General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 127 Station Road, PORT TALBOT, West Glamorgan, SA13 1NR

Pharmacy reference: 1043809

Type of pharmacy: Community

Date of inspection: 12/11/2019

Pharmacy context

This is a high street pharmacy in a small town. 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 provides medicines in multi-compartment compliance aids to a large number of patients who live in the surrounding area. 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. Substance misuse services are also available.

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	Good practice	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 not all 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	Standard not met	Medicines are not always labelled appropriately to make sure that people have all the information they might need to use them safely
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 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 systems in place to identify and manage risk, including the recording and analysis of dispensing errors and near misses. The manager said that action had been taken to reduce risks that had been identified. For example, sumatriptan and sildenafil had been separated on dispensary shelves and caution stickers had been used to alert staff to the risks of picking errors with these items following a recent dispensing error. Caution stickers had also been used to highlight the risks of picking errors with different strengths of haloperidol and carbimazole tablets. The accuracy checker understood her role and responsibilities and said that she only conducted accuracy checks on prescriptions that had been signed by the pharmacist to show they had been clinically checked. She said that she was unable to check Schedule 2 or 3 CDs, or any high-risk medicines such as warfarin, lithium and methotrexate.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The branch manager 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 near the medicines counter. Evidence showed that a recent complaint about a dispensing error was being dealt with appropriately by the branch and the superintendent's office.

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, some headings were missing from the methadone register. CD running balances were typically checked weekly. Running balances for methadone sometimes showed high volumes of overage and there was a risk that these might mask instances of dispensing errors or diversion.

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. A privacy notice displayed at the medicines counter signposted people to the company website for information on the way in which personal data was used and managed by the company. Leaflets displayed in the retail area explained how NHS Wales used prescription information to help them make better informed decisions about medicines and patient services.

The pharmacists and pharmacy technician had undertaken level two safeguarding training and had

access to guidance and local contact details that were filed in the dispensary. Staff had received in-house training and were able to identify different types of safeguarding concerns. The branch manager said that the pharmacy had a good relationship with the local medicines management team and often contacted them if they had any concerns about people who received their medicines in compliance aids. All staff were trained Dementia Friends. A summary of the chaperone policy was advertised in a poster displayed near the medicines counter. Leaflets that included information for people affected by dementia were also displayed at the medicines counter.

Principle 2 - Staffing ✔ Good practice

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

A regular pharmacist worked on most days. He was absent during the inspection and his role was being covered by a locum pharmacist. The pharmacists were assisted in the day-to-day operation of the pharmacy by the branch manager, who was a qualified dispensing assistant and accuracy checker. The support team consisted of a full-time pharmacy technician, a full-time dispensing assistant and a full-time medicines counter assistant who worked well together. A part-time dispensing assistant was 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. Staff members had the necessary training and qualifications for their roles. Targets were set for MURs, but these were managed appropriately, and the pharmacist said that they did not affect his professional judgement or compromise patient care.

The pharmacy served a close-knit community and staff had an obvious rapport with customers. They were happy to make suggestions within the team and said that they felt comfortable raising concerns with the pharmacist or Regional Development Manager. Staff said that a whistleblowing policy was available on the company's intranet site and that it included a confidential helpline for reporting concerns.

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 undertook online training on new products, clinical topics, operational procedures and services. They had recently completed training on the company's new hub pharmacy and patient medication record (PMR) systems. All staff had completed training provided by NHS Wales on improving the quality of services provided. The pharmacy technician said that she understood the revalidation process. She said that she had recently submitted her continuing professional development (CPD) portfolio, basing her entries on situations she had come across in her day-to-day working environment as well as on topics of interest. All staff were subject to six-monthly performance and development reviews and could discuss issues informally with the manager or 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 housed in an old building and the branch manager said that there had been a recent leak in the roof that had been reported and was to be fixed when the weather improved. As a temporary solution, maintenance workers had fitted a funnel and hose under the leak which directed any rainwater into the dispensary sink. This repair was clean and hygienic. The dispensary 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 and its availability was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services **Standards not all 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. It stores most medicines appropriately and carries out some checks to make sure they are in good condition and suitable to supply. Its working practices are generally safe and effective. But it does not always label medicines appropriately to make sure people have all the information they need to use them safely.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. A signposting directory provided by the local health board was available and a list of local sexual health clinics was displayed in the consultation room. Staff said that they would signpost people requesting services they could not provide to other nearby pharmacies. A 'health kiosk' allowed customers to measure their own weight, body mass index, blood pressure, heart rate and percentage body fat for free, giving them an indicator about their general health and wellbeing. Some health promotional material was on display in the retail area, although this was partially obscured by the kiosk. The regular pharmacist had recently visited the local surgeries 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 influenza vaccination service, smoking cessation service, high-risk medicines 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 usually initialled by the dispenser and checker to provide an audit trail, although this was not always the case for substance misuse daily doses. There was a risk that the lack of a complete audit trail might prevent a full analysis of dispensing incidents. 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.

Two clear prescription bags containing multiple unlabelled packs of insulin were found in a drug refrigerator. The dispensing labels were attached to the bag itself rather than to the individual items. One bag was labelled as Novorapid vials x 5 and the other was labelled as liraglutide 6mg/ml injection 3ml x 2. This practice increased the risk that errors might go unnoticed and that people might not have all the information they needed to use their medicines safely.

The pharmacy team said that a new pharmacy software system had recently been installed which allowed about 80% of their 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. A text messaging service was available to let patients know their medicines were ready for collection. The pharmacist said that the prescription storage area was regularly checked and 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.

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. Some supplies had been made against unsigned private prescriptions and there was a risk that any such supplies would not be in accordance with the directions of a prescriber. The branch manager admitted that this was an oversight.

A dispensing assistant said that the branch had recently begun to use stickers marked 'Therapy Check' 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 any patients prescribed valproate who met the risk criteria would been counselled appropriately and provided with patient information. 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 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. 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 four dedicated files that included their personal and medication details and arrangements for collection or delivery. Some individual sheets listing medication details were quite untidy. For example, some dosage changes had been altered by obliteration and were difficult to read, increasing the risk of errors. Staff said that they had previously included controlled drugs requiring safe custody in compliance aids, but since the new PMR system had been installed they were unable to do so and instead supplied them in a separate box. The reasoning for this was unclear and there was a risk that this might lead to people being less able to manage their medicines. Staff said that they would only supply new clients with medicines in compliance aids if requested by their GP or if an assessment showed that they would benefit from the service.

Patients supplied substance misuse treatments against instalment prescriptions were allocated a section in a dedicated file which included their prescription, details of any messages or changes, their claim form if supervised and any other relevant documents such as their signed contract.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, some bottles and boxes containing loose tablets and blisters 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 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. One fridge was a little untidy and different types of insulin were

mixed together, which increased the risk of errors. CDs were stored appropriately in two CD cabinets and obsolete CDs were segregated from usable stock. One cabinet was well-organised. The other contained doses of methadone and buprenorphine for a large number of substance misuse clients. These were stored untidily, with daily doses for different clients stored very closely together. This increased the risk of errors.

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 the pharmacy software system. The branch manager explained that the PMR software flashed up a real-time alert on the screen. She was able to describe how she would deal with a drug recall by contacting patients if necessary, 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 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. The pharmacy's team members use these 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 staff said that they would wash these after use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. Most equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. However, a hearing aid loop in the consultation room had failed a recent test. 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. 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.