General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, The Bryn, Trethomas, NEWPORT, Gwent, CF83 8GP

Pharmacy reference: 1043391

Type of pharmacy: Community

Date of inspection: 29/07/2019

Pharmacy context

This is a village pharmacy situated next to a medical centre. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a 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.

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	1.2	Good practice	Information about risk is reviewed and analysed to optimise the safety and quality of pharmacy services
		1.7	Good practice	Robust arrangements are in place to ensure all information is managed to protect the privacy dignity and confidentiality of patients and the public
2. Staff	Good practice	2.2	Good practice	Staff have the appropriate skills, qualifications and competence for their role and are supported to address their learning and development needs
		2.4	Good practice	A culture of continuous improvement through learning exists within the team
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. Its team members record and review their mistakes so they can learn from them. And they take action to help stop the same sorts of mistakes from happening again. The pharmacy keeps the records it needs to by law. It asks people to give their views about the services it provides. And it keeps people's private information safe. The pharmacy's 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 recording and monthly analysis of dispensing errors and near misses. Evidence showed that a root cause analysis had been conducted following a recent dispensing error. Some action had been taken to reduce risk: a caution sticker had been used to highlight the risks of picking errors with amlodipine 10mg and amitriptyline 10mg tablets and these had been separated following a series of near misses. Different forms of ramipril had also been separated on dispensary shelves to reduce the incidence of picking errors, as had tamsulosin and tamsulosin/dutasteride capsules and losartan and loratadine tablets. Staff were aware of the risks of picking errors with 'Look-Alike. Sound-Alike' drugs and demonstrated that these were not stored closely together on dispensary shelves.

A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. The accuracy checking technician (ACT) said that she could check most prescription items that had been marked as clinically checked by the pharmacist, except for methotrexate and controlled drugs (CDs) requiring safe custody.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. A poster on the consultation room door advertised the fact that these could be completed online or in store. The results of the most recent survey displayed on the consultation room door showed that feedback was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in a poster displayed in the retail area.

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, although CD running balances were usually checked weekly, there were sometimes periods of several weeks between checks and occasionally these were not accompanied by a clear audit trail to show who had carried out the check. There was a risk that the lack of a complete audit trail might make it difficult to deal with queries or errors effectively.

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 to access the pharmacy software system. The ACT explained that if a staff member left the company the relevant passwords were removed from the system by the company's IT department and the process documented as an audit trail.

The pharmacists and ACT had undertaken formal safeguarding training and had access to guidance and local contact details that were displayed in the dispensary. Staff had received in-house training and were able to identify different types of safeguarding concerns. They said that 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 detailed in a poster displayed on the consultation room door.

Principle 2 - Staffing ✔ Good practice

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

A regular pharmacist manager oversaw most professional activities; a locum pharmacist was covering his absence at the time of the inspection. There were enough suitably qualified and skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. The accuracy checking technician (ACT) said that the company was currently recruiting to fill a staff vacancy.

Targets were set for MURs and DMRs but these were managed appropriately and the ACT said they did not affect the pharmacist's professional judgement or patient care. Staff worked well together and had an obvious rapport with customers since they served a close-knit community. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist or Regional Development Manager. Posters advertising a confidential helpline for reporting concerns outside the organisation were displayed in the pharmacy office and on the staff noticeboard.

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 completed training modules on the new pharmacy software system, the dispensing hub, controlled drugs management and the Falsified Medicines Directive. They had also completed training provided by NHS Wales on improving the quality of services provided. The ACT understood the revalidation process and had submitted her continuing professional development portfolio. She said that she based her continuing professional development entries on situations she came across in her day-to-day working environment or clinical topics of interest to her. All staff were subject to six-monthly performance and development reviews and could discuss issues informally with the pharmacists or pharmacy manager whenever the need arose.

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 with enough space to allow safe working, although some stock and prescriptions were temporarily stored on the floor. The sink had hot and cold running water and soap and cleaning materials were available. A poster describing hand washing techniques was displayed nearby. 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 and can access them easily. If it can't provide a service it directs people to somewhere that can help. The pharmacy is well-organised and its working practices are generally safe and effective. It generally manages medicines well.

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 nearby pharmacies or other providers such as the local council, which offered a sharps collection service. The ACT explained that the pharmacist manager had recently visited the local surgery to discuss and promote services as part of a health board-funded collaborative working initiative. Visits had involved discussions around the repeat dispensing service, the influenza vaccination service, the common ailments service and high-risk medicines.

The pharmacy team said that a new pharmacy software system had recently been installed which allowed some prescription items to be assembled at the Well hub pharmacy in Stoke-on-Trent. The hub pharmacy could not assemble split packs, controlled drugs, fridge lines or monitored dosage system (MDS) trays and these continued to be dispensed at the branch. Prescription items scanned to the hub before 3pm were generally returned to the branch within 48 hours, although there were occasional delays.

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 MDS trays 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. Each bag label attached to a prescription awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail.

Each prescription awaiting collection was assigned to a specific storage location in the dispensary. When staff 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 the patient's items were being stored, including the drug fridge or CD cabinet where applicable. In addition, stickers were placed on bags to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. The ACT said that stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection to ensure these were not supplied to the patient or their representative more than 28 days after the date on the prescription. However, there was no evidence to confirm this and one prescription for diazepam assembled at the hub was not marked in this way. Stickers were used on prescriptions awaiting collection to identify patients eligible for an MUR.

Pre-printed slips were used to routinely identify prescriptions for patients prescribed warfarin. They included prompt questions to ensure that the member of staff handing out the prescription obtained all necessary information from the recipient, which was then added to the patient medication record

(PMR). However, other high-risk medicines such as lithium and methotrexate were not routinely identified. The pharmacy team were aware of the risks of valproate use during pregnancy. The ACT said that one patient prescribed valproate who met the risk criteria had been counselled appropriately and provided with appropriate information. She demonstrated that valproate patient information was stored in the dispensary. The pharmacy carried out regular high-risk medicines audits commissioned by the local health board. These audits were used to collect data about the prescribing, supply and record-keeping associated with high-risk medicines to flag up areas where risk reduction could be improved within primary care.

Each prescription storage location was assigned a barcode and this could be scanned to show details of the prescriptions stored there. Prescriptions remained on the shelf for four weeks before the patient was contacted and the medicines returned to stock after a further two weeks if not required.

Signatures were obtained for prescription deliveries. 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 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 MDS trays were used to supply medicines to a number of patients. Trays were labelled with descriptions, although these needed more detail to enable identification of individual medicines. Patient information leaflets were routinely supplied. Each patient had a section in one of four dedicated files that included their personal and medication details, collection or delivery details, contact details for representatives where appropriate, details of any messages or queries and any relevant documentation, such as current repeat prescriptions. A list of patients was available for reference. A separate file was kept for MDS patients who had been admitted to hospital.

Medicines were obtained from licensed wholesalers and stored appropriately. Stock for the repeat prescription collection service was temporarily stored on sections of the dispensary bench before being used to dispense prescriptions. Staff organised it alphabetically with space in between each product to reduce the risk of picking errors. Medicines requiring cold storage were stored in two tidy, well-organised drug fridges. Maximum and minimum temperatures were usually recorded daily and were generally within the required range. However, there were some gaps in the records which made it difficult for the pharmacy to be assured that medicines requiring cold storage were consistently stored appropriately. Some discrepancies had been recorded but evidence showed these had been reported to and monitored appropriately by the pharmacist. CDs were stored in a tidy, well-organised CD cabinet and obsolete CDs were segregated from usable stock.

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. The ACT was able to describe how the team had recently dealt with a recall for paracetamol tablets x 1000 by quarantining stock and returning it to the relevant supplier. She demonstrated that the PMR software flashed up a real-time alert on the screen when a recall was received. Drug recalls were printed, filed and signed to show that they had been actioned. The pharmacy had the necessary hardware and software to work in accordance with the Falsified Medicines Directive but the team said that they were not currently compliant due to some problems with the software that needed to be resolved.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services. These are safe and generally 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 and these were clearly marked. 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.

Most equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested but a hearing aid loop in the consultation room had failed this test. 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.