General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Pearn's Pharmacies Ltd, 36 Windsor Road, PENARTH, South Glamorgan, CF64 1YD

Pharmacy reference: 1043779

Type of pharmacy: Community

Date of inspection: 11/12/2019

Pharmacy context

This is a high street pharmacy in a seaside town. 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, 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 met**

Required Action: None

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Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	1.8	Good practice	Safeguarding is an integral part of the culture within the pharmacy
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	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 and review their mistakes so they can learn from them. And they take action to help stop mistakes 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 some systems in place to identify and manage risk, including the electronic recording of dispensing errors and near misses. The pharmacist said that records of patient safety incidents were sent to the company's area manager at the end of each day for review. Some action had been taken to reduce risks that had been identified: for example, after a series of quantity errors, staff had begun to write the quantity inside the packaging of split boxes to show they had double checked it. Different strengths of ibuprofen tablets had been separated on dispensary shelves to help reduce the incidence of picking errors. A separate section had been created for erectile dysfunction treatments. Staff said that this had helped to reduce the risk of selection errors with sildenafil, which came in the same strengths as sertraline and sumatriptan. The pharmacist said that many previous near misses appeared to be the result of distractions that interrupted the concentration of less experienced staff members during the dispensing process, such as answering the telephone. The issue had been discussed with the pharmacy team. As a result, all staff had agreed that if actively dispensing, they would focus on the task in hand to reduce risk. If they were carrying out a less risky task and could see that another member of staff was dispensing a prescription, they would ensure that they answered the telephone themselves.

A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. An appendix of the Roles and Responsibilities SOP showing the tasks that each staff member was expected to perform had not been completed, although staff were able to clearly describe their roles and responsibilities when questioned.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed in the retail area showed that this was overwhelmingly positive. A formal complaints procedure was in place. Information about how to make complaints was included in the practice leaflet displayed in the retail area, as well as in a poster at the pharmacy entrance. Other notices at the pharmacy entrance advertised the NHS complaints procedure 'Putting Things Right' and gave details of other organisations that could help, such as Community Health Councils and the Citizens Advice Bureau.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. CD running balances were typically checked monthly and the electronic methadone register showed high volumes of overage. There was a risk that this might mask concerns such as dispensing errors or diversion.

Staff 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. A privacy notice displayed at the pharmacy entrance explained the way in which data was used and shared by the pharmacy and gave details of the pharmacy's Data Protection Officer. A poster in the window described how NHS Wales used prescription information to help them make better informed decisions about medicines and patient services.

The pharmacist had undertaken level two safeguarding training and had access to guidance and local contact details that were available in the dispensary. Staff had received in-house training and were able to identify different types of safeguarding concerns. The pharmacy technician said that she had recently dealt with a concern about a vulnerable adult who was not managing his medicines properly. She had notified the person's GP and had also referred him to a local mental health charity. As a result, his medication had been changed and his condition had improved. A summary of the chaperone policy was advertised in a poster displayed at the pharmacy entrance.

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. A regular relief pharmacist covered his role on alternate Mondays and other relief pharmacists worked on Saturdays. The support team consisted of a pharmacy technician, three dispensing assistants and two medicines counter assistants who worked well together. A trainee dispensing assistant and a medicines counter assistant 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. Certificates were displayed as evidence that staff members had the necessary training and qualifications for their roles. The trainee dispensing assistant worked under the pharmacist's supervision.

Targets were set and incentives were provided for MURs. However, these were managed appropriately, and the pharmacist said that they did not affect his professional judgement or compromise patient care. Staff said that they were happy to make suggestions within the team and felt comfortable raising concerns with colleagues, the pharmacist or the Area Manager. A whistleblowing policy that all staff had read and signed was available in the branch manual in the dispensary. It gave details of how to raise concerns outside the organisation.

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 articles in trade magazines and information about new products from manufacturers. Some had recently attended external training on Alzheimer's disease and Parkinson's disease. The pharmacy technician said she understood the revalidation process. She said that she based her continuing professional development entries on situations she came across in her day-to-day working environment. All staff except for two people who worked only on Saturdays were subject to annual performance and development reviews. The pharmacist said that he discussed performance and development with the Saturday staff members on an ad-hoc basis or when necessary. All staff members could informally discuss issues with the pharmacist whenever the need arose. The lack of a structured training and development programme for all staff increased the risk that individuals might not keep up to date with current pharmacy practice and that opportunities to identify training needs could be missed.

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 sinks had hot and cold running water and soap and cleaning materials were available. 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'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 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 that were appropriately advertised. There was wheelchair access into the pharmacy and 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, which offered a sharps disposal service. Some health promotional material was on display in the retail area, as well as some information on local community support groups and healthcare services.

Baskets were not used for walk-in prescriptions, but these were dispensed and checked in separate areas of the dispensary to avoid the risk of transposition of medicines. Baskets were used for repeat prescriptions to help ensure that medicines did not get mixed up during dispensing. Dispensing labels were usually initialled by the dispenser and checker to provide an audit trail, although this was not the case for substance misuse clients' daily doses. The lack of an audit trail may prevent a full analysis of dispensing incidents.

The pharmacist said that stickers were used on prescriptions awaiting collection to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. He said that stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection and these were marked with the date after which the prescription was invalid and could no longer be supplied. However, one prescription for tramadol was found not to be marked in this way. Prescription bag labels were annotated to identify patients eligible for an MUR.

Pre-printed forms were attached to prescriptions to routinely identify patients prescribed warfarin. The forms included prompt questions to ensure that the member of staff handing out the prescription obtained all necessary information about blood tests and dosage changes from the recipient. This information was then passed on to the pharmacist who could counsel the patient if necessary. 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. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that one patient prescribed valproate who met the risk criteria had been counselled and provided with appropriate information. A valproate information pack was available in the consultation room. A notice displayed in the dispensary listed actions to be taken by the pharmacist and staff when dispensing a prescription for valproate.

Signatures were obtained for prescription deliveries. Separate signatures were obtained for deliveries of 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 compliance aids were labelled with descriptions to enable identification of individual

medicines and patient information leaflets were routinely supplied. Each patient had a section in one of four dedicated files that included their personal and medication details, details of any messages or changes and any relevant documentation, such as current prescriptions and discharge summaries. A list of patients was available at the front of each file for reference.

The pharmacy had carried out approximately 130 influenza vaccinations during the 2019/20 season. The pharmacist said that about 60% of these had been performed as part of the NHS enhanced service. Clients of the substance misuse service were allocated a section in a box file which included their current prescription, signed contract if supervised and notes of any messages or changes.

Medicines were obtained from licensed wholesalers and stored appropriately. 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 a well-organised CD cabinet and obsolete CDs were segregated from usable stock.

Stock was subject to regular expiry date checks. These were documented, and short-dated items were highlighted with stickers. 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 pharmacy team were able to describe how they had dealt with a recent recall for ranitidine by quarantining affected stock and returning it to the supplier. Drug recalls were printed, filed and signed to show that they had been actioned. The pharmacy was fully compliant with the Falsified Medicines Directive.

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. Separate measures were used for methadone. Triangles, a tablet counter and capsule counters were used to count tablets and capsules. The tablet counter was cleaned and calibrated regularly. A separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was clean and in good working order, although there was no evidence to show that it had recently been tested. However, the pharmacist said that most electrical equipment was replaced every three years. 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.