General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, St. David Medical Centre, Pentwyn Drive, Pentwyn, CARDIFF, South Glamorgan, CF23 7EY

Pharmacy reference: 1043731

Type of pharmacy: Community

Date of inspection: 19/09/2019

Pharmacy context

This is a pharmacy located in a health centre. 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

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	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	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
		4.2	Good practice	The pharmacy has robust systems in place to ensure that patients prescribed high-risk medicines are appropriately counselled.
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. But there is not much evidence to show that action is taken to try and stop them from happening again 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 and analysis of dispensing errors and near misses. A root cause analysis had been conducted following a recent dispensing error. Staff said that monthly meetings were held to discuss dispensing errors, near miss reviews and other patient safety issues such as similar packaging. The team also discussed case studies provided by the superintendent's office. The pharmacist said that action had been taken to reduce risks that had been identified: for example, a note had been added to dispensary shelves instructing staff to separate different forms of Qvar inhaler and different pack sizes of Glucogel. However, on investigation, neither were separated. She said that extra staff training had been provided after a series of near misses with different forms of Glucophage tablets and after a dispensing incident involving quinine and quetiapine. She said that quinine and quetiapine had been separated on dispensary shelves following the incident, but on investigation the controlled release form of quetiapine was still stored next to quinine tablets. She segregated the quinine tablets immediately using a white tablet box with 'quinine' written on it as an alert.

A range of electronic standard operating procedures (SOPs) underpinned the services provided; these were regularly reviewed. One dispensing assistant was in the process of reading and completing online declarations and assessments for all SOPs. A list of weekly tasks and the days to which they were allocated was displayed in the dispensary for reference.

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.

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, unlicensed specials and controlled drug (CD) records. However, emergency supply records were not always made in line with the legal requirements necessary to provide a clear audit trail in the event of queries or errors as they did not always include the nature of the emergency. 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 being able to identify confidential waste and dispose of it appropriately. Individual staff members had unique passwords to access the pharmacy computer system. Privacy notices displayed near the consultation room and at the medicines counter advertised the way in which personal data was used and managed by the company.

The pharmacist had undertaken level two safeguarding training and had access to guidance and local contact details that were available via the internet. Staff had undertaken level one safeguarding training and were able to identify different types of safeguarding concerns. All staff were trained Dementia Friends. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door.

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

Inspector's evidence

The pharmacist manager oversaw most professional activities and a regular locum covered her day off every Tuesday. The support team consisted of a full-time pharmacy technician and two full-time dispensing assistants who worked well together. 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. A 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. She said that she felt no pressure to complete MURs if other issues took priority. Staff were happy to make suggestions within the team and said that they felt comfortable raising concerns with the pharmacist or Regional Development Manager. A poster advertising a confidential helpline for reporting concerns outside the organisation was displayed in the staff area.

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. A mystery shopper from an external company visited the branch every quarter to assess their customer service and counter skills. Certificates showed that the pharmacy team had achieved a 100% result on two recent occasions.

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 and one of the dispensing assistants were also able to provide the blood pressure measurement service. All staff had recently completed training provided by NHS Wales on improving the quality of services provided. The pharmacy technician said that she had recently submitted her continuing professional development (CPD) portfolio and based her entries on situations she came across in her day-to-day working environment. All staff were subject to six-monthly performance and development reviews and could discuss issues informally with the pharmacist 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. Some stock and dispensed prescriptions awaiting collection were temporarily stored on the floor but did not pose a 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. It was not visible from the main retail area but staff said that they always offered it to patients who wished to speak to the pharmacist. 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 and can access them easily. 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 supports people taking higher-risk medicines by making extra checks and providing counselling where necessary. It stores most 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 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. A signposting directory provided by the local health board was available and staff said that they would signpost people requesting services they could not provide to other nearby pharmacies. A list of pharmacies participating in the local health board's palliative care scheme was displayed on the dispensary riser. Some health promotional material was on display in the retail area. The pharmacist explained that she had recently visited the local surgery and a nearby optician 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 (DMR) service and the Choose Pharmacy common ailments service.

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 some prescription items to be assembled at the company's hub pharmacy. The hub pharmacy could not assemble split packs, 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. The pharmacist said that the prescription storage area was checked at least once a month. 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 or fridge item 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. Stickers were used on prescriptions awaiting collection to identify patients eligible for an MUR or to alert staff that the pharmacist wished to speak to the patient or their representative at the point of handout.

Stickers marked 'Therapy Check' 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 PMR. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that patients prescribed valproate who met the risk criteria had been counselled appropriately and provided with patient information. She demonstrated that records had also been made on the PMR. 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 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.

Disposable compliance aid trays were used to supply medicines to a number of patients. Trays were labelled with descriptions to enable identification of individual medicines. Patient information leaflets were routinely supplied. A progress log for all patients was displayed and showed the status of each patient's tray at any given time. It included the patient's name and their collection or delivery details. It also included the initials of each member of staff involved in the dispensing process. Each patient had a section in one of four dedicated files that included their personal and medication details and details of any messages or queries. One patient was supplied a tablet that was added to their compliance aid in its blister packaging. The pharmacist said that she had discussed the risks and benefits of this with the patient and a professional decision had been made to supply the tablets in this way. She said that the patient collected their compliance aids from the pharmacy, so she was able to review the situation regularly to ensure it was still safe and appropriate.

Medicines were obtained from licensed wholesalers and generally stored appropriately. Some bottles containing loose tablets that had been removed from their original packaging were not adequately labelled either as stock or as named-patient medication. This increased the risk of error and did not comply with legislative requirements. Medicines requiring cold storage were stored in a well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. 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 and waste sharps. A scheme run in association with GSK allowed the pharmacy to recycle returned inhalers. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist was able to describe how she had dealt with a batch of paracetamol tablets that had been recalled as unfit for purpose by quarantining stock and returning it to the supplier. 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 services. 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. Separate measures were used for methadone. 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. All equipment was in good working order, clean 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.

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.