General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: A & J M Sheppard Ltd, 14-16 Commercial Street, Nelson, TREHARRIS, Mid Glamorgan, CF46 6NF

Pharmacy reference: 1043644

Type of pharmacy: Community

Date of inspection: 29/01/2020

Pharmacy context

This is a busy 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 not all met

Required Action: Improvement Action Plan

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	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
		4.3	Standard not met	Prescriptions awaiting collection are not being appropriately managed: - some dispensed items requiring refrigeration are stored at room temperature - the process in place for identifying dispensed items that are no longer suitable for supply is not robust
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 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 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 recording of dispensing errors and near misses. However, near miss recording was sporadic, with the last records made in July 2019. The pharmacist said that he 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. Some action had been taken to reduce risks that had been identified: for example, different forms of lansoprazole and ramipril had been separated on dispensary shelves to help reduce the incidence of picking errors. Co-codamol 30/500 and 15/500 tablets were also kept separately following a dispensing error. A poster describing the process to follow in the event of anaphylaxis was displayed in the dispensary.

A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. A medicines counter assistant who worked on Saturdays had not yet signed the SOPs, but the pharmacist said that she had been trained in the procedures relevant to her role. The accuracy checking technician said that the pharmacist manager labelled repeat prescriptions in the morning and clinically checked them during the labelling process. She said she would confirm with the pharmacist which prescriptions had been clinically checked and was then able to check the dispensed items with no restrictions. She said that prescriptions were not marked to show that they had been clinically checked. However, she explained that if she felt any uncertainty, she would show the dispensed items she had checked to the pharmacist on duty and ask them to perform a clinical check before supply to the patient. The lack of an audit trail to indicate a clinical check may prevent a full analysis of dispensing incidents.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of a recent survey were displayed behind the medicines counter and showed overwhelmingly positive feedback. A formal complaints procedure was in place. Information about how to make comments, compliments or complaints was included in the practice leaflet displayed near the consultation rooms. A poster advertising the NHS complaints procedure 'Putting Things Right' was displayed near the medicines counter.

A current certificate of professional indemnity insurance 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, including methadone, were typically checked monthly. The methadone register showed some high volumes of overage and there was a risk that this might mask concerns such as dispensing errors or diversion. The pharmacist manager said that he was aware of this risk and planned to begin checking methadone

running balances weekly in future.

Staff had signed confidentiality agreements and were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. A summary of the company’s confidentiality policy was displayed at the medicines counter. A privacy notice displayed at the medicines counter explained the way in which data was used by the pharmacy and gave details of the pharmacy’s Data Protection Officer. Leaflets displayed near the consultation rooms gave a comprehensive summary of the ways in which patient information was managed and safeguarded. However, these were not visible from the main retail area. A privacy notice displayed in the main consultation room described how the pharmacy used and managed personal data for people receiving services under patient group directions (PGDs).

The pharmacists and a pharmacy technician had undertaken level two safeguarding training and had access to guidance and local contact details that were available in the main consultation room. Other staff had undertaken level one safeguarding training and were able to identify different types of safeguarding concerns. They said that they would refer these to the pharmacist, who confirmed that he would report concerns via the appropriate channels where necessary. A summary of the chaperone policy was advertised in a poster displayed inside the main consultation room. Leaflets with information about local services for people affected by dementia were displayed near the consultation rooms, although they were not visible from the main retail area.

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 pharmacist manager worked at the pharmacy on most days, assisted by a second pharmacist every Wednesday. The support team consisted of an accuracy checking technician (ACT), two pharmacy technicians, a dispensing assistant and a medicines counter assistant. Another dispensing assistant and a medicines counter assistant 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.

Targets were set for MURs, but these were managed appropriately, and the pharmacist said that they did not affect his professional judgement or compromise patient care. Staff worked well together and had an obvious rapport with customers. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists, superintendent pharmacist or other head office staff. A whistleblowing policy that included details for reporting concerns outside the organisation was available in the SOP file.

A member of staff working on the medicines counter gave a coherent explanation of the WWHAM questioning technique and referred to the pharmacist on several occasions for further advice on how to deal with a transaction. Staff had access to informal training materials such as counter skills modules, articles in trade magazines and information about new products from manufacturers. However, the lack of a structured training programme might restrict the ability of individuals to keep up to date with current pharmacy practice. The ACT said that she understood the revalidation process and based her continuing professional development entries on issues she came across in her day-to-day working environment. All staff were subject to annual performance and development reviews. They could informally discuss issues 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 undergoing some renovation in the retail area following fire damage that had occurred the previous month. The pharmacist said that the work would be finished in about two weeks' time. Despite this, the pharmacy was clean, tidy and well-organised. The dispensary had enough space to allow safe working. Some tote boxes containing dispensed prescriptions were being temporarily stored on the floor but did not pose a trip hazard. The sinks had hot and cold running water and soap and cleaning materials were available. Two lockable consultation rooms were available for private consultations and counselling. The pharmacist said that both rooms were used on Wednesdays when two pharmacists worked at the branch. Signs on the doors advertised the availability of the rooms but they were not visible from the main part of the retail area. The lighting and temperature in the pharmacy were generally appropriate. The pharmacy felt a little cold as ongoing renovation work required the entrance door to be kept open and it was a cold day. However, heaters were being used to keep the dispensary warm.

Principle 4 - Services **Standards not all 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. The pharmacy's working practices are generally safe and effective. And it stores most medicines appropriately. But it does not always carry out checks to make sure these are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. Services that were deemed to be particularly relevant to people receiving medicines in compliance aids (MURs, DMRs, the smoking cessation service and the prescription collection and delivery service) were advertised on the front of these. There was a small step up to the pharmacy entrance, but the pharmacist said that the team would go out to people in wheelchairs and help them into the pharmacy if necessary. There was wheelchair access into the consultation rooms. Staff said that they would signpost people requesting services they could not provide to nearby pharmacies or other providers such as the local council, which provided a sharps collection service. A list of local sexual health clinics was available in the main consultation room. Some health promotional material was on display near the consultation rooms, although this was not easily visible from the main retail area. The pharmacist had recently visited the local surgery to discuss and promote services as part of a health board funded collaborative working initiative. Recent visits had involved discussions around the discharge medicines review service, the smoking cessation service and the soon-to-be-offered sore throat test and treat service.

The pharmacy received many faxed prescriptions from local surgeries due to its rural location. Some faxes present in the dispensary had not been signed by the prescriber and a fax for tramadol, a Schedule 3 CD, was also present. The pharmacist gave assurances that medicines were never supplied against unsigned faxes and that Schedule 2 and 3 CDs were only ever supplied against the original prescription.

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. Stickers were used on prescription bags awaiting collection to alert staff to the fact that a CD requiring safe custody or a fridge item was outstanding. Stickers were usually used to identify dispensed Schedule 3 and 4 CDs awaiting collection to help ensure that prescriptions were checked for validity before handout to the patient. However, a prescription for clonazepam, a prescription for gabapentin and a prescription for tramadol and pregabalin were found not to be marked in this way. Two of the prescriptions had expired and were no longer valid for supply. The pharmacist removed the prescriptions from the retrieval area immediately.

Prescriptions were not always retained for dispensed items awaiting collection, except for prescriptions for controlled drugs. Most prescriptions were scanned, and the image remained available for reference. However, this was not always the case and there was a risk that an accurate and complete record of the prescription details would not be available at the time of supply. Three prescriptions awaiting collection dated July 2019 were no longer valid, as more than six months had elapsed since the date on the prescription. The pharmacist removed these from the storage area as soon as this was pointed out and dealt with them appropriately. The process in place for identifying uncollected dispensed medicines is

not robust and there is a risk that non-compliance may not be identified or that medicines may no longer be appropriate for supply.

Stickers were used to routinely identify patients prescribed warfarin so that they could be counselled. Staff asked for relevant information about blood tests and dose changes and recorded this on the patient medication record (PMR). Patients prescribed other high-risk medicines such as lithium and methotrexate were not routinely identified and there was a risk that opportunities for counselling might be missed. However, the pharmacist said that he always discussed blood tests and dosage changes with these patients during MURs. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that two patients prescribed valproate who had met the risk criteria had been counselled and provided with appropriate information. Information for patients prescribed valproate was available in the dispensary. A poster displayed in the dispensary listed important actions that needed to be taken by the pharmacist and dispensing team when processing prescriptions for valproate. 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. Monitoring booklets for warfarin, lithium and methotrexate were available for provision to patients.

Signatures were obtained for prescription deliveries and 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.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a number of patients. The pharmacist said that all new patients requesting the service were assessed for suitability. The compliance aids were labelled with descriptions to enable identification of individual medicines. The pharmacist said that patient information leaflets were supplied monthly. A list of patients and their delivery or collection arrangements was available in the dispensary for reference. Each patient had a section in a dedicated file that included their personal and medication details and any delivery arrangements.

The pharmacy had carried out approximately 10 influenza vaccinations during the 2019/20 season. Most of these had been as part of the private vaccination service. The pharmacist said that the pharmacy would soon be providing a sore throat test and treat service, pending the accreditation of the pharmacy premises by the local health board. Patients supplied substance misuse treatments against instalment prescriptions were allocated a section in a dedicated file which included their current prescription and claim form if supervised.

Medicines were obtained from licensed wholesalers and generally stored appropriately. Medicines requiring cold storage were stored in two well-organised drug fridges. One was used to store stock and the other was used to store dispensed medicines. Maximum and minimum temperatures for the stock fridge were recorded daily and were consistently within the required range. Temperatures were not routinely recorded for the fridge containing dispensed medicines. However, the pharmacist said that he checked temperatures daily, and they were within the required range at the time of the inspection. He created a record on the pharmacy computer for the fridge and said that he would record temperatures going forward. One dispensed prescription for a Fostair inhaler dated September 2019 was found in the prescription retrieval area rather than in the drug fridge. The inhaler had a shelf life of three months when stored at room temperature after dispensing and was therefore no longer suitable for supply. The pharmacist said that he tended to store dispensed prescriptions for Fostair in the prescription retrieval area as they took up a lot of space in the drug fridge and, in his experience, they were usually collected

promptly by patients. On discussion, he understood the risks of this practice and dealt with the prescription appropriately. CDs were stored appropriately in two CD cabinets that were fairly well-organised. Obsolete CDs were segregated from usable stock.

Stock was subject to regular documented expiry date checks. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. An unsealed sharps bin containing used sharps was situated on the floor of the main consultation room, which could be accessed from the retail area. The bin was moved into a cupboard as soon as this was pointed out. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacy team were able to describe how they had recently dealt with a recall for ranitidine that had been recalled as unfit for purpose by quarantining affected stock and returning it to the supplier. The pharmacy had the necessary hardware to work in accordance with the Falsified Medicines Directive, but the software had not been installed and so the pharmacy was not yet in a position to comply with legal requirements.

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 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 staff said that these would be washed after use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was in good working order 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.