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: 12/10/2020

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. This inspection visit was carried out during the Covid-19 pandemic.

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	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 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 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 accuracy checking technician (ACT) said that she and the pharmacist tended to discuss near misses with 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.

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 newly recruited medicines counter assistant (MCA) 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 ACT said that the pharmacist manager produced labels for repeat prescriptions in the morning and clinically checked them at the same time. She confirmed with him which prescriptions had been clinically checked, marked these 'ACT', and then checked the corresponding dispensed items with no restrictions. She said that the prescriptions were not marked by the pharmacist manager 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. She said that the relief pharmacist present during the inspection always initialled prescriptions to show that they had been clinically checked. The lack of a consistent 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. Cards from the public thanking the team for their help and care were displayed on the dispensary riser. 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.

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.

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 and Friday. The support team consisted of an accuracy checking technician (ACT), two pharmacy technicians, a trainee dispensing assistant and a medicines counter assistant (MCA). Another dispensing assistant and a newly recruited MCA who worked on Saturdays 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. Most staff members had the necessary training and qualifications for their roles. The newly recruited MCA worked under the supervision of a pharmacist and trained members of staff.

There were no specific targets or incentives set for the services provided. 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 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 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 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 clean, tidy and well-organised, with enough space to allow safe working. The sinks had hot and cold running water and soap and cleaning materials were available. A poster describing hand washing techniques was displayed above the sink. Personal protective equipment and hand sanitiser were available for staff use and the pharmacy team were wearing face masks. Pharmacy surfaces were wiped down twice daily and staff cleaned the consultation room with disinfectant after each use.

A one-way system with floor markings at two-metre intervals had been implemented in the retail area to encourage customers to adhere to social distancing requirements. A plastic screen at the medicines counter had been installed to reduce the risk of viral transmission between staff and customers. Two lockable consultation rooms were available for private consultations and counselling. 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 appropriate.

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. The pharmacy's working practices are safe and effective. It stores medicines appropriately and carries 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 were advertised on the front of these. There was a small step up to the pharmacy entrance, but staff said that they would go out to people in wheelchairs and help them into the pharmacy if necessary. There was wheelchair access into the consultation rooms. Staff signposted people requesting services they could not provide to nearby pharmacies or other providers such as the local health board, 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. Information about coronavirus and related safety procedures was displayed on the pharmacy entrance door. The pharmacist had recently visited the local surgery to discuss and promote services as part of a health board funded collaborative working initiative. Visits had involved discussions around the discharge medicines review service and the smoking cessation service.

The pharmacy offered a repeat prescription collection service from four local surgeries. A box near the medicines counter in the retail area allowed patients to drop their repeat order form into the pharmacy without needing to speak to a staff member. The box included a different compartment for each of the four surgeries to reduce the amount of time staff spent sorting the orders before sending them to the surgeries.

The pharmacy received large numbers of faxed prescriptions due to its rural location. Staff 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 for repeat prescriptions to help ensure that medicines did not get mixed up during dispensing and to differentiate between different prescriptions. Baskets were not used for walk-in prescriptions, but the pharmacist and dispensing staff said that they always ensured that enough space was left between individual prescriptions being assembled on the workbench to reduce the risk of medicines becoming mixed up. This was achievable at the time of the inspection as there was ample bench space and the pharmacy was reasonably quiet, but it was unclear if it was still achievable during busy periods. 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 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. Prescriptions were not always retained for dispensed items awaiting collection, although 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 March 2020 were no longer valid, as more than six months had elapsed since the date on the prescription. The

prescriptions were for low-risk items such as emollient creams and dressings. The pharmacist explained that it was likely that these were repeat prescriptions generated by local surgeries at the start of the COVID-19 pandemic that had not been specifically requested or needed by the patient. He removed them from the storage area and dealt with them appropriately.

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, staff said that the pharmacists always discussed blood tests and dosage changes with patients presenting walk-in prescriptions for these items. The pharmacy team were aware of the risks of valproate use during pregnancy. Patients prescribed valproate who 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.

There had been an increase in demand for the prescription delivery service as a result of the pandemic. Prior to this, signatures had been obtained for prescription deliveries. However, to reduce the risk of viral transmission, the procedure had been changed. The driver now placed a package on the patients' doorstep, knocked or rang the doorbell and waited until it was collected. They then verbally confirmed the person's identity and made a note of this as an audit trail. 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. New patients requesting the service were assessed for suitability. There were no examples of compliance aids available, but staff said that they were labelled with descriptions to enable identification of individual medicines, and patient information leaflets were supplied monthly. Each patient had a section in a dedicated file that included their personal and medication details and any delivery arrangements. However, some individual sheets listing medication details were untidy. For example, some dosage changes had been altered by obliteration and were difficult to read, which may increase the risk of errors.There was a steady uptake of most enhanced and advanced services.

The pharmacy was not currently providing medicines use reviews, as this service had been suspended until April 2021 by Welsh Government in light of the pandemic. It had very recently begun to provide the 2020/21 seasonal influenza vaccination service. Staff said that there was a high demand for this service as one local GP surgery did not currently have any vaccination appointments and was signposting people to nearby pharmacies.

The pharmacist carried out four influenza vaccinations during the inspection. Many consultations for services had been carried out over the telephone where appropriate, in line with recommendations from Welsh Government. Pharmacists conducted face-to-face consultations at the required two-metre distance or wore PPE where this was not possible.

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. The file also included a letter from the local substance misuse agency that the pharmacy had provided to clients at the start of the pandemic. It explained how the service might change and gave information about what to do if their usual pharmacy had to close.

Medicines were obtained from licensed wholesalers and were generally stored appropriately, although some different products and different strengths of the same product were stored closely together on dispensary shelves. Medicines requiring cold storage were stored in two well-organised drug fridges. Maximum and minimum temperatures for the drug fridges were recorded daily and were consistently within the required range. 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. 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 drug recall by quarantining affected stock and returning it to the supplier. The pharmacy had the necessary hardware and software to work in accordance with the Falsified Medicines Directive. However, the pharmacy team were not currently decommissioning all medicines in this way.

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 rooms were 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.