General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Well, 77a High Street, Nantyffyllon, Maesteg, BRIDGEND, Mid Glamorgan, CF34 0BT

**Pharmacy reference:** 1043507

**Type of pharmacy:** Community

**Date of inspection:** 25/07/2019

## Pharmacy context

This is a village pharmacy. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a wide range of services including emergency hormonal contraception, smoking cessation, 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

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 | 1.8 | Good practice | Safeguarding is an integral part of the culture within the pharmacy |
| **2. Staff** | Standards met | 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 |
| **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 has written procedures to help make sure the team works safely. 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 are good at recognising and reporting concerns about vulnerable people to help keep them safe. Its team members record and review their mistakes so they can learn from them. But they do not review all mistakes. So they may miss some opportunities to learn from these. And they do not take much action to help stop the same sorts of mistakes from happening again.

### Inspector's evidence

The pharmacy had systems in place to identify and manage risk, including the recording and analysis of dispensing errors and near misses. However, the pharmacist said that few near misses had been recorded since the introduction of a new patient medication record (PMR) and hub-and-spoke dispensing system, as she and other pharmacists found that it was not always convenient to access the electronic recording software. As a result, she said that it was not always easy to spot patterns and trends during review. Little practical action had been taken to reduce risk: 'Similar Name' stickers were used on dispensary shelves to alert staff to the risk of picking errors but in some cases staff were unsure which products they had been used to highlight. Staff were aware of the risks of picking errors with 'Look-Alike, Sound-Alike' drugs and most were not stored closely together on dispensary shelves. However, one box of amitriptyline 50mg tablets was stored with atenolol 50mg tablets and some clarithromycin 500mg tablets were stored with ciprofloxacin 500mg tablets. The pharmacy team said that this was an oversight and moved the products to their correct storage positions. A poster describing the process to follow in the event of anaphylaxis was displayed in the consultation room. Patient safety incidents throughout the company were collated and analysed and the learning points from the results were disseminated to the branches via a monthly superintendent newsletter. A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. A list of activities that could and could not be carried out in the absence of the responsible pharmacist (RP) was displayed in the dispensary.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed near the medicines counter showed that this was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in a poster displayed on the side of the consultation room.

A current certificate of professional indemnity insurance was on display. 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, there were occasions on which the RP had not signed out of the responsible pharmacist record to show the time at which they had relinquished responsibility for the safe and effective running of the pharmacy. CD running balances were typically checked weekly, although some running balance checks for methadone 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 for some records 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 pharmacists 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 give examples of how they had identified and supported potentially vulnerable people, which had resulted in positive outcomes. A summary of the chaperone policy was detailed in a poster displayed on the side of the consultation room.

## Principle 2 - Staffing ✔ Standards met

### 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 part-time pharmacist oversaw professional activities on two days each week, with relief or locum pharmacists covering her absences from Monday to Wednesday. Pharmacists were assisted in the day-to-day operation of the pharmacy by the branch manager, a qualified dispensing assistant, who was shortly to be replaced by a manager with no pharmacy experience. There were enough suitably qualified and skilled staff present to manage the workload during the inspection and the staffing level appeared adequate for the services provided. The pharmacist and staff said that they had recently begun to dispense MDS trays for other local branches and the increase in workload along with the introduction of a new software system and hub-and-spoke process had caused them to fall behind schedule. They had been asked to do extra work at times when the pharmacy was closed to remedy this.

Targets were set for MURs but these were managed appropriately and the pharmacist said they did not affect her professional judgement or patient care. Staff worked well together and had an obvious rapport with customers since they served a small and 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. A poster advertising a confidential helpline for reporting concerns outside the organisation was displayed in the dispensary.

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 and the Falsified Medicines Directive. They had also recently completed training provided by NHS Wales on improving the quality of services provided. 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. The dispensary was small but there was enough space to allow safe working, although some stock and prescriptions were temporarily stored on the floor. A staff room on the first floor included an area that was used for the assembly of MDS trays. The sink had hot and cold running water and soap and cleaning materials were available. A poster describing hand washing techniques was displayed above the sink. 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 provides services that people can access easily. If it can't provide a service it directs people to somewhere that can help. The pharmacy's working practices are generally safe and effective. And it generally manages medicines appropriately.

### Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was a small step up to the pharmacy entrance, but the pharmacist said that the team would go out to patients in wheelchairs and help them into the pharmacy if necessary. There was wheelchair access into the consultation room. A hearing aid loop was available. Contact numbers for local healthcare services were displayed in the retail area and staff said that they would signpost patients requesting services they could not provide to other nearby pharmacies.

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. Stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was invalid and could no longer be supplied. Stickers were used on prescriptions awaiting collection to identify patients eligible for an MUR.

The pharmacist said that stickers were used to routinely identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate. However, there was no evidence available and one prescription for warfarin was not marked in this way, so it was possible that counselling opportunities could be missed. The pharmacist demonstrated that some relevant information about blood tests and dose changes was recorded on the PMR. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that any patients prescribed valproate who met the risk criteria would be 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.

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 not labelled with descriptions to enable identification of individual medicines and patient information leaflets were not always supplied. This created a risk that the patient might not have all the information needed for them to make informed decisions about their own treatment. Each patient had a section in one of four dedicated files that included their personal and medication details, contact details for representatives where appropriate, details of any messages or queries and any relevant documentation, such as current repeat prescriptions. The patient's record was flagged if their medication included a controlled drug that required safe custody. A list of patients and their delivery or collection arrangements was available for reference.

Medicines were obtained from licensed wholesalers and generally stored appropriately, although some different products and different strengths of the same product were mixed up together, which increased the risk of picking errors. Medicines requiring cold storage were stored in a tidy, well-organised drug fridge. Maximum and minimum temperatures were usually recorded daily and were consistently 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. CDs were stored in three tidy, well-organised CD cabinets 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. Two boxes of out-of-date medicines had not been removed from stock although these had been marked with stickers to show they were short-dated. The pharmacist said that she always checked expiry dates as part of her accuracy checking process. A scheme run in association with GSK allowed the pharmacy to recycle returned inhalers. The pharmacist was able to describe how she would deal with medicines or medical devices that had been recalled as unfit for purpose by contacting patients where necessary and returning quarantined stock 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. It makes sure these are always safe and 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. 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.

All equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. 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. Dispensed prescriptions could be seen from the retail area but no confidential information was visible.

## 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. |