General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: H Shackleton Ltd, Riverside, Beaufort, EBBW VALE, Gwent, NP23 5NT

Pharmacy reference: 1043375

Type of pharmacy: Community

Date of inspection: 08/04/2019

Pharmacy context

This is a busy community pharmacy located close to a large medical centre, in a residential area of Ebbw Vale. The pharmacy mainly dispenses NHS prescriptions. It supplies weekly compliance aid packs for people to use in their own homes, and delivers medication to people who are housebound. It also sells over-the-counter medicines and a limited range of health and beauty products.The pharmacy provides a number of other NHS services including a 'Choose Pharmacy' local minor ailments scheme, emergency hormonal contraception and smoking cessation. Substance misuse treatment services are also available.

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 generally delivers services safely and effectively. Pharmacy team members follow written procedures to help make sure they complete tasks safely. They try to record their mistakes so that they can learn and reduce risks in the future. And they keep people's private information safe and know what to do to protect vulnerable people. The pharmacy keeps the records it needs to by law. But pharmacy team members do not always carry out enough checks of some higher risk medicines. So they may not always identify issues or realise when things have gone wrong.

Inspector's evidence

The pharmacy had some processes in place to manage and reduce risk. Records of near misses were routinely maintained, with entries usually documented by the pharmacist or an accuracy checking pharmacy technician (ACT). Records contained a description of what happened and who was involved, but little information on contributing factors. They were reviewed for trends each month, but no record of this was maintained.

Action to reduce near misses was said to be taken on an ongoing basis, with stock locations being reviewed and adjusted if problems were identified. Dispensing incidents were recorded on forms produced by the Local Health Board (LHB), which provided a more detailed analysis of what went wrong and identified contributing factors. Dispensing incidents were discussed verbally with the pharmacy team. Onward reporting the National Patient Safety Agency (NPSA) also took place. Records were seen to this effect.

Standard operating procedures (SOPs) were available in a paper format, they had been recently reviewed and read by the pharmacy team. Team members signed to confirm their acknowledgement and understanding. General observation was used to ensure procedures were being implemented and any issues identified were addressed verbally. The SOPs defined the roles and responsibilities of team members, and a medicine counter assistant (MCA) was able to describe the activities which could and could not take place in the absence of the responsible pharmacist (RP).

People using pharmacy services were able to provide feedback in several ways, including verbally and in writing. Further information on how comments and concerns could be escalated were outlined in an NHS Wales 'Making it Right' leaflet. Feedback on the pharmacy and its services was also obtained through an annual community pharmacy patient questionnaire (CPPQ). A poster from a recent survey displayed generally positive results. Changes had previously been made to the seating arrangements in the pharmacy, in response to points of feedback which had been raised.

Insurance arrangements were in place. The correct RP notice was clearly displayed near to the medicine counter. The RP log was maintained electronically. The time at which RP duties ceased was not routinely recorded, which may create ambiguity. Controlled Drugs (CD) registers appeared generally in order. Running balances were maintained and balance checks were carried out, although not always at

the frequency defined in SOPs. Records of returned CDs were made in a designated register and destructions were signed and witnessed. Private prescription and emergency supply records were held electronically and overall the sample records checked appeared to be in order. Specials procurement records were completed with the relevant details which provided an audit trail from source to supply.

All staff had completed General Data Protection Regulation (GDPR) training and certificates were kept as a record of this. Additional discussions had taken place on maintaining confidentiality in the pharmacy and a privacy notice, which described how information was managed, was displayed on the medicine counter. Confidential waste was segregated into designated bags and taken for appropriate disposal to protect privacy. Completed prescriptions were stored in a location out of view of the public.

A safeguarding procedure was in place. The pharmacy team had completed child protection training and the pharmacist had recently updated his level 2 safeguarding training as part of the National Enhanced Services Accreditation (NESA) process. Team members demonstrated an awareness of some of the types of concerns that they would be looking to identify in vulnerable people. The pharmacist also discussed some previous instances where a referral had been made or further advice sought. Local contact details for escalating concerns were available. A chaperone policy was in place, but was not advertised. The pharmacist said he would offer this verbally prior to a consultation.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are suitably trained. They complete ongoing learning to keep their skills and knowledge up to date. They work well as a team, and are comfortable in raising concerns and providing feedback.

Inspector's evidence

The pharmacy team on the day comprised of the regular pharmacist, two registered ACTs, two qualified pharmacy assistants and two qualified MCAs. The team appeared to adequately manage the workload and the pharmacist felt that there was adequate support. Team members worked set hours and a master rota was in place to ensure that all tasks were completed each day. Team members also rotated duties, so that they were familiar with all the tasks and activities in the pharmacy. Cover for both planned and unplanned leave was provided through other team members working additional or changed hours. Where essential, team members from other nearby branches provided added support.

The pharmacy team were comfortable in using their professional judgement. A MCA discussed the questions that she would ask to help to ensure that sales were safe and appropriate. The MCA showed an awareness of some common interactions between prescription only medicines and over-the-counter medications. An appropriate response was also provided to a question regarding the sale of pseudoephedrine based medications. People on regular medications were referred to the pharmacist for checks to be made for potential interactions.

The pharmacy team were trained for the roles in which they were working, additional training took place on an ad hoc basis. Recent training completed included GDPR and any additional modules which were required to meet Community Pharmacy Wales requirements. Additional updates were provided by the pharmacist, where necessary, an example of a recent update included the changes to the status of pregabalin and gabapentin. Development had previously been reviewed using appraisals. The appraisal process was currently under a company review to ensure that it was robust in identifying learning needs. Feedback was also provided to the team on an ongoing basis.

The team had a positive rapport, they supported one another well and the environment appeared open and engaging. Team members were happy discuss concerns and feedback with the pharmacist and could also escalate concerns through a human resource manager. The pharmacy had also recently participated in a Wales Community Pharmacy Workforce Survey. Team members had access to a whistleblowing policy in the SOP folder.

There were targets in place for Medicine Use Reviews (MURs), the pharmacist only carried out services when appropriate and said that he did not feel any undue pressure.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are generally safe, secure and suitable for the provision of pharmacy services.

Inspector's evidence

The pharmacy premises, including the external facia was appropriately maintained. Maintenance issues were escalated through management and a local contractor also helped with some repairs. The pharmacist carried out routine health and safety checks and reported any issues identified. The retail area to the front was generally well presented. An enclosed consultation room was available from the retail floor. The glass door was covered with promotional posters to afford privacy to those using the room.

The dispensary generally had sufficient space for dispensing activities. The front portion of the dispensary had a large work bench, which was divided into separate areas for dispensing and checking. Stock medications were stored on a large number of shelving units. And a sink was available for the preparation of medicines. A separate area to the rear of the dispensary had an additional work space for the assembly of weekly compliance aid packs.

The pharmacy had an additional storeroom and office space, as well as a tea room and WC facilities which were equipped with appropriate handwashing materials. There was adequate lighting throughout the premises and the temperature appeared appropriate for the storage of medicines.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people and they are suitably managed, so people receive their medicines safely. But pharmacy team members do not always provide information leaflets with weekly compliance aid packs, which may mean that some people do not have access to all the information they need to take their medicines safely. The pharmacy sources and stores medicines safely and carries out regular checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy had a ramp in place to enable wheelchair access. The manual door was visible from the medicine counter so that people requiring assistance could be identified. Additional adjustments could be made for those with disabilities, such as producing large print labels to assist people with visual impairment.

There was some advertisement of pharmacy services and additional services available in the local area, along with other health promotion materials. A MCA discussed where people could be referred to for other services, not available at the pharmacy. The team had a general awareness of service providers in the area, but internet access was available for additional research, if required.

Baskets were used for dispensing to help prevent medications from being mixed up. A colour coded system also helped the workload to be prioritised. Medication labels were signed for dispensing and checking, so that those involved in the process could be identified. Prescription owing labels were used. These were stored alongside the original prescription form until the remaining balance had been collected. A system was in place to identify prescriptions which had undergone a clinical check by the pharmacist, and were suitable for a final accuracy check by the ACT. The system did not record the identity of the clinical checker.

The date on prescriptions for all CDs was highlighted to ensure an additional date check was carried out at the time of supply. Schedule 2 CDs were not routinely dispensed until the time of collection. The pharmacist said that where possible he carried out checks with people on high-risk medicines, to ensure that they were receiving monitoring. Records of this were made in some cases. A system was not in place to ensure that checks were made for all prescriptions of this nature.

The pharmacy team were aware of requirements which were in place regarding the supply of valproate based medications to females of childbearing potential. They did not have access to the most up to date safety materials to ensure compliance with MHRA guidance.

Audit trails were maintained to identify unreturned repeat prescription requests which had been placed with the GP surgery by the pharmacy. The pharmacist also discussed an ordering application which people used to request their repeat prescriptions and informed them when their prescription was ready for collection.

An organised four-week system was in place to manage medications for people who received weekly compliance aid packs. Records were made of any changes to medications and a master list was kept up

to date for each patient. Weekly compliance aid packs seen had identifying labels to the front, with signatures for dispensing and checking and descriptions of individual medicines were recorded. PILs were not routinely supplied as required by law.

Signatures were obtained for deliveries of medications. A separate signature sheet was also in place for the delivery of CDs.Medications from failed deliveries were returned to the pharmacy.

The pharmacist was accredited to provide all services in the pharmacy. The 'Choose Pharmacy' service was used regularly and a MCA was familiar with the conditions that could be treated and how the service worked. The pharmacist had access to the formulary and in-date PGDs for each treatment condition. Records were also held for the smoking cessation service. The pharmacist described the difference between the level 2 and level 3 service and PGDs and additional guidance was available for reference if required.

Stock was obtained from reputable sources and specials from a specials manufacturer. The pharmacy had some of the hardware required to be compliant with the European Falsified Medicine Directive (FMD), but the pharmacist said that it had been noted that more scanners were required. Registration with SecurMed had recently been completed and evidence of this was provided. The pharmacy was yet to be fully compliant.

Stock medications were stored in an organised manner. There was separation between internal and external liquids and solid dosage forms. Liquids had the date on which they were open recorded. Date checking had been carried out in January 2019, medications expiring within the next eight to nine months had been highlighted and recorded. Records were checked each month, and medications due to expire were removed. No expired medicines were identified from random samples. Returned and out of date medications were sorted and stored appropriately. A hazardous waste bin was also available, records of returned hazardous medicines were maintained and a guidance sheet could be used for reference.

CDs were stored appropriately and random balance checks on the day were found to be correct. Returned CDs were clearly marked and segregated. CD denaturing kits were available. The dispensary fridge was equipped with a maximum/minimum thermometer and was within the designated temperature range on the day. Records of temperatures were maintained.

Alerts for faulty medicines and medical devices were received via email. The system was checked each day. A record of this was kept and was provided as evidence. A record of any alerts received and the action taken was also maintained. The pharmacist had recently escalated a suspected adverse drug reaction as part of the national Yellow Card Scheme.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely.

Inspector's evidence

Validated crown-stamped measures were available for liquids, with separate measures marked for the use of controlled drugs only. A range of clean tablet and capsule counters were present, with a separate triangle clearly marked for cytotoxic medications. A carbon monoxide reader used as part of the smoking cessation service had recently been calibrated.

Reference sources were available and the pharmacy could also access up-to-date information on the internet. Electrical equipment appeared to be in good working order and underwent PAT testing. The pharmacy computer system was backed-up each day. Computer screens were positioned so that no information could be seen by members of the public. A cordless phone was available to enable conversations to take place in private.

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.