General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 37 New Road, Skewen, NEATH, West Glamorgan, SA10 6UT

Pharmacy reference: 1043792

Type of pharmacy: Community

Date of inspection: 19/05/2023

Pharmacy context

This is a pharmacy in a town 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. The pharmacy offers a 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	N/A	N/A	N/A
2. Staff	Standards met	2.2	Good practice	Staff have the appropriate skills and 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	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 their mistakes so they can learn from them. And they take action to help stop mistakes from happening again. But they do not always review everything that goes wrong, so they may miss some opportunities to learn. The pharmacy generally keeps the records it needs to by law. But some details are missing, so it may not always be able to show exactly what has happened if any problems arise. The pharmacy keeps people's private information safe. And its 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 electronic recording of dispensing errors and near misses. The pharmacist said that he was unsure how to view the data for analysis once it had been recorded but explained that he discussed near misses with relevant staff at the time of the occurrence. He said that if he identified any patterns or trends he would discuss these with the entire team. Some action had been taken to reduce risks that had been identified. For example, a warning sticker had been used to highlight shelf edges where labetalol and Lamictal tablets were stored to help reduce the incidence of selection errors following a dispensing error. A member of the pharmacy team demonstrated that methotrexate 2.5mg and 10mg tablets had been distinctly separated in the dispensary to reduce the risk of selection errors with these items. A local health board poster displayed in the dispensary gave information about the dangers of errors with the 'look-alike, sound-alike' drugs pregabalin and gabapentin.

A range of electronic standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Members of the pharmacy team were required to complete an online declaration and assessment for each SOP. They had recently refreshed their knowledge of the responsible pharmacist SOPs and basic dispensing SOPs. The trainee dispensing assistant was able to describe types of activities that could not take place in the absence of the responsible pharmacist. An accuracy checking technician (ACT) described her role and explained that she was able to check all prescriptions that had been marked as clinically checked by the pharmacist, apart from prescriptions for controlled drugs or high-risk medicines such as warfarin or insulin.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, but these had been suspended during the pandemic and had not yet resumed. The pharmacist said that verbal feedback from people using the pharmacy was mostly positive. A thank you card displayed in the staff area praised the pharmacy team for their caring and professional service. A formal complaints procedure was in place and information about making complaints was included in a poster displayed near the medicines counter.

Evidence of current professional indemnity insurance was available. All necessary records were kept, including responsible pharmacist (RP), private prescription, emergency supply, specials procurement and electronic controlled drug (CD) records. Most records were properly maintained, although the electronic RP register had not been completed on 17 May 2023 and there were occasions on which the pharmacist had not signed out of the RP register to show the time at which they had relinquished responsibility for the safe and effective running of the pharmacy. Two recently received patient-

returned CDs had not been entered into the register, which meant that instances of diversion might go unnoticed. 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. Privacy notices displayed inside the consultation room and near the medicines counter signposted people to the company's website for information about the way in which their personal data was used and managed.

The pharmacist and technicians had undertaken formal safeguarding training and had access to guidance and local contact details that were available via the company's intranet system. Members of the pharmacy team had received internal training. The pharmacy's 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 of their roles and responsibilities. They feel comfortable speaking up about any concerns they have.

Inspector's evidence

The regular pharmacist manager worked on most days. During the inspection he was supported by an accuracy checking technician (ACT) and a trainee dispensing assistant (DA). A pharmacy technician and two other DAs, one of whom was also a trainee, were absent. There were enough suitably qualified and skilled staff present to manage the workload safely during the inspection. However, the ACT explained that she had not been able to use her checking qualification for the last few weeks. This was because she had been required to assist with the dispensing workload due to staff shortages, and the company's SOP for accuracy checking did not permit her to check a prescription if she had also been involved in the dispensing process. The pharmacy's prescription workload had increased by about 30% since the start of the pandemic although staffing levels had remained the same. The team sometimes worked under pressure as a result and the pharmacy was currently recruiting for a part-time dispensing assistant to help manage the increased workload. Trainees worked under the supervision of the pharmacist and other trained staff.

Targets were set for services, but these were managed appropriately and did not affect the pharmacist's professional judgement or compromise patient care. Staff worked well together and said that they were happy to make suggestions within the team. They felt comfortable raising concerns with the pharmacist, area manager or regional development manager. A whistleblowing policy was displayed near the staff area alongside a poster advertising a confidential helpline for reporting concerns outside the organisation.

Members of staff working on the medicines counter were observed to use appropriate questions when selling over-the-counter medicines to people and referred to the pharmacist on several occasions for further advice on how to deal with transactions. Staff undertook regular online training provided by the organisation on new products, clinical topics, operational procedures and services. The ACT 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. Staff were subject to annual performance and development reviews and could discuss issues informally with the pharmacist or area manager whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and tidy. It is secure, has enough space to allow safe working and its layout protects people’s privacy.

Inspector's evidence

The pharmacy was well-organised and reasonably clean and tidy. However, multiple boxes of retail stock were being stored behind the medicines counter making it difficult to access this area easily: staff members said that this was due to staff shortages and gave assurances they would clear the area as soon as they were able to. Some prescriptions were being temporarily stored on the floor but these did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use. A plastic screen at the medicines counter had been installed to reduce the risk of viral transmission between staff and customers. A 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 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 carries out checks to help make sure that medicines are in good condition and suitable to supply. But members of the pharmacy team do not always know when higher-risk medicines are being handed out. So they might not always check that medicines are still suitable, or give people advice about taking them.

Inspector's evidence

The pharmacy offered a range of services which were appropriately advertised. There was wheelchair access into the pharmacy and consultation room and a hearing aid loop was available. Staff said that they would signpost patients requesting services they could not provide to nearby pharmacies or other healthcare providers, such as the local surgery. Some health promotional material was on display in the retail area. The pharmacist had recently met with representatives from local surgeries and opticians to discuss and promote services as part of a health board funded collaborative working initiative. Visits had involved discussions around smoking cessation services and the common ailments service.

About 60% of the pharmacy's prescription items were assembled offsite at the company's hub pharmacy. The hub pharmacy could not assemble split packs, fridge lines, most controlled drugs or multi-compartment compliance aid trays and these continued to be dispensed at the branch. Prescription items sent to the hub before the end of the working day were generally returned to the branch within 48 hours, although there were occasional delays. The pharmacy team had a good relationship with the local surgery team, which meant that queries and problems were usually dealt with efficiently and effectively.

Dispensing staff used a colour-coded basket system to 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 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 that their medicines were ready for collection.

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 prescription bags to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. Stickers were also used to alert staff where the pharmacist wished to speak to the patient or their representative at the point of handout. Prescriptions for dispensed Schedule 3 and 4 CDs awaiting collection were not routinely identified and there was a risk that these items might be supplied when the prescription was no longer valid. However, members of the pharmacy team were all dispensary-trained and those present said that they would recognise prescriptions for Schedule 3 or 4 CDs and check that these were still valid at the point

of handout.

Prescriptions for patients prescribed high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified and there was a risk that counselling opportunities could be missed. However, the pharmacist explained that patients prescribed warfarin tended to present staff with their current INR result when collecting their medication, so he could view the information and counsel them at that point if necessary. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacy did not currently have any patients prescribed valproate who met the risk criteria, but the pharmacist said that any such patients would be counselled and provided with information at each time of dispensing. A valproate patient information pack was available in the dispensary and a poster which included patient safety information about valproate was displayed in the pharmacy. The pharmacy 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.

Disposable compliance aid trays were used to supply medicines to a number of people in the community. The pharmacist explained that all new patients were assessed for suitability. Trays were labelled with descriptions of individual medicines and patient information leaflets were routinely supplied. Each patient had a section in a file that included their personal and medication details, suitability assessment form and collection or delivery arrangements. A workload tracker for each patient was available and showed the status of each patient's tray at any given time. The pharmacy had a good relationship with the local health board's medicines management team and were in frequent contact with them to resolve any problems involving compliance aid patients.

The pharmacy provided a range of services. There was a steady uptake of the common ailments service, with many referrals from local surgeries and opticians. Uptake of the emergency supply of prescribed medicines service was also steady, with most requests made on Saturdays and around bank holidays. The pharmacy provided a discharge medicines review service, although uptake of this was relatively low. It also offered a technician-led smoking cessation service and an EHC service. Uptake of the seasonal influenza vaccination service had been lower than usual, as local clinics had provided combined influenza and COVID vaccination appointments and most people eligible for the free NHS service had attended these in preference to the single influenza vaccination appointment offered by the pharmacy. There had also been a delay in receipt of influenza vaccine stock which had led to delays in providing the service. A private pneumonia vaccination service was also offered, but uptake was very low, with only one or two vaccinations administered each year. The pharmacy offered a supervised consumption service. People who were supplied with substance misuse treatments against instalment prescriptions were allocated a section in a dedicated file which included their prescription, details of supervision or collection and any relevant documents such as collection authorisation letters.

The pharmacy provided a prescription collection service from seven local surgeries. It also offered a free prescription delivery service. Signatures were not obtained for prescription deliveries as an audit trail, but the pharmacist gave assurances that the delivery driver confirmed the identity of the recipient before each prescription was supplied. Separate signatures were not obtained for controlled drugs. However, these were supplied in separate clear bags and marked 'CD' on the delivery list, 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.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. Stock

medicines requiring cold storage were stored in a drug fridge. There was limited space in the fridge which meant that different products were stored closely together, increasing the risk of errors. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored in three well-organised CD cabinets and obsolete CDs were segregated from usable stock.

Stock was subject to regular documented expiry date checks, although the team had fallen behind with these over the last few weeks as they had been short-staffed. However, no out-of-date medicines were found. Stickers were used to highlight short-dated stock and pharmacy team members explained that they included a date check as part of their dispensing and checking procedures. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received drug recalls and alerts via its intranet system. The PMR software flashed up a real-time alert on the screen when a recall was received. A recent drug recall for Emerade injections had been dealt with appropriately by contacting patients and segregating affected stock. Drug recalls were printed, signed when actioned and then filed for reference.

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 and a capsule counter were used to count tablets and capsules. A separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources available. Equipment was in good working order, clean and appropriately managed. There was evidence to show that it had recently been tested. Staff had access to personal protective equipment such as face masks. 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. Some 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.