General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 100 Holmesdale Street, Grangetown, CARDIFF, South Glamorgan, CF11 7BW

Pharmacy reference: 1043706

Type of pharmacy: Community

Date of inspection: 18/02/2020

Pharmacy context

This is a pharmacy in a multicultural suburb of Cardiff. 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 range of services including emergency hormonal contraception, smoking cessation and treatment for minor ailments.

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 not all met	2.1	Standard not met	The pharmacy team is not always able to manage the workload or provide services effectively
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 review things that go wrong so that they can learn from them. But they do not record all of their mistakes. So they may miss some opportunities to learn. The pharmacy generally 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, pharmacy team members said that they were often too busy to access the recording software and it was likely that some incidents had not been captured. The relief pharmacist said that she had not had time to record near misses that had occurred during the inspection but had discussed them with staff at the time of each occurrence. Staff said that the pharmacist manager reviewed near misses regularly. They demonstrated that methotrexate 2.5mg and 10mg tablets had been separated in the dispensary to reduce the risk of selection errors with these items.

A range of electronic standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Staff said they were in the process of reading and completing online declarations and assessments for some new versions of SOPs. A list of activities that could take place if the responsible pharmacist (RP) was signed in but not physically present was displayed in the rear of the dispensary for reference.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. Survey results from 2018 displayed at the medicines counter showed that this was mostly positive. However, staff said that there had recently been a lot of negative feedback about long waiting times for prescriptions. During the inspection the pharmacy received a telephone call from a patient who had become worried about the length of time it was taking for a relative to collect their prescription. The regional development manager took the call and apologised to the patient for the delay. 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. Another poster near the consultation room advertised the NHS complaints procedure 'Putting Things Right'.

Evidence of current professional indemnity insurance was available. All necessary records were kept and generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, specials procurement and controlled drug (CD) records. However, some historic supplies made against private prescriptions had not yet been recorded, contrary to the legal requirement that the record should be made on the day of supply or the following day. CD running balances were usually checked at the time of dispensing.

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 for accessing the pharmacy software system.

The pharmacists had undertaken level two safeguarding training and had access to guidance and local contact details that were available via the internet. Most staff, except for the newest member, had received in-house training. Staff who had completed training were able to identify safeguarding concerns and said that they would report these to the pharmacist, who confirmed that she would report concerns via the appropriate channels where necessary. All staff were trained Dementia Friends. A summary of the chaperone policy was available in a poster displayed on the consultation room door and inside the room itself.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy generally has enough staff members who undergo regular training. But they are not all suitably skilled to manage the workload and provide services effectively. Pharmacy team members feel comfortable speaking up about any concerns they have.

Inspector's evidence

A regular pharmacist worked at the branch on most days. Her role was being covered by a relief pharmacist during the inspection, although she was present for the first hour. She explained that she had come in on her day off to help the team as they were behind with their workload. The support team consisted of a pharmacy technician and two dispensing assistants, one of whom was a trainee. Another dispensing assistant was absent. The pharmacist said that a full-time member of staff had recently left the business and she was actively recruiting for another member of staff to replace her. In the meantime, other team members were working extra hours to provide cover: that day, one dispensing assistant was working on her usual day off and another was working later than she normally would. During the inspection, the regional development manager (RDM) arrived to provide the team with some help and support, working in his capacity as a pharmacist where necessary. Staff members had the necessary training and qualifications for their roles. The trainee dispenser worked under the supervision of the pharmacist.

The pharmacy was busy during the inspection, with a steady stream of people presenting walk-in prescriptions or arriving to collect prescriptions that had already been submitted. The team found the workload challenging as the recent loss of a full-time member of staff had occurred just after a new pharmacy computer system had been introduced. The pharmacist said that it had not been easy to implement and manage the new system with fewer resources. She explained that one dispensing assistant had recently returned from a long-term absence and did not have any experience of using the system. Another was a new recruit who had not worked in a pharmacy before. The pharmacist said that both staff members needed a lot of support and direction and it was often difficult to manage the workload effectively with an inexperienced team. However, despite the stressful environment, staff and the pharmacists were consistently polite, professional and helpful to customers.

Targets were set for MURs. The regular pharmacist said that these were managed appropriately and did not affect her professional judgement or patient care. However, she said that she found it very difficult to leave the dispensary to carry out MURs as the workload was so intense, and the team were consequently not meeting their targets. She said that there was some pressure to complete MURs, but the RDM was aware that the core dispensing service took priority. Staff said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist and RDM. Details of a confidential helpline for reporting concerns outside the organisation were included in a poster displayed in the staff area. Another poster included details of a local trade union representative.

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. Staff undertook online training provided by the organisation on new products, clinical topics, operational procedures and services. They were able to access this training from home and had recently completed modules on the management of dry eyes and dry skin. The pharmacy technician said she

understood the revalidation process. She explained that she based her continuing professional development entries on training provided by the company and on situations she came across in her day-to-day working environment. All staff were subject to six-monthly performance and development reviews. They were able to discuss issues informally with the pharmacist whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and tidy. It is secure and its layout protects people’s privacy.

Inspector's evidence

The pharmacy was generally tidy and well-organised. However, large quantities of stock and prescriptions were being temporarily stored on the floor and posed a potential trip hazard. These were cleared away during the inspection. Some areas of the pharmacy, including the staff kitchen, were not very clean. Staff said that this was because they did not have enough time to clean every day. 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 lockable 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. People can usually access services but there are sometimes delays. If pharmacy team members can't provide a service, they direct 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 range of services and most were appropriately advertised. However, the influenza vaccination service was advertised as being accessible without an appointment. In practice this was unlikely to be the case, as the regular pharmacist was unable to provide the service. Staff said that vaccinations could only be provided on Tuesdays or every other Saturday if the pharmacist on duty was accredited. 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 room. Staff said that they would signpost patients requesting services they could not provide to other nearby pharmacies. The pharmacy technician had recently visited local surgeries to discuss and promote services as part of a health board-funded collaborative working initiative. Visits had involved discussions around the smoking cessation service, the repeat dispensing service and the common ailments service.

A new pharmacy software system had recently been installed which allowed about 30% of the pharmacy's prescription items to be assembled at the company's hub pharmacy. The hub pharmacy could not assemble split packs, compliance aids, fridge lines or most controlled drugs 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. However, staff said that as they were behind with their workload, they were not always able to process prescriptions for the hub promptly. This meant that many prescriptions were not ready when people returned to collect them. In these cases, the prescriptions had to be re-dispensed in branch, which was time-consuming and led to long waits.

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 usually initialled by the dispenser and checker to provide an audit trail. However, labels on some bulk items supplied with compliance aid trays did not include the dispenser's initials. Controlled drugs requiring safe custody, fridge lines and compliance aid trays 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. Each bag label attached to a prescription 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 patients know their medicines were ready for collection. Each prescription awaiting collection could be 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 the patient's items were being stored, including the drug fridge or CD cabinet where applicable. However, many prescriptions were still at the processing stage or

had not been received from the hub when people arrived at the pharmacy to collect them. This meant that staff were unable to use the scanning system to locate them, leading to confusion and time-consuming searches.

Stickers were placed on bags to alert staff to the fact that a patient was eligible for an MUR, or that a CD requiring safe custody or fridge item was outstanding. The pharmacist said that stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection. However, some prescriptions for diazepam, midazolam and clonazepam were found present that had not been marked in this way.

Staff said that 'pharmacist advice' stickers were used to routinely identify prescriptions for patients prescribed high-risk medicines such as warfarin, lithium and methotrexate. The pharmacy team were aware of the risks of valproate use during pregnancy. They said that any patients prescribed valproate who met the risk criteria would be counselled and provided with appropriate information, which would be printed from the internet. 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.

Disposable compliance aid trays were used to supply medicines to a number of patients. Staff said that any new patients requesting the service were assessed for suitability. Trays were labelled with descriptions to enable identification of individual medicines. Patient information leaflets were routinely supplied. Each patient had a section in one of five dedicated files that included their personal and medication details, collection or delivery arrangements, contact details for representatives where appropriate, details of any messages or changes. It also contained relevant documents, such as repeat prescription order forms and completed assessment forms. A separate file was available for patients known to be in hospital. A progress log for all patients was available and showed the status of each patient's tray at any given time.

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 CD. 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 generally stored appropriately. However, dispensary shelves, the drug stock fridge and the CD cabinet were quite untidy: different products and different strengths of the same product were often mixed together, increasing the risk of errors. Several bottles of loose tablets that had been removed from their original packaging were found in the compliance aid area. The bottles had not been adequately labelled either as stock or named-patient medication. This increased the risk of errors and did not comply with legal requirements. Medicines requiring cold storage were stored in two drug fridges. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored in a large CD cabinet and obsolete CDs were segregated from usable stock.

Stock was subject to regular expiry date checks. Staff said that these were documented, although the electronic system used to record date-checks could not be accessed during the inspection. Most short-dated items were highlighted with stickers. One pot of vitamin B compound tablets and one box of Keflex capsules were found to be out-of-date. The pharmacist and staff said that they checked expiry dates as part of their dispensing and checking processes. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. A scheme run in association with GSK allowed

the pharmacy to recycle returned inhalers. Staff were able to describe how they had dealt with a drug recall for paracetamol tablets by quarantining affected stock and returning this to the supplier. They explained that they received drug alerts and recalls through the pharmacy software system. These were then 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. Triangles were used to count tablets and a separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. Equipment was clean, 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 computer was password-protected, 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.