General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 175 Caerleon Road, NEWPORT, Gwent, NP19 7FX

Pharmacy reference: 1043393

Type of pharmacy: Community

Date of inspection: 28/10/2019

Pharmacy context

This is a community pharmacy on a shopping street in the northern suburbs of the city of Newport. Most people using the pharmacy are elderly. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It also supplies medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines.

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	2.4	Good practice	The staff are encouraged to keep their skills up to date and they do this in work time.
		2.5	Good practice	The team members are well supported by their immediate manager. They are comfortable about providing feedback to him to improve services and this is acted on.
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's working practices are generally safe and effective. The working areas are tidy and organised. The pharmacy is appropriately insured to protect people if things go wrong. It keeps the up-to-date records that it must by law. The pharmacy team members keep people's private information safe and they know how to protect vulnerable people. But, they could learn more from mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team identified and managed most risks. All dispensing errors and incidents were recorded, reviewed and appropriately managed. There had been an error in April 2019, where amlodipine 10mg had been supplied against a prescription calling for amlodipine 5mg. Because of this, the two strengths were now stored on separate shelves. Near misses were recorded electronically on Datix. The person who made the error was responsible for the recording to allow learning from reflection. But, insufficient information was documented to allow any useful analysis, such as, a mistake where 28 zopiclone was picked instead of the 14 on the prescription. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. In addition, the electronic recording meant, that in order to enter the details, anyone using the computer, for normal dispensing duties, had to interrupt this work. Or, it was entered later when the person may not clearly recollect the reason for the error. General trends could however be identified. Company policy was to review these each month. But, the last review of near misses had been done several months before the inspection. However, all the staff reported that mistakes were thoroughly discussed at the time. Company-wide issues, such as, the new sodium valproate guidance were communicated by the superintendent's office in monthly 'share and learn' emails.

The dispensing areas were tidy and organised. There was the main dispensary and a separate room for multi-compartment compliance aids. Both areas had dedicated labelling, assembly and checking stations. There was a clear audit trail of the dispensing process and all the 'dispensed by and checked by' boxes on the labels examined had been initialled. The pharmacy currently sent 40 – 60% of their regular repeat prescriptions to an off-site dispensing hub in Stoke-on-Trent. The prescriptions for all these patients were clinically checked by the pharmacist prior to this. And, there was an electronic audit trail demonstrating this. In addition, the pharmacy completed a daily on-going quality assurance record where there was a physical check of a prescription fully assembled by the hub, partially assembled by the hub and fully assembled at the pharmacy.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were continually reviewed by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. The questions to be asked of customers requesting to buy medicines were available close to the till. A NVQ2 trained dispenser said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. She was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as chloramphenicol eye drops and Ella One and referred requests for these to the pharmacist. Another dispenser knew that fluconazole capsules should not be sold to women over the age of 60 for the treatment of vaginal thrush.

The staff were clear about the complaints procedure and reported that feedback on all concerns was encouraged. The pharmacy did an annual customer satisfaction survey. In the 2018/2019 survey, there had been some feedback about the temperature in the pharmacy in the summer. Because of this, cooling fans were placed in the retail area. There had also been some feedback about the seating for people who were waiting. The staff said that this was difficult to address because of the size of the pharmacy. They had however moved a seat closer to the medicine till.

Current public liability and indemnity insurance was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order.

There was an information governance procedure and the staff had also recently completed training on the new data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was collected for appropriate disposal. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had read the company's policy on the safeguarding of children and vulnerable adults . They had also completed level 1 training provided by the Wales Centre for Pharmacy Professional Education (WCPPE). The pharmacist had done the level 2 training. Local telephone numbers were available to escalate any concerns relating to both children and adults. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough staff to manage its workload safely. The staff are encouraged to keep their skills up to date and they do this in work time. The team members are well supported by their manager. They are comfortable about providing feedback to him to improve services and this is acted on. But, the company does not often provide help when people are sick or on holiday. And, the pharmacist feels some pressure to achieve the targets set by the company for some services because not many people visit the pharmacy.

Inspector's evidence

The pharmacy was on a shopping street in the northern suburbs of the city of Newport. They mainly dispensed NHS prescriptions with the majority of these being repeats. Several domiciliary patients received their medicines in compliance aids. Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, the manager and three part-time NVQ2 qualified dispensers (3x30 hours per week). The dispensing help staffing hours were due to change in November to 2x30 hours plus 1x16 hours. This was said to be mainly as a result of the off-site dispensing. The pharmacy was currently advertising for the 16 hour a week post. One staff member, 30 hours a week, was going to join the relief team.

The staff, all part-time, were flexible and generally, they were able to cover any unplanned absences. However, they said that if this was not possible, they rarely got any help from other branches. One trained dispenser was due to be off for two weeks, commencing the week after the visit. At the time of the visit, no plans were in place to cover her time off. Planned holiday was booked well in advance and only one member of the staff could be off at one time. The remaining staff did their best to cover these holidays. The staff members said that they rarely got help from the company to cover these periods.

The staff worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal with a six-monthly review where any learning needs could be identified. Review dates would be set to achieve this.

The staff were encouraged with learning and development and completed regular 'e-expert' e-Learning. They said taht they spent about 30 minutes each month of protected time learning. The pharmacist completed 'Expert-you' interactive learning. All the staff reported that they were supported to learn from errors. The pharmacist said that all learning was documented on his continuing professional development (CPD) records.

The staff knew how to raise a concern and reported that this was encouraged and acted on. There were weekly staff meetings where the staff could raise any issues. A qualified dispenser had recently raised issues about medicines not being collected. Because of this, the shelves were now checked each week and letters were sent to patients who had not collected their medicines. In addition, patients who had given their consent were sent a text message saying that their medicines were ready to collect. All the staff were aware of the company's whistle-blowing policy.

The pharmacist reported that he was set targets for enhanced and advanced NHS services. He said that

there was a low footfall in the pharmacy and that he did feel some pressure to achieve these targets. In addition, the area manager sent regular emails, nearly daily, showing the current figures for the pharmacies in the region.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally looks professional. There is signposting to the consultation room so it is clear to people that there is somewhere private for them to talk. But, the room is small and the door opened inwards. This may make it difficult for the emergency services to gain access to the room if a person had to be placed in the recovery position on the floor.

Inspector's evidence

The pharmacy was well laid out and generally presented a professional image. The dispensing areas were tidy and organised. The floors were clear. The premises were clean and generally well maintained.

The consultation room was small and the door opened inwards. This meant that access by the emergency services would be difficult if a patient had to be placed in the recovery position of the floor. The pharmacy did offer a flu vaccination service and the pharmacist said that he had raised that the door could be hung so that it opened outwards. The design of the room also made it difficult for people to sit face-to-face. The trim on the table in the room needed repair. And, the chairs were covered with fabric which may make them difficult to clean. The room was signposted. It contained a computer but no sink. Conversations in the consultation room could not be overheard.

The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot. The temperature in the pharmacy was below 25 degrees Celsius. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a good range of services. Most people can access these services. But, some people with specific mobility needs many have difficulty entering the pharmacy. The services are effectively managed to make sure that they are provided safely. The pharmacy team members make sure that people have the information that they need to use their medicines correctly. They intervene if they are worried about anyone. The pharmacy gets its medicines from appropriate sources. The medicines are stored and disposed of safely. The team members make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room but no bell on the door to alert the staff to anyone who may need help entering the pharmacy. There was access to Google translate on the pharmacy computers for non-English speakers and this had been used in the past. The pharmacy printed large labels for one sight-impaired patient. There were two hearing loops for hearing-impaired people.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), Discharge Medicine Reviews (DMRs), supervised consumption of methadone and buprenorphine (but currently no clients), emergency hormonal contraception (EHC), Choose Pharmacy scheme, smoking cessation (nicotine replacement) and seasonal flu vaccinations. The latter was also provided under a private scheme. The services were well displayed and the staff were aware of the services offered.

The pharmacist had completed suitable training for the provision of seasonal flu vaccinations including face-to-face training on injection technique, needle stick injuries and anaphylaxis. He had also completed suitable training for the provision of the free NHS EHC service and the Welsh Choose Pharmacy scheme. The latter allowed the provision of some ‘prescription only medicine’ items, under patient group directions, such as, nystatin for the treatment of oral thrush in babies.

Several domiciliary patients received their medicines in compliance aids (blister packs). These were assembled in a separate organised room on a four-week rolling basis. They were evenly distributed throughout the week to manage the workload. There were dedicated folders for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. These were referred to at the checking stage. Procedures were in place to ensure that all patients who had their medicines in compliance aids and, were prescribed high-risk drugs, were having the required blood tests.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. There was also an electronic audit trail of when medicines were collected or delivered to patients. Interventions were seen to be recorded on the patient’s prescription medication record. Green ‘see the pharmacist’ stickers were used. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were recorded. He was seen to counsel most ‘walk-in’ patients. He said that he targeted those patients prescribed amongst others, antibiotics, new drugs and any changes for counselling. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. All the staff were aware of the new sodium valproate

guidance. They had no patients who could become pregnant.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Potential non-adherence or other issues were identified at labelling and hand-out. Any patients giving rise to concerns were targeted for counselling. The pharmacist reported that he frequently identified during MURs that asthmatic patients did not know how to use their inhalers and spacers correctly. He gave them advice about this.

Medicines and medical devices were obtained from HSC, AAH and Alliance Healthcare. Specials were obtained from IPS Specials. Invoices for all these suppliers were available. A scanner was available to check for falsified medicines as required by the Falsified Medicines Directive (FMD) but not yet operational. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were no patient-returned or out-of-date CDs. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed records. Date checking procedures were in place with electronic records. Designated bins were available for medicine waste and used. There was a separate bin for cytotoxic and cytostatic substances and a list of such substances that should be treated as hazardous for waste purposes.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 28 October 2019 about ranitidine 150mg/ml liquid. The pharmacy had none of the affected batches but all unexpired stock, 2 bottles, was returned to Alliance Healthcare, as directed by the alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriate equipment for the services it provides. And, the team members make sure that it is clean.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 500ml). There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 2018/2019 Children's BNF. There was access to the internet.

The fridge was in good working order and maximum/minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was collected for appropriate disposal. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.