General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Evans Pharmacy - Glen, 2A No Acre, Gas Lane The Norton, TENBY, SA70 8AG

Pharmacy reference: 1089959

Type of pharmacy: Community

Date of inspection: 25/07/2022

Pharmacy context

This is a pharmacy in a popular seaside resort. 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, smoking cessation, treatment for minor ailments and a seasonal 'flu vaccination service.

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	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 some of their mistakes so they can learn from them. And they take action to help stop mistakes from happening again. 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. 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

A range of standard operating procedures (SOPs) underpinned the services provided. These were regularly reviewed. The pharmacy had 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 in recent months and it was likely that some incidents had not been captured. Learning points from patient safety incidents were shared within the pharmacy team to reduce risks that had been identified. A poster clearly displayed in the dispensary highlighted pairs of 'look-alike, sound-alike' drugs, as well as drugs for which incorrect strengths had previously been selected, to remind staff of the risks when selecting these medicines.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, although these had been suspended during the pandemic. The pharmacy team said that verbal feedback from people using the pharmacy was overwhelmingly positive. During the inspection a customer was overheard to thank the pharmacy team for providing a good service. A formal complaints procedure was in place and information about how to make complaints was included in the practice leaflet displayed in the retail area.

A current professional indemnity insurance certificate was displayed. All necessary records were kept and properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. CD running balances were subject to regular checks.

Evidence showed that most staff members had signed confidentiality agreements. One member of staff who had not signed an agreement explained that she had undertaken information governance training as part of her previous job in another pharmacy. She understood the need to protect confidential information, for example by offering people the use of the consultation room for private conversations. Staff were able to identify confidential waste and disposed of it appropriately.

The pharmacist and staff had undertaken formal safeguarding training. The pharmacy team had access to local guidance and contact details that were displayed in the dispensary. A poster advertising a support group for people living with dementia was displayed at the pharmacy entrance. And there were leaflets that advertised the All-Wales Domestic Abuse and Sexual Violence helpline and booklets that included information about carers' rights. A summary of the pharmacy's chaperone policy was advertised in a poster on the consultation room door. The pharmacy technician explained how she had recently contacted the local surgery to discuss the safeguarding needs of a vunerable person which had resulted in them receiving additional support.

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. His support team consisted of a full-time pharmacy technician and four part-time dispensing assistants, two of whom 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. Staff members had the necessary training and qualifications for their roles.

There were no specific targets or incentives set for the services provided. Staff worked well together and had an obvious rapport with customers. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist, area manager or superintendent pharmacist. The pharmacy technician said that she would contact the GPhC if she wished to raise a concern outside the organisation.

Members of staff working on the medicines counter were observed to use appropriate questions when selling over-the-counter medicines to patients. They referred to the pharmacist on several occasions for further advice on how to deal with transactions. Staff said that they would feel confident refusing a sale and had done so in the past when dealing with what they considered to be an inappropriate request for a product containing codeine.

Staff had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They said that much of their learning was via informal discussions with the pharmacist. The lack of a structured training programme increased the risk that individuals might not keep up to date with current pharmacy practice. All staff were subject to annual performance and development reviews. One staff member who had worked at the pharmacy for less than a year said that she had not yet had a formal appraisal, but she could informally discuss performance and development issues with the pharmacist whenever the need arose. The pharmacist and pharmacy technician understood the revalidation process. They said that they based their portfolio entries on external training and on situations they came across in their day-to-day working environment.

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. The lighting and temperature in the pharmacy were appropriate. Some dispensed prescriptions awaiting collection were being temporarily stored on the floor but these did not pose a trip hazard. A conspicuous sign at the pharmacy entrance alerted customers to a section of loose carpet which had been temporarily secured with tape. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff and customer use. A floor-to-ceiling plastic screen had been installed across the length of the medicines counter 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. A podiatrist used a room on the first floor of the premises and held weekly clinics there during pharmacy opening hours. Clients had to walk past the pharmacy’s prescription retrieval area to reach the room and a rail with a curtain had been installed to screen off prescriptions awaiting collection and preserve patient confidentiality. Some paperwork that included patient details was displayed on the wall in this area but staff ensured that it was permanently removed from view as soon as this was pointed out.

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 generally safe and effective. It stores 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 wide range of services that were clearly and appropriately advertised. There was wheelchair access into the pharmacy and consultation room. A signposting file provided by the local health board was available in the dispensary. A list of local pharmacies and opticians was displayed in the retail area, along with a poster advertising the online service Choose Well Wales, which signposted people to an appropriate NHS service depending on their symptom or problem. Staff said that they would signpost patients requesting services they could not provide to nearby pharmacies or other providers such as the local surgery. Some health promotional material was displayed in the retail area. The pharmacist explained that he had recently visited 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 influenza vaccination service and the Choose Pharmacy common ailments service.

Dispensing staff used a basket system to ensure that medicines did not get mixed up during dispensing. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Controlled drugs requiring safe custody and fridge lines were usually 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 person receiving the wrong medicine. The pharmacy dispensed medicines against some faxed prescriptions from local surgeries. There were mechanisms in place to ensure that Schedule 2 or 3 CDs were only ever supplied against the original prescription.

Stickers were used on prescriptions awaiting collection to alert staff to the fact that a CD or fridge item was outstanding. Schedule 3 and 4 CDs awaiting collection were not routinely identified to ensure that they were not supplied to patients against an invalid prescription. Patients on high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified and there was a risk that counselling opportunities might be missed. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist explained that any patients prescribed valproate who met the risk criteria would be counselled and provided with patient information, which 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.

The pharmacy provided a prescription collection service from two local surgeries. It also offered a prescription delivery service. Signatures were obtained for deliveries of controlled drugs. In the event of a missed delivery, the driver put a notification card through the door and brought the prescription back

to the pharmacy. The company had recently implemented a policy to charge people for re-delivering their medication, but the pharmacy team had not received any requests for a redelivery since the charge had been introduced.

Disposable compliance aid trays were used to supply medicines to about 65 patients. The company had recently introduced a monthly charge for new patients who wished to receive the service. Trays were labelled with descriptions to enable identification of individual medicines. Patient information leaflets were not routinely supplied and so there was a risk that patients might not always have all the information they need for them to make informed decisions about their own treatment. A list of patients and their delivery or collection arrangements was displayed inside a cupboard door in the compliance aid area for reference. Each patient had a section in a dedicated file that included their personal and medication details. Some individual sheets listing medication details were untidy. For example, some dosage changes had been altered by obliteration and were difficult to read. There was a possibility that this might increase the risk of errors.

The pharmacy provided a wide range of services. The pharmacist explained that he promoted the common ailments service heavily within the local community and uptake was high as a result. The discharge medicines review service also had a high uptake as about 80% of patient discharge information was sent directly to the pharmacy electronically via the Choose Pharmacy software platform. The pharmacy had recently begun to provide a new UTI service to symptomatic females between the ages of 60 and 64 and had asked the local surgery to refer any eligible patients where appropriate. Consequently, uptake of the service had been high and so far about 80% of people using the service had been suitable for treatment with antibiotics. A ‘triage and treat’ minor injuries service commissioned by the local health board was not often used as the pharmacy was situated opposite the local cottage hospital, which had a walk-in minor injuries service. The pharmacy had carried out about 300 influenza vaccinations during the 2021/22 season as part of the NHS enhanced service. It had also held a walk-in clinic for booster COVID vaccinations.

Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were kept in a well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored in two large, well-organised CD cabinets and obsolete CDs were segregated from usable stock. Stock was regularly checked and date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received drug alerts and recalls via its NHS email account. These were printed and filed for reference. The pharmacist was able to describe how he would deal with medicines or devices that were unfit for purpose by contacting patients 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. A separate measure was used for liquid controlled drugs. Triangles and a tablet counter were used to count tablets and 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: the computer was password-protected 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.