General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Usk Pharmacy, 59 Bridge Street, USK, Gwent, NP15 1BQ

**Pharmacy reference:** 1043466

**Type of pharmacy:** Community

**Date of inspection:** 29/01/2020

## Pharmacy context

This is a community pharmacy in the town of Usk to the north east of the city of Newport. A wide variety of people use the pharmacy but they are mainly elderly. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It also supplies several 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

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 | 2.5 | Good practice | The team members are comfortable about providing feedback to their manager to improve services and he acts on this. |
| **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 safe and effective. It is appropriately insured to protect people if things go wrong. The pharmacy keeps the up-to-date records that it must by law. The team members keep people's private information safe and they know how to protect vulnerable people. But, they could learn more from their 'near miss' mistakes to reduce the likelihood of an actual error to a person.

### Inspector's evidence

The pharmacy team identified and managed most risks. Any dispensing errors or incidents would be recorded, reviewed and appropriately managed. However, there had been no known errors in the last five years. Near misses were recorded but insufficient information was documented to allow any useful analysis, such as a recent picking error involving propranolol and pravastatin. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded.

The dispensary was organised with labelling, assembly, checking and multi-compartment compliance aids areas. Coloured baskets were used but, only distinguished prescriptions for patients who were waiting and those sent from the surgery. This meant that the pharmacist may not be able to suitably prioritise the workload. 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. Three independent people were involved in the dispensing process when the pharmacy was busy and this reduced the risk of errors.

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 company's sales protocol was displayed and included questions to be asked of customers requesting to buy medicines and when customers should be referred to the pharmacist, such as specific patient groups and those requesting multiple sales. But, this was not signed or dated and included no local additions. However, a medicine counter assistant (MCA) trainee said that she referred anything that she was uncertain of, to the pharmacist. A NVQ2 trainee dispenser would refer all requests for multiple sales 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. The staff knew about the NFA-VPS (non-food animal, veterinarian, pharmacist, suitably qualified person) status of veterinary medicines and 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 actively encouraged. The pharmacy did an annual customer satisfaction survey. In the latest survey, 96% of people who completed the questionnaire rated the pharmacy as excellent or very good overall. There had been some feedback, 3.3%, about having somewhere private to talk. The consultation room was signposted, but this was not prominent and easily visible when people entered the pharmacy. The pharmacist said that he would get a more prominent sign.

Public liability and indemnity insurance, provided by the National Pharmacy Association (NPA) and valid until 31 October 2020, 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.

An information governance procedure was in place and the staff had also completed training on the general 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 shredded. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and, except for the new MCA employee, had completed level 1 training provided by the Wales Centre for Pharmacy Professional Education (CPPE). The pharmacist and technician had completed the level 2 training. Local telephone numbers were available to escalate any concerns relating to both children and adults.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff to manage its workload safely. The team members are comfortable about providing feedback to their manager to improve services and he acts on this. Those team members who are in training are well supported by the manager. All the team are signed up to a regular on-going learning programme but they have not done this for a few months. So, they may not be aware of any new developments.

### Inspector's evidence

The pharmacy was in the town of Usk to the north east of the city of Newport. They mainly dispensed NHS prescriptions. Several domiciliary patients received their medicines in multi-compartment compliance aids.

The current staffing profile was one pharmacist, the manager, one part-time NVQ3 qualified technician, one part-time NVQ2 qualified dispenser, one NVQ2 trainee dispenser, three part-time medicine counter assistant (MCA) trainees and one part-time delivery driver.

The part-time staff were flexible and generally covered any unplanned absences. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The staff clearly worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. There was an annual performance appraisal where any learning needs could be identified. Review dates would be set to achieve this. The staff were encouraged with learning and development and were signed up to the NPA hub training. However, they said that they had not completed any of these modules for some time, August 2019. They had completed compulsory training, such as on safeguarding. Staff enrolled on accredited courses, such as the NVQ2 dispensing assistant course, were allocated work time for learning but there was no dedicated rota for this. The pharmacist said that he would introduce a training rota for all the staff. 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 reported that this was encouraged and acted on. There were monthly staff meetings and the staff said that they felt able to raise any issues. The technician had recently raised concerns about the storage of the two strengths of zopiclone. Because of this, they had been clearly separated in order to reduce the risk of errors with these. All the staff were aware of the company’s whistle-blowing policy. The pharmacist reported that he was set overall targets, such as for Medicine Use Reviews (MURs). He said that he only did clinically appropriate reviews and did not feel unduly pressured by the targets.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy generally looks professional. It is suitable for the services it provides. The pharmacy signposts its consultation room but, this signage is not prominent. And so, some people may not know that there is somewhere private for them to talk.

### Inspector's evidence

The pharmacy was well laid out and presented a professional image. The dispensing benches were uncluttered and the floors were clear. The premises were clean and mainly well maintained. The bell on the front door, alerting staff to anyone who may need assistance entering the pharmacy, was not working. The staff said that this had been escalated to the maintenance department of the company. There were also a couple of soiled ceiling tiles, following previous water damage.

The consultation room was quite spacious and the door opened outwards. So, access by the emergency services, if someone had to be placed in the recovery position on the floor, would not be impeded. However, the room could be tidier and better signposted (see under principle 1). 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 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. But, some people with specific mobility needs, may have difficulty entering the pharmacy. It manages its services effectively to make sure that they are delivered safely. The team members make sure that people have the information that they need to take their medicines properly. The pharmacy gets its medicines from appropriate sources. And, it stores and disposes of them safely. The team members make sure that people only get medicines or devices that are safe.

### Inspector's evidence

There was no independent wheelchair access to the pharmacy and the consultation room because of a small step up. And, the bell on the front door, alerting staff to anyone who may need assistance entering the pharmacy, was not working. The staff could access an electronic translation service for non-English speakers and the pharmacist spoke Urdu. The pharmacy could print large labels for sight-impaired patients and had done so in the past.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), Discharge Medicine Reviews (DMRs), smoking cessation level 3, the Welsh Choose Pharmacy Scheme, the Aneurin Bevan MAR (medicine administration record) chart service, the sore throat testing service 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 Choose Pharmacy Scheme. This allowed the provision of numerous medicines including, ‘prescription only medicines’, such as Nystatin, for the treatment of oral thrush in babies. He was shortly due to do the required training for the provision of the free NHS emergency hormonal contraception service.

Several domiciliary patients received their medicines in compliance aids. These were assembled on a dedicated separate bench, one at a time, in order to keep the space as clear as possible. The medicines for the compliance aids were checked after picking and prior to assembly to reduce the likelihood of errors. They were assembled on most days to manage the workload and on a four-week rolling basis. 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 but there was not a concise audit trail of any changes for easy reference by the pharmacist at the checking stage. The assembled compliance aids were stored tidily.

There was a good audit trail for all items dispensed by the pharmacy. They did not order prescriptions on behalf of patients. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. He asked about international normalised ratios (INR). He also counselled patients prescribed amongst others, antibiotics, new drugs, any changes and complex dosage regimes. CDs and insulin were checked with the patient on hand-out. All the staff were aware of the sodium valproate guidance relating to the pregnancy protection programme. 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. The pharmacist reported that the patients visiting the pharmacy were well informed about their medicines. He had in the past, during MURs, identified side effects related to simvastatin. He gave diabetic patients healthy lifestyle advice.

Medicines and medical devices were obtained from AAH, Alliance Healthcare, DE Pharma and OTC. Specials were obtained from AAH Specials. Invoices for all these suppliers were available. CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. But, there were a number of patient-returned CDs. These were clearly labelled and separated from usable stock but were occupying valuable space in the cabinet. The pharmacist said that he would destroy these as soon as possible. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with signed 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. They were signed and dated by the person checking the alert. Any required actions were recorded. A separate audit log was also completed. The pharmacy had received an alert on 5 December 2019 about ranitidine tablets. The pharmacy had two of the affected batches which were returned to the wholesaler.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides. And, the team members make that they are clean and fit-for-purpose.

### Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (100 - 500ml) and ISO stamped straight measures (10ml). There were two tablet-counting triangles, one of which was kept specifically for cytotoxic substances and two capsule counters. These were clean and the staff reported that they were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 78 and the 20179/2020 Children's BNF. There was access to the internet.

The fridge was 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 shredded. 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. |