharmacy's prescription items were assembled offsite at the company's hub pharmacy. The hub pharmacy could not assemble split packs, fridge lines, most controlled drugs, or multi-compartment compliance packs and these continued to be dispensed at the branch. Dispensing staff used colour-coded baskets to ensure that medicines did not get mixed up during dispensing and to differentiate between different people's prescriptions. Dispensing labels were usually initialled by the dispenser and accuracy checker to provide an audit trail. However, some daily doses for substance misuse clients and some compliance packs were found to be missing these initials. The pharmacist said that that this was an oversight and not usual practice. Controlled drugs requiring safe custody, fridge lines and multi-compartment compliance packs were dispensed in clear bags. This allowed pharmacy team members to check these items at all points of the dispensing process and helped reduce the risk of a person receiving the wrong medicine. Each bag label attached to a prescription awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail. A text messaging service was available to let people know that their medicines were ready for collection.

Each prescription awaiting collection was assigned to a specific storage location in the dispensary. When pharmacy team members needed to locate a prescription, the patient's name was typed into a handheld device and this brought up a list of locations in which their items were being stored, including medical fridges or the CD cabinet where applicable. In addition, stickers were placed on prescription bags to alert team members to the fact that a CD requiring safe custody or fridge item was outstanding. Prescriptions for dispensed Schedule 3 and 4 CDs awaiting collection were not routinely identified and there was a risk that these items might be supplied past their 28-day validity period. However, pharmacy team members were suitably trained and said that they recognised prescriptions for Schedule 3 or 4 CDs and checked that they were still valid at the point of handout. They explained that the prescription storage area was checked every week, and anyone who had not collected their prescription within a month was contacted as a reminder. After a further two weeks, the medicines were returned to stock if not collected, and the corresponding prescription was returned to the surgery.

Prescriptions for people prescribed high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified and there was a risk that counselling opportunities could be missed.

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 wherever possible. The pharmacist knew of one person prescribed valproate who met the risk criteria. She confirmed that their representative was counselled appropriately and provided with information at each time of dispensing. A poster that listed actions to be taken by the pharmacy team when dealing with valproate prescriptions was displayed in the dispensary.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community, and some residents of a brain injury rehabilitation centre. New patients requesting the service were assessed for suitability. Compliance packs were usually labelled with descriptions of the medicines they contained so that individual medicines could be easily identified. However, some descriptions were missing, so there was a risk that people might not always be able to make informed decisions about their own treatment. Patient information leaflets were routinely supplied. A list of patients and their delivery or collection arrangements was available in the dispensary for reference. Each patient was allocated a section in a file that included their personal and medication details, details of any messages or queries for communication purposes and any relevant documentation, such as repeat prescription order forms. Progress logs showed the status of each patient's compliance pack at any given time. An original pack and MAR chart dispensing service was also provided to some people.

The pharmacy provided a discharge medicines review service which was run by the pharmacists and a relief ACT. It also provided a common ailments service, an EHC and bridging contraception service, a seasonal influenza vaccination service, a smoking cessation service (supply and monitoring) and a UTI service for women aged 16 to 64. Some substance misuse services were provided, including a supervised consumption service and a needle and syringe provision service. Uptake of the emergency supply of prescribed medicines service was low, as the pharmacy was situated close to local surgeries and kept similar opening hours, so people were usually able to obtain a valid prescription from a GP in an emergency. There was also a low uptake of most other services. The team explained that this was because there were several other pharmacies nearby that provided a similar range of services. The local health board (LHB) had recently commissioned a new MAR chart service as part of a pilot scheme. The pharmacist said that the team had received training and would soon be providing this service to people referred to them by the LHB.

The pharmacy provided a prescription collection service from six local surgeries. It also offered a free medicine delivery service, which was managed electronically. Each prescription was scanned into a handheld device and patients, or their representatives, signed this to acknowledge receipt of the delivery as an audit trail. Separate signatures were not obtained for controlled drugs. However, these were supplied in separate clear bags and the delivery sheet was marked with a CD sticker, which alerted the driver to notify the patient they were receiving a controlled drug. 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.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. However, one bottle of a time-sensitive reconstituted antibiotic stored in a medical fridge had not been marked with the date of opening. So it was unclear whether or not it was still suitable for supply. Some medicines that had been removed from their blister packaging had been put into an unlabelled bottle which was then stored in the original outer box. This meant that it would be difficult to identify the medicine if the bottle became separated from the box, which might lead to errors. There was no record of the medicine's batch number or expiry date which could make it harder for the pharamcy to respond effectively to a query or safety recall. The pharmacist disposed of both items appropriately as soon as they were pointed out to her. Medicines requiring cold storage were kept in two medical fridges.

Maximum and minimum temperatures for the fridges were checked and recorded daily. CDs were stored in two well-organised CD cabinets and most obsolete CDs were kept separately from usable stock. However, one open bottle of methadone that was not frequently used was not marked with the date of opening, so it was unclear whether it was still suitable for use. The pharmacist marked the bottle as obsolete and separated it from usable stock immediately after this was pointed out to her.

Stock was subject to regular expiry date checks. These were documented electronically, and stickers were used to highlight short-dated stock. The pharmacy team said that an expiry date check was built into their dispensing and checking processes. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received drug alerts and recalls via its NHS email account and its intranet system. The pharmacy team described how they would deal with a drug 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. And 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 methadone to prevent cross-contamination, and these were clearly marked. Triangles were used to count loose tablets and a separate triangle was available for use with 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 pharmacy software system was protected with a password and computer screens were not visible to people using the pharmacy. The consultation room was used for private conversations 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.