General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Gravell's Pharmacy, Ashgrove Medical Centre, Llanelli Town Centre, Thomas Street, LLANELLI, Dyfed, SA15 3JH

Pharmacy reference: 1088385

Type of pharmacy: Community

Date of inspection: 21/10/2022

Pharmacy context

This is a busy pharmacy located in the grounds of a medical centre. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It provides medicines in multi-compartment compliance aids to a large number of people. It offers a wide range of services including emergency hormonal contraception, smoking cessation, treatment for minor ailments and a seasonal 'flu vaccination service for both 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	N/A	N/A	N/A
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 and review some things that go wrong so that they can learn from them. But they do not always record all of their mistakes, so they may miss some opportunities to learn and improve. The pharmacy 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 some systems in place to identify and manage risk, including the recording of dispensing errors and near misses. However, very few near misses had been recorded over the last six months and it was likely that some incidents had not been captured. Dispensing error records did not always include details of people involved, which might prevent a full analysis of incidents. Some action had been taken to reduce the risk of patient safety incidents: ramipril tablets and capsules had been separated in the dispensary following some near misses with these products.

A range of written standard operating procedures (SOPs) underpinned the services provided. These had been signed to show that they had been read and understood by all staff. However, the signature sheets sometimes covered a suite of similar SOPs rather than individual procedures. This meant that if new versions or procedures were added it might not be clear if staff had been trained to follow them. Dispensing assistants who had an accuracy checking qualification adhered to the current accuracy checking SOP and understood that they were not able to accuracy check prescriptions for controlled drugs and insulin, injectable items, or prescriptions for children under the age of eight. They explained that they were able to check all other prescription items that had been clinically checked by a pharmacist. Staff demonstrated that the pharmacists stamped and initialled prescriptions to show when these had been clinically checked.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, although these had been suspended during the pandemic. Staff said that recent verbal feedback from people using the pharmacy had been mostly positive. A formal complaints procedure was in place, and this was advertised on a poster in the retail area.

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. However, electronic private prescription and emergency supply records were not always made in line with legal requirements as prescriber details were not always recorded correctly, and some emergency supply records did not include the nature of the emergency. Some records of unlicensed specials did not include patient details. CD records were electronic, apart from records of patient-returned CDs, which were kept in a paper register. CD running balances were typically checked monthly.

Confidentiality agreements had been signed by the pharmacy team as part of their contract of employment. All staff 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 in the retail area explained the way in which data was used by the pharmacy and gave details of the pharmacy's Data Protection Officer.

The pharmacists and pharmacy manager had undertaken formal safeguarding training and had access to guidance and local contact details that were displayed in the dispensary and consultation rooms. All members of the pharmacy team had read and signed a safeguarding SOP which was available in the dispensary.

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 superintendent pharmacist and a regular second pharmacist worked at the pharmacy on most days. They were assisted in the day-to-day operation of the pharmacy by the pharmacy manager, who also worked as a dispensing assistant and had recently gained an accuracy checking qualification. The support team consisted of five other dispensing assistants (DA), two of whom had an accuracy checking qualification, four trainee DAs, one of whom was employed on a zero-hour contract, and a new member of staff who worked on Saturday mornings and had not yet completed any formal training. The pharmacy manager said that the new staff member would shortly be enrolled on a formal training course relevant to her role. The pharmacy's six part-time delivery drivers had also undertaken accredited training courses relevant to their roles. 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. Trainees worked under the supervision of the pharmacists and other trained staff.

There were no specific targets or incentives set for the services provided. Staff worked well together and had an obvious rapport with customers. The pharmacy team were happy to make suggestions and said that they felt comfortable raising concerns with the pharmacists. There was no formal system in place for reporting concerns outside the company.

A member of staff working on the medicines counter used 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 transactions. Pharmacy team members had access to articles in training magazines and information about new products, but there was no formal training programme in place. Most learning was via informal discussions with the pharmacists. There was no formal appraisal system, but staff could discuss issues informally with the pharmacists whenever the need arose. The lack of a structured training and development programme increased the risk that individuals might not keep up to date with current pharmacy practice, and opportunities to identify training needs could be missed.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and fairly well-organised, with sufficient space to allow safe working. However, it was clear that more storage and workbench space would be beneficial, as some dispensary work surfaces were a little cluttered and large quantities of stock were being temporarily stored on the floor. The sinks had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff and customer use. Three well-appointed lockable consultation rooms were available for private consultations and counselling. Their availability was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy effectively 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. Its 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. 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 that were appropriately advertised. There was wheelchair access into the pharmacy and consultation rooms. The team said that they would signpost patients requesting services they could not provide to nearby pharmacies or to other healthcare providers such as the local GP surgery. The superintendent pharmacist worked closely with the local surgery to discuss and promote services as part of a health board funded collaborative working initiative. Recent visits had involved discussions around the repeat prescription service and the 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 (CDs) requiring safe custody and fridge items were not dispensed until the patient or their representative came to collect them. Prescriptions for these items were stored in a dedicated area of the dispensary, and stickers were attached to prescriptions to alert staff to the fact that these items were outstanding. There was no strategy in place to ensure that Schedule 3 or 4 CDs were not supplied to the patient or their representative more than 28 days after the date on the prescription.

Prescriptions for high-risk medicines such as warfarin, lithium and methotrexate were not highlighted and there was a risk that counselling opportunities could be missed. However, the pharmacist said that he asked all walk-in patients prescribed these medicines for information about recent blood tests and dosage changes, although this was not always recorded on the patient medication record (PMR). The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that two patients prescribed valproate who met the risk criteria were counselled appropriately and provided with information at each time of dispensing. 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.

The pharmacy provided a prescription collection service from seven local GP surgeries. It also provided a prescription delivery service. Patients or their representatives signed to acknowledge receipt of any controlled drugs. In the event of a missed delivery, a notification card was put though the door and the prescription was returned to the pharmacy. The pharmacy redelivered any returned prescriptions for a small charge.

Disposable compliance aids were used to supply medicines to many people. Compliance aids were labelled with descriptions to enable identification of individual medicines and patient information

leaflets were routinely supplied. Some people were supplied orodispersible tablets that were added to the compliance aid in their blister packaging. The pharmacist said that the pharmacy team and the GP had discussed the risks and benefits of this practice with the patient or their representative and a professional decision had been made to supply the tablets in this way, with regular review to ensure the situation was still safe and appropriate. Each patient had a section in one of five dedicated files that included their personal and medication details, repeat prescription order forms and any current prescriptions. Collection and delivery details and any messages or changes were recorded on each patient's PMR.

The pharmacy worked closely with the local health board (LHB) to provide services that matched the needs of the local community. The discharge medicines review service had a high uptake as most patient discharge information was sent directly to the pharmacy electronically via the Choose Pharmacy software platform. Uptake of the common ailments service was also high as many people were referred to this service from the adjacent medical centre. There was a steady uptake of the All-Wales EHC service and the smoking cessation services. There had been a high uptake of the seasonal influenza vaccination service so far and the team had vaccinated about 600 people. The pharmacy had recently resumed provision of the sore throat test and treat service that had been suspended during the pandemic. It had also recently begun to provide a new UTI service to symptomatic females between the ages of 60 and 64.

The pharmacy provided a private weight loss service, supplying Saxenda under a patient group direction (PGD). Patients were asked to make an initial appointment during which their weight, BP and BMI were recorded, alongside any action they had already taken to lose weight and any current medication they were taking. The service was explained to them, and the pharmacist discussed their expectations. If eligible for the service, they were enrolled on the programme and shown how to use the Saxenda pen injection. They were supplied with a titration pen and needles and counselled to begin on a low dose and gradually increase this over time. They were also supplied with advice about diet and exercise and signposted to NHS resources for support and advice. Regular consultations were held with the patient to check their progress and answer any queries. The pharmacist said that the treatment seemed to work well for most people, who usually stayed on the programme for 8-12 weeks before reaching their goal and stopping the service. The pharmacy also provided a private health check for a charge, which encompassed a blood pressure check, BMI measurement and blood glucose, cholesterol and uric acid checks. Some referrals had been made to customers' GPs following these checks: the pharmacists had picked up cases of gout, hypertension, diabetes and atrial fibrillation which had all required medical assessment and in most cases, further treatment.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. Some bottles containing loose tablets that had been removed from their original packaging were not adequately labelled either as stock or named-patient medication, which increased the risk of error. The pharmacist disposed of these appropriately as soon as this was pointed out. Medicines requiring cold storage were stored in three drug fridges. Maximum and minimum temperatures for these fridges were recorded daily and were consistently within the required range. CDs were stored appropriately in two CD cabinets. Obsolete CDs were segregated from usable stock. The CD keys had been left in the doors of the cabinets, compromising the security of these medicines. The pharmacist removed the keys and secured them in a coded key safe as soon as this was pointed out. He said that the only people who had access to the code were the two pharmacists.

Stock was usually subject to documented expiry date checks, although these had not been recorded for several months. However, the pharmacists and accuracy checking dispensers said that an expiry date check was part of their final accuracy check. Date-expired medicines were disposed of appropriately, as

were patient returns, waste sharps and clinical waste. The pharmacy received drug alerts and recalls via email. Alerts were printed and filed for reference. The pharmacist was able to describe how he would normally deal with drug recalls by contacting patients where necessary and returning quarantined stock to the relevant supplier.

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. Separate measures were used for methadone. Triangles and a tablet counter were used to count tablets and capsules. The tablet counter was calibrated before each use. 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 computer system was password-protected and the consultation rooms were 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.