General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 31 De Winton Street, Pandy Square, TONYPANDY, Mid Glamorgan, CF40 2RA

Pharmacy reference: 1043638

Type of pharmacy: Community

Date of inspection: 05/12/2019

Pharmacy context

This is a busy town centre pharmacy. 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 company. 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.

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	1.8	Good practice	Safeguarding is an integral part of the culture within the pharmacy
2. Staff	Good practice	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. Its team members record some of their mistakes. But they do not always take action to stop them from happening again and they do not always review everything that goes wrong. So they may miss some opportunities to learn. 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.

Inspector's evidence

The pharmacy had systems in place to identify and manage risk, including the recording of dispensing errors and near misses. However, the pharmacist said that the reporting of near misses had been sporadic in recent months and a team meeting had been held to reinforce the importance of learning from these incidents. She said she tended to discuss near misses with relevant staff at the time of each occurrence rather than analyse all patient safety incidents on a regular basis to identify patterns and trends. However, she was able to demonstrate some action that had been taken to reduce risks that had been identified: for example, different forms of Tegretol and ramipril had been separated on dispensary shelves following some selection errors with these items. A pack of quetiapine 25mg tablets was found to be stored with stocks of quinine tablets and the pharmacist remedied this as soon as it was pointed out.

A range of electronic standard operating procedures (SOPs) underpinned the services provided. These were regularly reviewed. The trainee dispensing assistant was in the process of reading and completing online declarations and assessments for all SOPs. The ACT said that she could check most prescription items that had been clinically checked by the pharmacist, except for warfarin, lithium, methotrexate and CDs requiring safe custody. She explained that the pharmacist annotated the top of each prescription to show it had been clinically checked.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. Staff said that results were mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in a poster displayed on the consultation room door. The NHS complaints procedure 'Putting Things Right' was also advertised on the consultation room door.

Evidence of current professional indemnity insurance was available. All necessary records were kept and properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. CD running balances were typically checked every fortnight, except for methadone running balances, which were checked twice a week.

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 being able to identify confidential waste and dispose of it appropriately. Individual staff members had unique passwords to access the pharmacy computer system. A privacy notice displayed at the medicines counter signposted people to the company's website for more information on the way in which personal data was used and managed by the company.

The pharmacist and ACT had undertaken level two safeguarding training and had access to guidance and local contact details that were available via the internet. Most staff had received in-house training although the trainee dispensing assistant had yet to complete this. All staff were trained Dementia Friends. They said that they had recently raised concerns about an elderly confused patient who was displaying symptoms of memory loss. The pharmacist had contacted the patient's GP, who had referred her to the local memory clinic for treatment. The pharmacist said that the delivery driver had recently alerted her to a problem with an elderly patient who received his medicines in compliance aids. The patient lived alone and had not been taking his medicines. The pharmacist said that she had contacted the GP who had arranged a care package and changed the way the patient's medicines were supplied so that carers could administer them. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door.

Principle 2 - Staffing ✔ Good practice

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 in the pharmacy on most days assisted by a second pharmacist every Thursday. She said that this arrangement would soon change as she was leaving to work in another branch. She explained that she would be replaced by a regular pharmacist and a non-pharmacist manager. The support team consisted of a full-time accuracy checking technician (ACT), two dispensing assistants and a newly-recruited trainee dispensing assistant. All worked well together. Another dispensing assistant and a relief pharmacy technician who was working at the branch to complete his ACT training were absent. 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. Staff members had the necessary training and qualifications for their roles. The trainee dispensing assistant worked under the pharmacist's supervision.

Targets were set for MURs, but these were managed appropriately and the pharmacist said that they did not affect her professional judgement or compromise patient care. The pharmacy served a close-knit community and staff had an obvious rapport with customers. Staff were happy to make suggestions within the team and said that they felt comfortable raising concerns with the pharmacist or Regional Development Manager. The pharmacist said that a whistleblowing policy for reporting concerns outside the organisation was available on the company's intranet system. She printed a copy of the policy and displayed it in the dispensary during the inspection.

A member of staff working on the medicines counter gave a coherent explanation of the WWHAM questioning technique and gave appropriate examples of situations she would refer to the pharmacist. She said that she would feel confident refusing a sale and had done so in the past when dealing with what she considered to be inappropriate requests for products containing codeine. Staff undertook online training on new products, clinical topics, operational procedures and services. They were able to access training modules from home and had recently completed training on the company's new patient medication record (PMR) system. The pharmacy technician had been trained to provide the smoking cessation level three service (supply and monitoring). She understood the revalidation process and based her entries on situations she came across in her day-to-day working environment. All staff were subject to annual performance and development reviews. The newly-recruited member of staff said that she would undergo an initial performance review after three months. Staff could discuss issues informally with the pharmacist whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and generally tidy. It is secure, has enough space to allow safe working and its layout protects people's privacy.

Inspector's evidence

The pharmacy was clean, fairly tidy and well-organised, with enough space to allow safe working. However, many tote boxes containing stock and dispensed prescriptions were being temporarily stored on the floor and posed a possible trip hazard. 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 was clearly advertised. A semi-private screened area of the medicines counter was used by substance misuse and needle exchange clients. The pharmacist said that all clients were offered the use of the consultation room as an alternative. The lighting and temperature in the pharmacy were generally appropriate, although the rear of the dispensary was quite cold. Staff said that this was because the pharmacy was housed in an old building which did not have good heat insulation.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy for people to access. If it can't provide a service, it directs people to somewhere that can help. Its working practices are generally safe and effective. It stores most medicines appropriately and carries out some checks to make sure they are in good condition and suitable to supply. The pharmacy's team members take extra care with high-risk medicines to help make sure that people use these safely.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. Hearing aid loops were available in the consultation room and at the medicines counter. Staff said that they would signpost people requesting services they could not provide to nearby pharmacies or other providers, such as the local surgery or the health board's sharps collection service. Some health promotional material was on display in the retail area.

Dispensing staff used a colour-coded basket system to help 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 compliance aids 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 team said that a new pharmacy software system had recently been installed which allowed about 50% of their prescription items to be assembled at the company's hub pharmacy. The hub pharmacy could not assemble split packs, most controlled drugs, fridge lines or compliance aids 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. A text messaging service was available to let patients know their medicines were ready for collection. The pharmacist said that the prescription storage area was checked weekly. Any patient who had not collected their prescription after four weeks was contacted as a reminder. After a further two weeks, the medicines were returned to stock if not collected and the prescription was returned to the surgery.

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 their 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 was outstanding. CD 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. However, one prescription for pregabalin was found not to be marked in this way. The pharmacist remedied this immediately it was pointed out. Stickers were used on prescriptions awaiting collection to identify patients eligible for an MUR.

Pre-printed notes or 'pharmacist advice' stickers were used to routinely identify prescriptions for patients prescribed high-risk medicines such as warfarin, lithium and methotrexate. Information about blood tests and dosage changes was recorded on the patient medication record (PMR). The pharmacist demonstrated that when an INR result was recorded for a patient whose medical condition had been

entered onto the PMR, an alert was produced if the INR was too low or high for that condition. This allowed the pharmacist to counsel the patient appropriately and alert the prescriber if necessary. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that four patients prescribed valproate who met the risk criteria had been counselled appropriately and provided with patient information. A valproate patient information pack was available 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 controlled drug. In the event of a missed delivery, the delivery driver put a notification card though the door and brought the medicines back to the pharmacy. The original prescription was then re-attached to the bag.

Disposable compliance aid trays were used to supply medicines to a number of patients. They were assembled in a room on the first floor of the building. Staff said that new patients were assessed for suitability before receiving the service. Trays were labelled with descriptions to enable identification of individual medicines. Patient information leaflets were routinely supplied. A labelled basket for each patient contained a record card that included their personal and medication details, collection or delivery arrangements and details of any messages or queries, as well as their current prescription. A note was attached to the basket of any patient currently in hospital.

The pharmacy had carried out approximately 200 influenza vaccinations during the 2019/20 season. The pharmacist said that most of these had been as part of the NHS enhanced service. She said that there was currently a high uptake of the newly-commissioned sore throat test and treat service, with many referrals from the local surgery.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, some loose blister strips that had been removed from their original packaging were found not to be adequately labelled either as stock or as named-patient medication. This increased the risk of error and did not comply with legislative requirements. Stock for the repeat prescription collection service was temporarily stored in a well-organised fashion on designated dispensary shelves before it was used to dispense corresponding prescriptions.

Medicines requiring cold storage were stored in two drug fridges. Maximum and minimum temperatures were recorded daily and were consistently within the required range. Storage space was limited and some different products and different strengths of the same product were stored very closely together, increasing the risk of errors. CDs were stored appropriately in two 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, waste sharps and clinical waste. A scheme run in association with GSK allowed the pharmacy to recycle returned inhalers. The pharmacist was able to describe how she had dealt appropriately with a recent recall for ranitidine tablets by quarantining affected stock and returning it to the supplier. She explained that the PMR software flashed up a real-time alert on the screen for all drug recalls. 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 its services. It generally makes sure these are 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. Two of these had broken bases. A Methameasure machine was used to measure substance misuse clients' daily methadone doses. The pharmacist provided records to show that the machine was calibrated each morning and sometimes twice daily. She said that the machine was cleaned by flushing it with water once a day. Triangles were used to count tablets. They were dusty but staff said that they would be washed before use. A separate clean triangle was available for use with loose cytotoxics. 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 it had recently been tested. However, a hearing aid loop in the consultation room had failed a recent test. 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.

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.