General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Unit 4 Urban Village, 215 High Street, SWANSEA, SA1 1NW

Pharmacy reference: 1123106

Type of pharmacy: Community

Date of inspection: 19/11/2019

Pharmacy context

This is a high street pharmacy in a busy 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. 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 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	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 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 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 are good at recognising and reporting concerns about vulnerable people to help keep them safe.

Inspector's evidence

A range of electronic 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 and analysis of dispensing errors and near misses. Staff said that they had received training on the risks of selection errors with 'Look-Alike, Sound-Alike' or 'LASA' drugs and some action had been taken to reduce these risks. For example, amlodipine and amitriptyline tablets had been separated on dispensary shelves, as had quinine and quetiapine tablets and rivaroxaban and risperidone tablets.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey showed that this was overwhelmingly positive. A formal complaints procedure was in place and information about how to make complaints was included in posters displayed on the consultation room door and at the medicines counter.

Evidence of current professional indemnity insurance was available. 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 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. Individual staff members had unique passwords to access the pharmacy computer system.

The pharmacist had undertaken level two safeguarding training and had access to guidance and local contact details that were available in the dispensary. Staff had undertaken in-house training and were able to identify different types of safeguarding concerns. They said that they had recently contacted the local community's street nurse as they had concerns about a vulnerable homeless person. The nurse had attended to the patient and arranged for them to be seen by a GP. All staff were trained Dementia Friends. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door.

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

The pharmacist manager worked at the pharmacy on most days, assisted by a pharmacy technician and two dispensing assistants, who worked well together. 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. They appeared competent and compassionate when dealing with members of the public.

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. Staff were happy to make suggestions within the team and said that they felt comfortable raising concerns with the pharmacist or regional development manager. A poster advertising a confidential helpline for reporting concerns outside the organisation was displayed in the staff area.

Members of staff working on the medicines counter were observed to use appropriate questions when selling over-the-counter medicines and referred to the pharmacist when necessary for further advice on how to deal with a transaction. They said that they would feel confident refusing a sale and had done so in the past when dealing with what they considered to be inappropriate requests for products containing codeine. Staff undertook online training on new products, clinical topics, operational procedures and services. They had recently completed training on the company’s new patient medication record (PMR) system. All staff were subject to annual performance and development reviews and could discuss issues informally with the 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 clean, tidy and well-organised, with enough space to allow safe working. The sink had hot and cold running water and soap and cleaning materials were available. A poster describing hand washing techniques was displayed near the sink. A consultation room was available for private consultations and counselling and was clearly advertised. A semi-private hatch that opened into the dispensary from a quiet part of the medicines counter was used by substance misuse clients. No confidential information was visible from this area. 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. Its working practices are safe and it generally manages medicines appropriately. The pharmacy's team members take extra care with high-risk medicines to help make sure that people use these 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. Hearing aid loops were available in the consultation room and at the medicines counter. A signposting directory provided by the local health board was available in the dispensary. Staff said that they would signpost people requesting services they could not provide to nearby pharmacies, or other providers such as the local hospital or sharps collection service. A list of local sexual health clinics was displayed in the consultation room. Some health promotional material was on display in the retail area. The pharmacist explained that he had recently visited local surgeries to discuss and promote services as part of a health board funded collaborative working initiative. Recent visits had involved discussions around the repeat dispensing service 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. However, this was not the case for daily doses dispensed for substance misuse clients. There is a risk that the lack of a complete audit trail may 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.

The pharmacist said that the dispensing workload was easy to manage as most of it consisted of repeat prescriptions with occasional walk-ins. He explained that a new software system had recently been installed which allowed about 15% of all prescription items to be assembled at the company's hub pharmacy. A notice informing people that their prescriptions might be processed at the hub pharmacy was displayed at the medicines counter. The hub pharmacy could not assemble split packs, fridge lines, compliance aids or most controlled drugs 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. 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 pharmacist said that the prescription storage area was checked weekly. Any patient who had not collected their prescription after three 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 attached to prescriptions awaiting collection to identify patients eligible for an MUR.

Staff and the pharmacist said that stickers were used to routinely identify prescriptions for patients prescribed high-risk medicines such as warfarin, lithium and methotrexate so that they could be counselled. 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 three people prescribed valproate who met the risk criteria had been counselled appropriately and provided with patient information. He said that he had also conducted MURs with these patients. Stocks of valproate patient information cards were 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 CD. If a patient or their representative was not at home to receive a delivery, the delivery driver either returned the medication to the pharmacy or took it to a Well branch near to the patient's home address. Any prescriptions taken to another branch were returned to the pharmacy the next working day. A notification card informed the patient which pharmacy the prescription had been returned to. It was unclear if patients had given consent for their prescription to be sent to another branch and there was a risk that this practice might compromise confidentiality.

Disposable compliance aid trays were used to supply medicines to a number of patients. Staff said that any new patients requesting the service were assessed for suitability. Patient information leaflets were routinely supplied but trays were not labelled with descriptions to allow identification of individual medicines. This meant that patients might not always have all the information they need for them to make informed decisions about their own treatment. A progress log for all patients was displayed and showed the status of each patient's tray at any given time. Each patient had a section in one of five dedicated files that included their personal and medication details, collection or delivery arrangements, details of any messages or changes and documents such as completed assessment forms and discharge letters. Some trays were marked 'staged' and the pharmacist said that this arrangement was generally made for people who had many similar-looking medicines included in their tray. He explained that 'staged' trays were initially checked for accuracy by the pharmacist after a few medicines had been added and then checked again after a few more had been dispensed, until the tray was complete. He said that this simplified the checking process for him and reduced the likelihood of errors. A separate file was kept for patients who were currently in hospital.

The pharmacist said that uptake of the influenza vaccination service was high and he had carried out approximately 140 vaccinations so far during the 2019/20 season. He said that the majority of these had been as part of the NHS enhanced service.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, there was limited storage space for stock medicines and some different products and different strengths of the same product were stored closely together, which increased the risk of picking errors. Medicines requiring cold storage were stored in a well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored

appropriately in a large, well-organised CD cabinet and obsolete CDs were segregated from usable stock. Patients supplied substance misuse treatments against instalment prescriptions were allocated a section in a dedicated file which included their prescription and claim form if supervised.

Stock was regularly checked and date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacist was able to describe how the pharmacy team had dealt with a recent drug recall for ranitidine tablets by quarantining affected stock and returning it to the supplier. Staff demonstrated that the PMR software flashed up a real-time alert on the screen for all drug alerts. 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. 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 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. 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.