General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 12 Station Road, Radyr, CARDIFF, South Glamorgan, CF15 8AA

Pharmacy reference: 1043740

Type of pharmacy: Community

Date of inspection: 17/02/2020

Pharmacy context

This is a pharmacy located in an affluent semi-rural 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, 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 roles 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 their mistakes. And they take action to help stop mistakes from happening again. But they do not 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

A range of electronic standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. The pharmacy had some systems in place to identify and manage risk, including the recording of dispensing errors and near misses. There was no documented analysis of patient safety incidents and staff said that they did not think near misses were regularly reviewed to identify patterns and trends. However, they said that the pharmacist always discussed near misses with them at the time of each occurrence. They demonstrated that different strengths of citalopram had recently been separated on dispensary shelves after some selection errors with these similarly-packaged items. Staff understood the risks associated with dispensing 'Look-Alike, Sound-Alike' or 'LASA' drugs.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed near the consultation room showed that this was mostly positive. However, there were some negative comments about the time it took to be served and the efficiency of the service provided. A formal complaints procedure was in place and information about how to make complaints was included in a poster displayed near the medicines counter. Another poster that advertised the NHS complaints procedure 'Putting Things Right' was displayed near the consultation room.

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, unlicensed specials 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 some were not marked with patient details. 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 in the consultation room and at the medicines counter signposted people to the company's website for information about how 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 in-house training and were able to identify different types of safeguarding concerns. A summary of the chaperone policy was

advertised in a poster displayed near the medicines counter.

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

Inspector's evidence

The regular pharmacist worked on most days and relief or locum pharmacists covered her day off every Wednesday. She was assisted in the day-to-day operation of the pharmacy by the branch manager, who was a qualified dispensing assistant. The support team consisted of a part-time pharmacy technician and a full-time trainee dispensing assistant. Another dispensing assistant worked only on Saturdays. There were enough suitably qualified and skilled staff present to manage the workload during the inspection and the staffing level appeared adequate for the services provided. However, the pharmacy manager said that it was sometimes more difficult to manage the workload effectively on Thursdays and Fridays as the team consisted only of the pharmacist and two other staff members. Staff members had the necessary training and qualifications for their roles. A trainee dispensing assistant worked under the supervision of the pharmacist and other qualified members of staff.

Targets were set for MURs, but these were managed appropriately, and the pharmacy manager said that they did not affect the pharmacist's professional judgement or compromise patient care. Staff were happy to make suggestions within the team and said that they felt comfortable raising concerns with the pharmacist, pharmacy manager or regional development manager (RDM). A poster on the staff noticeboard encouraged colleagues to speak to their RDM if they had concerns about being unable to cope with their workload following the introduction of new systems in the dispensary. A whistleblowing policy was available on the company's intranet site.

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 on new products, clinical topics, operational procedures and services. The pharmacy technician said that she understood the revalidation process and based her continuing professional development entries on situations she came across in her day-to-day working environment. All staff were subject to six-monthly performance and development reviews. The trainee dispensing assistant said that she had recently received probationary reviews at six weeks and 12 weeks. All staff could discuss issues informally with the pharmacist or pharmacy manager whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was fairly clean, tidy and well-organised. There was enough space to allow safe working, although the dispensary worktops were a little cluttered. Some stock and dispensed prescriptions stored on the floor posed a potential 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 lockable consultation room was available for private consultations and counselling and was clearly advertised. 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 generally safe and effective. It stores most 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 which were advertised in the practice leaflet, although this was not displayed in the retail area. There was wheelchair access into the pharmacy and consultation room. A hearing aid loop was available in the consultation room. Staff said that they would signpost people requesting services they could not provide to nearby pharmacies or other providers, such as the local surgery. 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. This reduced 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.

The pharmacy team said that a new pharmacy software system had recently been installed which allowed about half of the pharmacy's prescription items to be assembled at the company's hub pharmacy. The hub pharmacy could not assemble split packs, fridge lines, compliance aids 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. A text messaging service was available to let patients know their medicines were ready for collection. The pharmacy manager said that dispensed prescriptions were usually stored in the retrieval area for four weeks before the patient was contacted as a reminder. She said that after a further two weeks, the medicines were returned to stock if not collected and a note was added to the patient's medication record. However, this procedure had not been followed for all prescriptions and some owing balances awaiting collection were found that had been dispensed in November 2019.

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. However, during the inspection some dispensed prescriptions could not be found in the storage locations they had been assigned to, which caused delays. Stickers were placed on prescription 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. However, one prescription for pregabalin was found not to be marked in this way and was no longer valid. The pharmacy manager removed the prescription from the retrieval area and dealt with it appropriately. Stickers were used on prescriptions awaiting collection to identify patients eligible for an

MUR.

Staff said that stickers marked 'Pharmacist Advice' were used to routinely identify prescriptions for patients prescribed high-risk medicines such as warfarin, lithium and methotrexate. They said that they asked patients or their representatives for information about blood tests and dosage changes. INR monitoring booklets and steroid cards were available in the dispensary for provision to patients. 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 patient information, which was available in the dispensary. The pharmacy manager said that the team 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 prescription back to the pharmacy.

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 by the pharmacist. Trays were labelled with descriptions to enable identification of individual medicines, although these were handwritten, and some were a little hard to read. Patient information leaflets were routinely supplied. A list of patients and their collection or delivery arrangements was available in the dispensary for reference. Each patient had a section in one of five dedicated files that included their personal and medication details, collection or delivery arrangements and details of any messages or changes. It also included relevant documents, such as their current prescription, repeat order form and any hospital discharge summaries. A separate file was kept for patients that were known to be in hospital. Patients that received their compliance aids weekly were allocated individual labelled baskets which contained their stock medicines. A workload tracker for each patient was available and showed the status of each patient's tray at any given time.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, the pharmacy had limited storage space for the volume of stock medicines it held. This meant that some different products and different strengths of the same product were stored very closely together, increasing the risk of errors. A pet medicines stand in the retail area contained packs of Advantage flea treatment pipettes. These are classified as NFA_VPS medicines which must be supplied by a pharmacist. As the pipettes were available for self-selection, there was a risk that they might be sold by a non-pharmacist member of staff in error. The pharmacy manager moved the packs immediately this was pointed out.

Medicines requiring cold storage were stored in two well-organised drug fridges. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in a large, well-organised CD cabinet. Most obsolete CDs were segregated from usable stock, although an out-of-date box of Oxycontin 30mg tablets had not been segregated. The pharmacy manager moved it as soon as this was pointed out.

Stock was subject to regular expiry date checks. These were documented, and short-dated items were highlighted with stickers. However, four out-of-date Abasaglar insulin pens were found in the drug fridge. The pharmacy manager said that this was an oversight and removed the pens immediately.

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 emails or through the pharmacy software system. The pharmacy manager was able to describe how staff would deal with medicines or medical devices that had been recalled as unfit for purpose 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, 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 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. Triangles were used to count tablets and staff said that they would wash these after 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.