General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 1 Main Road, Church Village, PONTYPRIDD, Mid Glamorgan, CF38 1PY

Pharmacy reference: 1043593

Type of pharmacy: Community

Date of inspection: 13/09/2024

Pharmacy context

This pharmacy is in a large village near Pontypridd. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. Some NHS prescriptions are assembled off-site at another pharmacy owned by the same company. The pharmacy offers a range of services including provision of emergency hormonal contraception, treatment for minor ailments and smoking cessation services. Substance misuse services are also available.

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	2.2	Good practice	Pharmacy team members have the appropriate skills, qualifications and competence for their roles 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. Its team members record and review their mistakes so they can learn from them. And they take action to help reduce the risk of similar mistakes happening again. The pharmacy keeps the records it needs to by law. Pharmacy team members keep people's private information safe. And they 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. The pharmacist explained that she discussed near misses with relevant staff at the time they came to light. And that any patterns or trends that emerged were discussed with the whole team. Some action had been taken to reduce risks that had been identified. For example, different forms of omeprazole been distinctly separated on dispensary shelves following some near misses. A poster provided by the local health board highlighting the risks of selection errors with pregabalin and gabapentin was displayed in the dispensary.

A range of electronic standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Members of the pharmacy team were required to complete an online declaration and assessment for each SOP. They were currently in the process of being trained on an updated version of the SOP for controlled drugs (CD) record keeping following the implementation of a new electronic CD register. A trainee dispensing assistant described the activities that could not take place in the absence of the responsible pharmacist. The responsible pharmacist notice displayed was incorrect, but the pharmacist remedied this as soon as it was pointed out.

The pharmacy team explained that verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place, and this was advertised in a notice displayed in the retail area.

Evidence of current professional indemnity insurance was available. Records were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed medicines and electronic CD records. CD running balances were typically checked weekly.

Staff received annual training on the information governance policy and had signed confidentiality agreements. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. A privacy notice displayed at the medicines counter signposted people to the company's website for information about the way in which their personal data was used and managed. The pharmacist and trainee pharmacy technician had undertaken advanced formal safeguarding training. All other team members had undertaken basic formal safeguarding training. They had access to guidance and local safeguarding contact details that were available in the pharmacy's safeguarding SOP and online. A summary of the pharmacy's chaperone policy was advertised in a notice displayed behind the medicines counter. A poster behind the medicines counter advertised the 'Ask for ANI' domestic abuse scheme. Pharmacy team members reported that they had all received training on the scheme, but had not received any requests to implement it.

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. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacist manager worked at the pharmacy on four days each week. Her absences were covered by locum pharmacists or relief pharmacists employed by the company. She was assisted by three dispensing assistants (DAs), a trainee DA and a pharmacy student who was employed on a zero hours contract. One of the DAs was enrolled on an accuracy checking course, and another was a trainee pharmacy technician. Trainees worked under the supervision of the pharmacist or other trained members of the pharmacy team. Relief DAs employed by the company were available to cover team members' absences. Pharmacy team members were able to safely manage the workload and the staffing level appeared adequate for the services provided.

Members of the pharmacy team working on the medicines counter were observed using appropriate questions when selling over-the-counter medicines to people. And they referred to the pharmacist on several occasions for further advice on how to deal with transactions. Team members undertook regular online training provided by the organisation on clinical topics, operational procedures and services. The company had a formal appraisal system in place and team members received a performance and development review every six months. They also discussed performance and development issues informally with the pharmacist whenever the need arose.

Targets were set for certain services, but these were managed appropriately, and the pharmacist said that they did not affect her professional judgement or compromise patient care. Pharmacy team members worked well together and had an obvious rapport with people using the pharmacy. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist and area manager. A whistleblowing policy was available on the pharmacy's intranet system. It included details of organisations that could be contacted if team members wished to raise a concern outside the organisation.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and tidy. It is secure and has enough space to allow for safe working. There is a room where people can have conversations with team members in private.

Inspector's evidence

The pharmacy was clean. The dispensary was very small, but there was enough space to allow for safe working. However, it was clear that more storage and workbench space would be beneficial, as dispensary work surfaces were a little cluttered, and large quantities of medicine stock and some prescriptions were being temporarily stored on the floor. Some of these posed a potential trip hazard and pharmacy team members moved them as soon as this was pointed out. A separate room on the first floor was used for the assembly of multi-compartment compliance packs. The sink had hot and cold running water and soap and cleaning materials were available. A poster illustrating hand washing techniques was displayed above the dispensary sink. Hand sanitiser was available for staff use.

A consultation room was available for private consultations and counselling, and this was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy for people to access. Its working practices are generally safe and effective. It stores medicines appropriately and carries out some checks to help make sure that they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy team offered a range of services, which were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. Pharmacy team members signposted people requesting services they could not provide to nearby pharmacies or other providers such as the local council, which offered a needle and sharps collection service.

About 70% of the pharmacy's prescription items were assembled offsite at the company's hub pharmacy. The hub pharmacy could not assemble split packs, fridge lines, most controlled drugs, or multi-compartment compliance packs and these continued to be dispensed at the branch.

Dispensing staff used baskets to ensure that medicines did not get mixed up during the dispensing process. Dispensing labels were initialled by the dispenser and accuracy checker to provide an audit trail. Controlled drugs requiring safe custody, fridge lines and compliance packs were dispensed in clear bags to allow pharmacy team members to check these items at all points of the dispensing process. This helped to reduce the risk of a person receiving the wrong medicine. Bag labels attached to dispensed medicines awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail. A text messaging service was available to let people know their medicines were ready for collection.

Dispensed medicines awaiting collection were assigned to specific storage locations in the dispensary. When pharmacy team members 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 their items were being stored, including medicine fridges or the CD cabinet where applicable. In addition, stickers were placed on prescription bags to alert team members to the fact that a CD requiring safe custody or fridge item needed to be added. 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. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

Supplies had recently been made against two private prescriptions that had not been signed by the prescriber. The pharmacist explained that this was an oversight and arranged to return the prescriptions to the prescriber for signing. She agreed to review the pharmacy's process for dispensing private prescriptions going forward.

Stickers were sometimes, but not always, used to identify people prescribed higher-risk medicines such as warfarin, lithium and methotrexate so that they could be counselled. The pharmacy team asked people about relevant blood tests and dose changes but did not record these conversations. They were aware of the risks of using valproate-containing medicines and topiramate during pregnancy. They were also aware of the requirement to supply valproate products in original packs. The pharmacist said that some people prescribed valproate who met the risk criteria had been identified. She explained that

they were routinely counselled and provided with information, and alerts had been added to their patient medication records. A poster that listed actions to be taken by the pharmacy team when dealing with valproate prescriptions was displayed in the dispensary.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. Compliance packs were labelled with descriptions of the medicines they contained. However, these did not always include enough detail to enable identification of individual medicines, with many described simply as 'tabs'. So, there was a risk that patients might not always be able to make informed decisions about their own treatment. On discussion, the pharmacy team understood the risks and agreed to review their dispensing processes going forward. Patient information leaflets were routinely supplied. Each patient had a clear plastic wallet that included their personal and medication details, collection or delivery arrangements, details of any messages or changes for communication purposes and any relevant documentation, such as current prescriptions and hospital discharge letters. A list of people receiving their medicines in compliance packs was available for reference. An original pack and medication administration record (MAR) chart dispensing service was provided to some care home residents. This service was also provided to some people in the community as part of a local health board commissioned scheme.

Uptake of the pharmacy's discharge medicines review service and emergency supply of prescribed medicines service was steady. Demand for the common ailments service and sore throat test and treat service was high, as the pharmacy received frequent referrals from GP surgeries and a local optician. The pharmacy offered an EHC (emergency hormonal contraception) and bridging contraception service, a smoking cessation (supply and monitoring) service, a seasonal influenza vaccination service and a free blood pressure measurement service. A supervised consumption service was also available. The pharmacist had recently become accredited to provide the UTI (urinary tract infection) service and was waiting for a clinical waste bin to be delivered before she could start offering it.

The pharmacy provided a prescription collection service from four local surgeries. It also offered a medicines delivery service. Patients or their representatives provided a signature to acknowledge receipt of delivery as an audit trail. Separate signatures were obtained for controlled drugs. 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.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in two well-organised medical fridges. Maximum and minimum temperatures for the fridges were checked and recorded daily and were usually within the required range. A discrepancy had been recorded on the day of the inspection, but evidence showed it had been monitored appropriately. CDs were stored in a large, well-organised CD cabinet and obsolete CDs were kept separately from usable stock. Pharmacy only medicines were stored in locked glass-fronted cabinets in the retail area.

Most stock was subject to regular documented expiry date checks. Short-dated items were usually highlighted with stickers. However, three out-of-date medicines that had not been highlighted in this way were found in a room where compliance packs were assembled. The pharmacy team explained that this was an oversight as these medicines were not often used for compliance pack patients. On discussion, they understood the risks and agreed to check expiry dates for all compliance aid medicine stocks regularly going forward. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received safety alerts and recalls via its NHS email account and its intranet system. These communications were printed and filed for reference. The pharmacy team described how they had recently dealt with a medicine recall for a specific brand of atomoxetine by

quarantining affected stock and returning it to the supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities it needs to provide the services they offer. And 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. Oral syringes were used to measure small volumes. Separate measures were used for methadone to prevent cross-contamination. Triangles were used to count loose tablets and a separate triangle was available for use with cytotoxic medicines. The triangles were dusty, but the dispensing team confirmed that they were washed before each use. The pharmacy had a range of up-to-date reference sources.

Most equipment was in good working order, clean and appropriately managed. Evidence showed that electrical equipment had recently been tested. However, a hearing aid loop in the dispensary had failed a recent test and could not be used. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the consultation room was used for private conversations and counselling. The pharmacy software system was protected with a password and computer screens were not visible to people using the pharmacy.

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.