General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Well, 63 Alexandra Road, Gorseinon, SWANSEA, West Glamorgan, SA4 4NU

**Pharmacy reference:** 1089734

**Type of pharmacy:** Community

**Date of inspection:** 25/02/2020

## Pharmacy context

This is a high street pharmacy located next door to a doctor's surgery. 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 wide range of services including smoking cessation, 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 | 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. But they do not always 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 are good at recognising and reporting 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 recording and analysis of dispensing errors and near misses. A comprehensive root cause analysis had been undertaken for a recent dispensing error. Monthly patient safety reviews were available but the most recent of these had been completed in 2019. The pharmacy manager said that this was a result of work pressure and reviews would begin again shortly. Staff understood the risks of errors with 'Look-Alike, Sound-Alike' or 'LASA' drugs and were able to demonstrate that allopurinol and atenolol had been separated on dispensary shelves as a result of a recent error. Different strengths of metformin modified-release tablets had also been separated following an error. The pharmacy manager said that when she had started work at the pharmacy the previous year, one area of the pharmacy was being used as both a dispensing and a checking station, which had led to confusion and errors. She said that she had separated the two processes by creating a dedicated checking area, which had reduced the rate of incidents. A poster describing the process to follow in the event of anaphylaxis was displayed in the consultation room.

A range of electronic standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Staff members were in the process of reading and completing online declarations and assessments for a new version of the Pharmacy Services SOP. The branch manager had an accuracy-checking qualification. She said that she could not check controlled drugs, including codeine and tramadol, or high-risk medicines such as warfarin, lithium and methotrexate. She said that she would only check prescriptions that had been initialled by the pharmacist to show that they had been clinically checked.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. Staff said that this was mostly positive. However, there had been some negative feedback around the length of time people had to wait to be served or for their prescriptions to be dispensed. A formal complaints procedure was in place and information about how to make complaints was included in a poster on the consultation room door.

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, there were three missing entries from the RP register on 4 November, 5 December and 31 December 2019. The failure to maintain the RP register is a breach of legislation and there is a risk that it would not be possible to identify the pharmacist accountable in the event of an error or incident.

Records of unlicensed specials 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 monthly, although checks were also sometimes made at the time of dispensing.

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 in the consultation room gave a summary of the way in which personal data was used and managed by the company and signposted people to the company's website for more information.

The pharmacist had undertaken level two safeguarding training and had access to guidance and local contact details that were available on the company's intranet site. Staff had received in-house training and were able to identify different types of safeguarding concerns. The branch manager said that she had recently referred a concern to the pharmacist about a patient who received their medicines in a compliance aid tray. The patient was becoming increasingly confused and unable to manage her medicines properly. The manager said that she had visited the patient at home and realised that she needed extra support, so the concern had been referred to the GP. The GP had assessed the patient and had arranged a care package that included medicines management. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members complete regular training and understand their roles and responsibilities. They feel comfortable speaking up about any concerns they have.

### Inspector's evidence

A regular pharmacist had joined the branch the previous day. She was being assisted in the operation of the pharmacy by the branch manager, who was a dispensing assistant with an accuracy checker qualification. The manager said that the pharmacist was employed to work on most days, but relief or locum pharmacists would cover her day off every Thursday. The support team consisted of a pharmacy technician, four dispensing assistants, one of whom was training as an accuracy checker, and a medicines counter assistant. Another dispensing assistant was absent. 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. Staff members had the necessary training and qualifications for their roles. The trainee accuracy checker worked under the supervision of the pharmacist and other trained staff members.

Targets were set for MURs, but these were managed appropriately, and the branch manager said that they did not affect the pharmacist's professional judgement or compromise patient care. The pharmacy was busy during the inspection, with many people queuing to present walk-in prescriptions or to collect prescriptions that had already been submitted. However, although the workload was heavy, staff members and the pharmacist were consistently polite and professional and had an obvious rapport with customers. 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. A poster advertising a confidential helpline for reporting concerns outside the organisation was displayed in the dispensary.

A member of staff working on the medicines counter gave a coherent explanation of the WWHAM questioning technique and referred to the pharmacist on several occasions for further advice on how to deal with a transaction. She said that she always checked with the pharmacist when dealing with inappropriate or frequent requests for products containing codeine. Staff undertook online training on new products, clinical topics, operational procedures and services. They were able to access training modules from home. However, the pharmacy manager said that staff had not received any training on operational aspects of the new delivery service, which had caused some difficulties. All staff were subject to six-monthly performance and development reviews and could discuss issues informally with the pharmacy manager or pharmacist 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 housed in an old building and some of the fixtures needed to be repaired: a minor leak in the roof had been reported to head office, as had a broken door handle on a connecting door between two dispensary areas. The dispensary was fairly clean and tidy. It was spacious, but some stock and dispensed prescriptions awaiting collection were being temporarily stored on the floor and posed a possible trip hazard. The sinks had hot and cold running water and soap and cleaning materials were available. A consultation room was available for private consultations and counselling and this 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. 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 help make sure that 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. There was a hearing aid loop in the consultation room, but this was not in working order. Staff said that they would signpost people requesting services they could not provide to other nearby pharmacies. They said that the local surgeries were aware that the sore throat test and treat service was unlikely to be available on Thursdays, unless the covering pharmacist was accredited to provide the service. The telephone number for a local physiotherapy walk-in clinic was displayed in the dispensary for reference. Some health promotional material was on display in the retail area. The pharmacy manager explained that the previous pharmacist had recently visited local surgeries to discuss and promote services as part of a health board funded collaborative working initiative. His visits had involved discussions around the sore throat test and treat service, the repeat dispensing service, the common ailments service, the influenza vaccination service and the discharge medicines review 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. However, daily doses for substance misuse clients were only marked with the checker's initial which might prevent a full analysis of dispensing incidents. Controlled drugs requiring safe custody and fridge lines 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.

The pharmacy manager said that a new software system had recently been installed which allowed about 36% of prescription items to be assembled at the company's hub pharmacy. However, she said that most prescriptions were presented as walk-ins, as the pharmacy was situated next door to one GP surgery and within a short walk of another and these continued to be dispensed at the branch. The hub pharmacy could not assemble split packs, fridge lines or most controlled drugs and these were also dispensed at the branch. Prescription items scanned to the hub before 3pm were generally returned to the pharmacy 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 the prescription storage area was checked every six to eight weeks. Any medicines that had been awaiting collection for over four weeks were returned to stock and the prescription was returned to the surgery.

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. There was no strategy in place to identify Schedule 3 or 4 CDs and ensure that these prescriptions were checked for validity before supply to the patient or their representative.

Patients prescribed high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified and there was a risk that opportunities for counselling might be missed. However, the pharmacy manager said that staff asked for information about blood tests and dosage changes if a patient telephoned the pharmacy to order these medicines. 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 appropriately and provided with patient information. They demonstrated that information was attached to original packs of valproate and could also be printed from the internet. 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 delivery service was managed electronically: patients or their representatives signed a handheld electronic device to acknowledge receipt of delivery as an audit trail. Separate signatures were obtained for deliveries of controlled drugs. In the event of a missed delivery, the delivery driver put a notification card through the door and brought the prescription back to the pharmacy.

The pharmacy manager said that there had been a high uptake of the sore throat test and treat service since its recent introduction. She explained that the pharmacy received many referrals from local surgeries and the pharmacy carried out an average of ten tests each day. Patients supplied substance misuse treatments against instalment prescriptions were allocated a section in a dedicated file which included their personal details, current prescription and claim form if supervised. A list of patients and a communications sheet were available at the front of the file for reference.

Medicines were obtained from licensed wholesalers and generally stored appropriately. Medicines requiring cold storage were stored in a large drug fridge. However, it was clear that stock levels were at capacity. The lack of space meant that some items such as different insulin products were stored closely together, increasing the risk of errors. Maximum and minimum temperatures were recorded daily and were usually within the required range. However, some discrepancies had been recorded. The pharmacy manager said that she was personally responsible for recording temperatures, and always monitored these if they were outside the required range. A large quantity of Trimbow inhalers that had been ordered in error were being stored in the staff fridge. The pharmacy manager said that she had initially checked maximum and minimum temperatures for this fridge, but the thermometer had recently broken and had not yet been replaced, so no checks were currently being made. This made it difficult for the pharmacy to be assured that these medicines were safe and fit for purpose. The pharmacy manager said that she would order a new thermometer to monitor temperatures and would transfer stock into the drug fridge where space allowed. CDs were stored appropriately in three well-organised CD cabinets 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, waste sharps and clinical waste. An unsealed sharps bin containing used sharps was situated in the unlocked consultation room, which could be accessed from the retail area. The pharmacy manager moved this as soon as it was pointed out. She said that the bin for cytotoxic waste had been collected the previous week but had not been replaced. However, she said that she would contact the waste

contractor to order another, and that any cytotoxic waste received in the meantime would be segregated. A scheme run in association with GSK allowed the pharmacy to recycle returned inhalers. The pharmacy software system flashed up a real-time alert on the computer screen when a drug alert or recall was received. The pharmacy manager said that the team had recently dealt with a recall for Beconase aqueous nasal spray 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 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 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 were used to count tablets. These were a little dusty, but the pharmacy manager said that they would be washed before their next use. A separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. Equipment was clean and appropriately managed. It was regularly tested, and most was in good working order, although 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. |