General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Malpas Pharmacy, 361 Malpas Road, NEWPORT, Gwent, NP20 6WB

**Pharmacy reference:** 1043425

**Type of pharmacy:** Community

**Date of inspection:** 26/11/2019

## Pharmacy context

This is a community pharmacy on a busy through-road on the outskirts of the city of Newport. A wide variety of people use the pharmacy. It dispenses NHS and private prescriptions and sells over-the-counter medicines. The pharmacy supplies many medicines in multi-compartment compliance aids to help vulnerable people in their own homes to take their medicines. And, it supplies medicines to the residents of several care homes.

## 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 | 2.1 | Good practice | The pharmacy has enough staff to manage its workload safely. They cope well when team members are off sick and they plan their workload effectively. |
| | | 2.5 | Good practice | The owner actively encourages all his staff to develop their careers. They feel 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 | 5.1 | Good practice | The pharmacy uses innovative technology to reduce the risk of mistakes. |

## Principle 1 - Governance ✔ Standards met

### Summary findings

The pharmacy's working practices are generally safe and effective. The team members discuss the written procedures to make sure that they fully understand them. The pharmacy is appropriately insured to protect people if things go wrong. The pharmacy mainly keeps the up-to-date records that it must by law. The pharmacy team members know how to protect vulnerable people and they generally keep people's private information safe. 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 a recent form error with mirtazapine. Because of this, cardboard dividers had been placed to separate the orodispersible from the ordinary tablets. Near misses were recorded but insufficient information was documented to allow any useful analysis. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. General trends could be identified but, whilst the log was said to be reviewed each week, this was not documented.

The dispensing areas were large and divided into three distinct areas; a walk-in and general repeat prescription area, a care home area and a domiciliary multi-compartment compliance aid area. These were organised with dedicated labelling, assembly and checking stations. The front dispensary also had an administrative area and an area for deliveries.

Coloured baskets were used and distinguished prescriptions for patients who were waiting, those for collection and those for delivery. There was mainly clear audit trail of the dispensing process but assembled methadone had no completed audit trail. Baskets in the front dispensary were seen to be stored on top of one another and the name and address label was placed on the rim. This increased the likelihood of transference to the wrong basket and hence an error. The staff stopped this practice during the visit.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place. These were currently under review. The staff discussed an SOP each week to ensure that they clearly understood the procedures. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. There was no displayed sales protocol, but the medicine counter assistant trainee said that she would refer all medicine sales requests that she was unsure of, to the pharmacist. A NVQ2 trained dispenser said that she would refer all medicine sale requests for pseudoephedrine and multiple sale requests for codeine-containing 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 also referred these requests to the pharmacist.

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 2019 survey, 96% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback about giving advice on physical exercise. The pharmacist said that she would

try to give more proactive advice on this.

Public liability and professional indemnity insurance provided by the National Pharmacy Association (NPA) and valid until 31 July 2020 was in place. The responsible pharmacist log, controlled drug (CD) registers, emergency supply records, specials records, fridge temperature records and date checking records were in order. The private prescription records mainly recorded only one date, the date of the supply. There were many empty fields in the patient-returned CD records, including signatures indicating that they had been destroyed.

There was an information governance procedure and the staff had also completed training on the new data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was mainly stored securely but patient-sensitive information was stored on open shelves in the consultation room. The superintendent said that he would address this. 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 completed level 1 training provided by the Wales Centre for Pharmacy Professional Education (WCPPE). The pharmacists and technicians had also completed level 2 training. Local telephone numbers were available to escalate any concerns relating to both children and adults. Some of the staff had completed 'Dementia Friends' training.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff to manage its workload safely. And, they cope well when team members are off sick. The pharmacy plans its workload well in advance to accommodate busy times such as Christmas. The team members are well supported by the owner. He actively encourages all his staff to develop their careers They feel comfortable about providing feedback to him to improve services and this is acted on. The team members have regular on-going training but there are no formal appraisals and so some gaps in their knowledge may not be identified.

### Inspector's evidence

The pharmacy was on a busy through-road on the outskirts of the city of Newport. They dispensed many items, mainly against NHS prescriptions. Few private prescriptions were dispensed. A large proportion of the business at the pharmacy was the assembly of medicines into compliance aids for domiciliary patients and the assembly of medicines for several care homes (nursing and residential).

The current staffing profile was: two full-time pharmacists, one part-time pharmacist (in charge of the care home room), one full-time NVQ3 qualified technician, one part-time NVQ3 qualified technician, four full-time NVQ2 qualified dispensers (one, the supervisor who was off sick), three part-time NVQ2 qualified dispensers (one, enrolled on the NVQ3 course), one full-time NVQ2 trainee dispenser, two part-time NVQ2 trainee dispensers, three part-time medicine counter assistants (one off sick), two full-time drivers and four part-time drivers.

The part-time staff were flexible and generally covered any unplanned absences. Two members of staff were off sick but the pharmacy was coping well with their workload. They had already put plans in place to cope with the busy Christmas period ahead. Planned leave was booked well in advance and only one member in each dispensary team could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The staff were well qualified and clearly worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. There were frequent one-to-one meetings but no formal appraisals. Recently a qualified dispenser had said that she would like to do the technician training. Because of this, she had been enrolled on the course. The owner reported that he actively encouraged all of his staff to further their careers. A qualified technician will soon start the accuracy checking technician accreditation.

The staff were encouraged with learning and development but were not signed up to any formal on-going learning. They attended occasional Numark training sessions and were also provided with regular training in their weekly staff meetings. Recent topics had been on swallowing, beads in the ears of young children and Parkinson’s disease. The NVQ3 trainee technician had no dedicated time towards her course but she said that she was well supported by the pharmacists. The owner said that he would look into having a dedicated training rota for all the staff that were enrolled on accredited training courses. All the dispensary staff reported that they were supported to learn from errors. The GPhC registrants reported that all learning was documented on their continuing professional development (CPD) records.

The staff knew how to raise a concern and said that this was encouraged and acted on. A qualified dispenser had recently raised issues with the telephone service. The pharmacy had four telephone lines but just one number. Because of this, the owner was investigating an automatic transfer system so the staff did not have to waste time manually transferring calls to the appropriate department.

The staff were not set any targets or incentives.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy looks professional. The work areas are tidy and organised. The pharmacy signposts its consultation room but it is behind the medicine counter and difficult to see. So, some people may not know that there is somewhere private for them to talk. And, the room is small with an inward opening door. This means that the emergency services may not be able to easily access a person who had to be placed in the recovery position on the floor.

### Inspector's evidence

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

The consultation room was signposted. But, it was located behind and, at right-angles, to the medicine counter and so difficult to see. The room was small and the door opened inwards. This may impede access by the emergency services if necessary. The pharmacy did offer a flu vaccination service. The consultation room contained a computer and a sink. Conversations in the consultation room could not be overheard.

The pharmacy computer screens were not visible to customers. The screen in the consultation room was on the wall and all the staff said that only the details of the patient currently in the room would be displayed. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

There was air conditioning and the temperature in the pharmacy was below 25 degrees centigrade. 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 may have difficult entering the pharmacy. The services are effectively managed to make sure that they are delivered safely. The pharmacy has good procedures for the services it supplies to care homes. The pharmacy gets its medicines from appropriate sources. The medicines are stored and disposed of safely. The pharmacy team members make sure that people have the information that they need to use their medicines properly. But, they could have a better audit trail demonstrating 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 front door to alert the staff to anyone who may need assistance entering the pharmacy. There was access to an electronic translation service on the pharmacy computers for use by any non-English speakers. The pharmacy could print large labels for sight-impaired patients.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), Discharge Medicines Reviews (DMRs), the Welsh Choose Pharmacy scheme, emergency hormonal contraception (EHC), level 2 smoking cessation (nicotine replacement), supervised consumption of methadone and buprenorphine, palliative care rota 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 pharmacists had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. They had recently provided this service to the staff of Newport High School. The pharmacists had also completed suitable training for the provision of the free NHS EHC service and the Choose Pharmacy scheme. The latter allowed a comprehensive list of medicines to be supplied including, prescription only medicines, such as Nystatin for the treatment of oral thrush in babies.

The palliative care rota was provided in conjunction with the emergency services and covered the whole of Gwent. The owner was sometimes called out five times a week. He met the emergency services at the pharmacy.

Several substance misuse patients had their medicines supervised and some took their medicines home. Assembled methadone was seen with no completed dispensing audit trail. The pharmacist seen said that she had done both the assembly and checking of these that morning. She gave assurances that this would be addressed. The owner said that, in future, he would get a technician to pour the methadone and the pharmacist would check it so, two independent people were involved. And, he said that they would each initial the dispensing label at the time of performing the task.

A large proportion of the business at the pharmacy was the assembly of medicines into compliance aids for domiciliary patients and the assembly of medicines for the residents of several care home patients (nursing and residential). The care homes were wide-spread. There were spacious, organised separate rooms for these activities with clear labelling, assembly and checking areas.

The domiciliary compliance aids were mainly assembled on a four-week rolling basis and 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. There was a concise audit trail of any changes for easy reference by the pharmacist. The pharmacy ordered the prescriptions on behalf of these patients. The assembled dosettes were stored tidily in individual baskets on shelves above the dispensing bench. 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. INR levels were recorded on the patient's electronic prescription medication record. If necessary, these patients would be counselled by telephone.

The pharmacy also provided services to several care homes. It used innovative CAPA technology developed by Invatech Health. This was soon to be aligned with new Titan prescription medication record software. The homes ordered the prescriptions using the CAPA technology. The pharmacy printed these off and took the orders to the surgeries. There was a clear electronic audit trail of who had ordered the items. The pharmacy sent copies of the prescriptions to the homes for checking. They also sent written confirmation to the homes of any missing items or other issues at least one week in advance of the delivery date. The homes mainly chased the surgeries for these. The homes were also responsible for ensuring that any patients prescribed high-risk medicines were having the appropriate blood tests. Some surgeries put notes on the prescriptions about these tests. The pharmacy had done an audit on all the people who were prescribed sodium valproate. All of the staff were aware of the new guidelines on this.

The CAPA technology was also used to scan the boxes at assembly. This reduced the risk of errors. Any split boxes were counted and scanned by two independent people to reduce the risk of errors. A few homes had their medicines racked. The homes sent a monthly up-to-date racking list. The CAPA technology also allowed the pharmacy to see any missed administrations. They printed off a daily list and contacted the homes about these. The homes were visited every six months. Nurses completed dedicated e-Learning and care home staff also did training. The pharmacy provided any advice over the phone if necessary.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed, except methadone (see above) by the pharmacy. Interventions were seen to be recorded on the patient's prescription medication record. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were recorded. She also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. The pharmacist proactively prepared a grid chart for patients with confusing dosage regimes. CDs and insulin were checked with the patient on hand-out.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were only obtained indicating the safe delivery of controlled drugs. A delivery driver said that he occasionally delivered medicines through letterboxes. Owing slips were used for any items owed to patients. Potential non-adherence or other issues were identified at labelling and ordering. Any patients giving rise to concerns were targeted for counselling. The pharmacist said that the pharmacy had a lot of type II diabetic patients and so she gave them dietary advice during MURs. She also contacted the surgery if patients, prescribed metformin, were suffering from diarrhoea. This was usually replaced with a modified release preparation that was better tolerated.

Medicines and medical devices were obtained from AAH, National Generics, Phoenix, Lexon and Alliance Healthcare. Specials were obtained from Arcadia Specials. Invoices for all these suppliers were

available. CDs were stored in a dedicated room in accordance with the regulations. Access to the room was appropriate. There were many patient-returned but no out-of-date CDs. These were clearly labelled and separated from usable stock. The pharmacist said that these would be destroyed as soon as possible. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with electronic records. Date checking procedures were in place with signatures recording who had undertaken the task. 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. Not all actions were recorded and some recent alerts, such as about ranitidine were not in the folder.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides. It uses innovative technology to reduce the risk of mistakes. And, it upgrades its equipment to make sure that it works well.

### Inspector's evidence

The pharmacy used several British Standard crown-stamped conical measures (10 - 100ml) and ISO stamped straight measures (10 - 100ml). There were several 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 care home room used innovative CAPA technology which reduced the risk of errors. This technology was also used in the homes and reduced the risk of medication errors (see under principle 4). The pharmacy recently had an issue with the CAPA system. They called Invatech Health. The problem was related to the internet. As a result of this, they now had full-fibre broadband.

The fridges were in good working order and maximum and 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. |