General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** A & J M Sheppard Ltd, 56 Llangewydd Road, Cefn Glas Estate, BRIDGEND, Mid Glamorgan, CF31 4JR

**Pharmacy reference:** 1043508

**Type of pharmacy:** Community

**Date of inspection:** 20/06/2022

## Pharmacy context

This is a pharmacy in a parade of shops. 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 | 1.2 | Good practice | Information about risk is reviewed and analysed to ensure all information is managed to protect the privacy, dignity and confidentiality of patients and the public |
| **2. Staff** | Standards met | N/A | N/A | N/A |
| **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 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 electronic recording and monthly analysis of dispensing errors and near misses. Results of the analysis were shared with staff for information. Action had been taken to reduce risks that had been identified: for example, after two consecutive near misses that involved 'look-alike, sound-alike' or 'LASA' drugs, the pharmacist had organised a training presentation for the team to inform them of the risks of errors with these medicines and had put steps in place to reduce the risks of such an incident occurring in future. Highlight stickers had been used on dispensary shelf edges for the most common LASA drugs, including allopurinol, atenolol, quinine, quetiapine, rosuvastatin and rivaroxaban. The system of 'TALLman' lettering had been used on the stickers, to highlight the part of the drug name that was different for medicines that were often confused: eg quINine, quETIAPine. Information about LASA drugs was displayed prominently in the dispensary for reference. After some selection errors with different forms of ramipril, a sticker had been added to the shelf on which it was stored to remind staff to check whether the prescription specified the form as capsules or tablets. A list of generic medicines and their equivalent brand names was available in the dispensary for the trainee dispensers to refer to when required.

Patient safety incidents throughout the company were collated and analysed and the learning points from the results were disseminated to the branches via a quarterly patient safety newsletter that staff had read and signed. The newsletter was very detailed and included key findings and examples of significant incidents with learning points.

The pharmacy also received a weekly bulletin from the superintendent's office that included patient safety issues: the current bulletin included an article about supplying valproate safely. Pharmacies in the area were members of an instant messaging group set up by the health board's local cluster pharmacist, which allowed them to post photographs and descriptions of potential patient safety risks they had encountered, such as items with similar packaging, to help reduce risk.

A range of standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. The newest member of staff was still in the process of being trained on SOPs relevant to her role but was able to describe her basic responsibilities.

A 'buzzbox' situated at the medicines counter was used to obtain customer service and general feedback on a regular basis: customers were asked to press buttons to rate different aspects of their experience in the pharmacy as green (good), yellow (neutral) or red (bad). A formal complaints procedure was in place and information about how to make complaints was displayed on the

consultation room door, along with a poster advertising the NHS complaints service ‘Putting Things Right’.

A current professional indemnity insurance certificate was on display. All necessary records were kept and were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. CD running balances were typically checked monthly.

Most staff had received training on the information governance policy and had signed confidentiality agreements. The newest member of staff had not yet signed a confidentiality agreement but understood the importance of confidentiality and had received training on information governance and data protection as part of her previous job role in another pharmacy. Staff were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. A privacy notice displayed on the consultation room door explained the way in which data was used by the pharmacy and gave details of the pharmacy’s Data Protection Officer.

The pharmacist and most staff had undertaken formal safeguarding training and had access to guidance and local contact details via the internet. One of the pharmacists was able to give an example of how they had identified and supported a potentially vulnerable person, which had resulted in a positive outcome.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff to manage its workload. They are properly trained for the jobs they do. And they feel comfortable speaking up about any concerns they have.

### Inspector's evidence

The regular pharmacist manager usually worked at the pharmacy assisted by a full-time relief pharmacist employed by the company. Their support team consisted of two pharmacy technicians (one of whom was absent), a dispensing assistant (also absent), two trainee dispensing assistants and a staff member who had worked at the pharmacy for two weeks and was yet to be enrolled on a training course. The pharmacist explained that the absent pharmacy technician was trained as an accuracy checker but was not currently using her qualification to check prescriptions. Staff members had the necessary training and qualifications for their roles or worked under the supervision of the pharmacist and other trained members of staff. 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 pharmacy technician present was due to move to another branch later in the year and the pharmacist explained that he was in the process of recruiting another member of staff to replace her.

There were no specific targets or incentives set for the services provided. Staff worked well together and said that they were happy to make suggestions within the team. They said that they felt comfortable raising concerns with the pharmacists or management team. A whistleblowing policy was available in the SOP file and gave some details of organisations that could be contacted if staff wished to raise a concern externally.

The member of staff working on the medicines counter did not always use appropriate questions when selling over-the-counter medicines to patients. She usually, but not always, referred to the pharmacist for further advice on how to deal with transactions. However, both pharmacists explained that they were aware that this staff member had only been working at the pharmacy for a month and was not experienced in the sale of OTC medicines. They said that they always listened to all conversations arising from a medicine or advice request made by a customer and intervened where necessary, which was borne out by observation. This was possible as the pharmacist checking stations were very near the medicines counter and one pharmacist was always in the vicinity. A poster describing the WWHAM questioning technique was displayed in the dispensary near the medicines counter. The pharmacist agreed to move this to the counter itself so that it could be referred to more easily by inexperienced staff members.

Staff undertook online training provided by the organisation, which could be accessed from home. They had completed a recent module on the management of hay fever. Staff enrolled on the formal dispensing assistant training course were given four hours of protected time each per week to complete this. The pharmacy technician and one of the pharmacists questioned said that they understood the revalidation process. They said that they based their continuing professional development entries on situations they came across in their day-to-day working environment. The pharmacist explained that although the company had a formal appraisal system in place, the team had not yet been subject to any performance and development reviews, as the pharmacy had only recently changed ownership. Staff

could discuss issues informally with the pharmacists 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 and tidy. The dispensary was well-organised and there was enough clear bench space for safe working. Some stock and dispensed prescriptions awaiting collection were temporarily stored on the floor but did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use. A plastic screen at the medicines counter had been installed to reduce the risk of viral transmission between staff and customers. 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's working practices are generally safe and effective. It stores medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply.

### Inspector's evidence

The pharmacy offered a wide range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. The pharmacy team signposted people requesting services they could not provide to other local pharmacies or healthcare services, such as local GP surgeries, and kept a log of these referrals. The pharmacist demonstrated that he was able to use the local pharmacy instant messaging group to locate nearby services and signpost people appropriately. The pharmacist manager had recently visited local surgeries to discuss and promote services as part of a health board funded collaborative working initiative. These visits had involved discussions around the sore throat test and treat service and the Choose Pharmacy common ailments service.

Dispensing staff used a basket system to ensure that medicines did not get mixed up during dispensing and dispensing labels were initialled by the dispenser and checker to provide an audit trail. Controlled drugs and fridge lines 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. The pharmacy dispensed medicines against some faxed prescriptions from local surgeries. There were mechanisms in place to ensure that Schedule 2 or 3 CDs were only ever supplied against the original prescription.

Dispensed prescriptions that included controlled drugs (CDs) requiring safe custody were kept in a dedicated area of the dispensary and the CD was not added until the patient or their representative came to collect the prescription. Stickers were used on prescriptions awaiting collection to alert staff to the fact that a fridge item was outstanding. Stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

Prescriptions for high-risk medicines such as warfarin, lithium and methotrexate were not highlighted and there was a risk that counselling opportunities could be missed. The pharmacy team were aware of the risks of valproate use during pregnancy. A poster detailing action to be taken by pharmacists when supplying valproate was displayed in the dispensary. The pharmacist said that the pharmacy supplied valproate to about five patients who met the risk criteria. He explained that he counselled each person or their representative appropriately and provided them with information at each time of dispensing. The pharmacy carried out regular audits of high-risk medicines, which were 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.

Prescriptions awaiting collection were marked with six different coloured stickers that corresponded to

specific weeks. They remained on the shelf for six weeks before the medicines were returned to stock if not collected or required. Any corresponding prescriptions were stored in a dedicated file for reference. The pharmacist said that he checked the file regularly for any high-risk items and would report these to the relevant surgery.

The pharmacy provided a prescription collection service from several local surgeries. It also offered a prescription delivery service. Signatures were obtained for deliveries and the driver annotated their delivery sheet with the time of delivery for reference. Separate signatures were obtained for controlled drugs. In the event of a missed delivery, the driver put a notification card through the door and brought the prescription back to the pharmacy. A company consent form that people were asked to sign when requesting the delivery service included an option for routinely posting medicines through letterboxes. The pharmacist said that he recognised the risks of this practice and always crossed through this paragraph to show that it was not an option at that pharmacy.

The pharmacy provided a wide range of services. It was one of only a few pharmacies in the health board area that currently provided a sore throat test and treat service, and uptake was high, as many people were referred from outside the area. There was also a high uptake of the common ailments service. Uptake of the influenza vaccination service had been high compared to previous years: the pharmacy had vaccinated about 450 people during the 2021/22 season, most of whom were eligible for the free NHS service. Substance misuse services were managed well. Each substance misuse client had a designated section in a file that was used to hold prescriptions, supervised consumption claim forms and any other relevant information or messages. The pharmacist explained that although he provided a discharge medicines review service, the local hospital did not automatically send electronic copies of discharge letters to the pharmacy through the Choose Pharmacy software platform and so he was reliant on patients to bring paper copies of their discharge letter to the pharmacy. This meant that uptake of the service was relatively low.

The pharmacy currently provided medicines in disposable multi-compartment compliance aids to about 100 patients. The compliance aids were labelled with descriptions and patient information leaflets were routinely supplied. Each patient had a section in a dedicated file that included their personal and medication details, collection or delivery arrangements, details of any messages or changes and any relevant documentation, such as current prescriptions and repeat order forms. A list of patients was available in the front of the file for reference. The pharmacist explained that the compliance aids were gradually being moved to another nearby branch to reduce the pharmacy's workload, at the rate of about eight compliance aids each week.

Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were stored in two well-organised drug fridges. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored in one large, well-organised CD cabinet and obsolete CDs were segregated from usable stock.

Stock was subject to regular documented expiry date checks and short-dated items were highlighted using stickers. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. There was no separate bin for disposing of cytotoxic waste but the pharmacist manager said that he was in the process of ordering one from their waste contractor and would segregate any cytotoxic waste they received in the meantime. The pharmacy received drug alerts and recalls via its NHS email account which was usually checked at the beginning and end of each day. These were printed and filed for reference. The pharmacist was able to describe how he had recently dealt with some baby milk that was unfit for purpose by contacting patients and returning quarantined stock to the relevant supplier.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide its 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 were washed after 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 pharmacy software system was protected with a password 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. |