General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Tynycoed Surgery, 20 Merfield Close, Sarn, BRIDGEND, Mid Glamorgan, CF32 9SW

Pharmacy reference: 1123108

Type of pharmacy: Community

Date of inspection: 03/12/2019

Pharmacy context

This is a busy health centre pharmacy in a village. 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 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	Standards not all met	2.1	Standard not met	The pharmacy team is not always able to manage the workload or provide services effectively
3. Premises	Standards not all met	3.1	Standard not met	The dispensary is not always safe as the floor is used to store large quantities of bulky items that constitute significant trip hazards.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	Baskets containing dispensed medicines are often stored in unstable piles and there is a risk that transposition of medicines might occur.
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 generally 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

The pharmacy had systems in place to identify and manage risk, including the recording and analysis of dispensing errors and near misses. Root cause analyses had been conducted following recent dispensing errors. Staff demonstrated that action had been taken to reduce risk: Solareze and Voltarol gels had been separated in the dispensary after similar packing had contributed to selection errors. Ropinirole and risperidone tablets and different strengths of gliclazide tablets had also been separated to reduce the incidence of errors. Staff said that regular 'huddle' meetings were held every few weeks to discuss current patient safety issues, including near miss trends. They said that they had recently discussed the risks of picking errors with 'Look-Alike, Sound-Alike' drugs.

A range of electronic standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. The pharmacy had opened about twenty minutes late due to staffing issues and staff members were able to describe the activities which could not take place in the absence of the responsible pharmacist (RP). The responsible pharmacist notice displayed was incorrect, but the pharmacist remedied this as soon as it was pointed out to him. The accuracy checking technician (ACT) said that she could check all prescription items that had been clinically checked by a pharmacist except for controlled drugs requiring safe custody and methotrexate. She explained that the pharmacists initialled each prescription to show it had been clinically checked.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. Staff said that there had been some positive feedback and two cards displayed in the pharmacy office thanked staff for their kind service. However, they said there had also been a lot of negative feedback about long waiting times for prescriptions. During the inspection many customers complained about the long waits, with one customer alleging that he had been in the pharmacy for an hour and ten minutes. The regional development manager said that he was aware of this feedback and was currently formulating a plan to address waiting times in conjunction with the superintendent's office. A formal complaints procedure was in place and information about how to make complaints was included in a poster displayed in the waiting area.

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, specials procurement and controlled drug (CD) records. However, the RP register had not always been signed out to show the time at which the pharmacist had relinquished responsibility for the safe and effective running of the pharmacy. Also, some amendments to the RP register had been made by obliteration with no clear audit trail. This might make it difficult for the pharmacy team to resolve queries or investigate errors. Emergency supply records were not always made in line with legal requirements as some did not include the nature of the emergency. There was a

risk that there might not be enough information available to allow the pharmacy team to fully resolve queries or deal with errors effectively. One prescription for gabapentin, a Schedule 3 CD, had been supplied although it had not been written on the correct legal prescription form, and a copy had not been sent to the pricing authority to provide an audit trail. CD running balances were typically checked every two weeks, although running balances of methadone were 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 for accessing the pharmacy software system. The pharmacists and ACT had undertaken formal safeguarding training and had access to guidance and local contact details that were displayed in the dispensary. Staff had received in-house training. A summary of the chaperone policy was available in a poster displayed in the waiting area.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy team is not always able to manage the workload or provide services effectively. Members of the team are suitably qualified for the jobs they do and they receive additional training to keep their knowledge up to date. They are comfortable speaking up about any concerns they have.

Inspector's evidence

A regular pharmacist worked at the branch and was assisted in the day-to-day operation of the pharmacy by the branch manager, a qualified dispensing assistant, who was absent. The regular pharmacist was also absent for most of the inspection, but his role was being covered by a relief pharmacist and the regional development manager, who was acting as a second pharmacist. Staff said that second pharmacist cover was provided by the company on two days each week, although not always on the same days. The support team consisted of an accuracy checking technician (ACT) and four dispensing assistants. Another dispensing assistant was absent. A relief pharmacy technician had been drafted in to help with the workload that day as cover for the pharmacy manager.

The pharmacy was extremely busy during the inspection, with the retail area constantly full of people waiting to be served or waiting for prescriptions. There were so many people waiting that they were unable to form an orderly queue and staff were often unsure who was waiting and who had yet to be served. The environment in the dispensary was chaotic and morale was low. The ACT said that a member of staff who worked on the medicines counter for 25 hours a week had left when a new pharmacy software system had been introduced a few months previously and had not been replaced. The loss had been unexpected, and the team had not adjusted well to managing the new pharmacy system with fewer resources. The workload had consequently built up and was not being managed effectively. Staff said that one dispensing assistant who was absent did not understand how to use the new software system and covered the medicines counter as she could not help in the dispensary. The ACT said that she was not able to check many prescriptions as she was often required to assist with the dispensing workload. She said that the standard operating procedure for accuracy checking did not permit her to check a prescription if she had also been involved in the dispensing process. Staff members appeared frustrated as they often could not locate prescriptions or resolve queries quickly. However, they were polite and helpful to customers. The pharmacists worked methodically, calmly and professionally throughout.

Targets were set for MURs. Staff said that these were managed appropriately and did not affect the pharmacists' professional judgement or patient care. However, the ACT said that the pharmacists found it very difficult to leave the dispensary to carry out MURs as the workload was so intense, and the team were consequently not meeting their targets. She said that there was some pressure to complete MURs, but the Regional Development Manager was aware that the core dispensing service took priority. Staff said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists, Regional Development Manager or superintendent's office. A poster displayed in the staff area included a confidential helpline for reporting concerns outside the organisation.

Members of staff were observed to use appropriate questions when selling over-the-counter medicines to patients and referred to the pharmacists on several occasions for further advice on how to deal with a transaction. A computer terminal was situated at the medicines counter. This allowed staff to access

patient medication records to help them make decisions about sales of medicines or provision of advice. Staff undertook online training provided by the organisation on new products, clinical topics, operational procedures and services. They had recently completed training modules on the new pharmacy software system. All staff had also completed training provided by NHS Wales on improving the quality of services provided. The ACT said she understood the revalidation process. She said that she based her continuing professional development entries on situations she came across in her day-to-day working environment. The regional development manager said that all staff were subject to six-monthly performance and development reviews. However, one member of staff said that she had only received one review in the past three years. Infrequent performance and development review may mean that opportunities to identify training needs could be missed. Staff were able to discuss issues informally with the pharmacists or pharmacy manager whenever the need arose.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is clean and secure. But the pharmacy's team members do not always keep the floor free from trip hazards. There is enough space to allow safe working and the pharmacy layout protects people's privacy.

Inspector's evidence

The pharmacy was fairly clean and generally well-organised. However, large quantities of stock and prescriptions were being temporarily stored on the floor, which made it difficult for staff members to move around the dispensary. During the inspection, one member of staff tripped over a box of stock that was waiting to be put away. 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. A semi-private screened area of the medicines counter was used by substance misuse clients and for quiet conversations and counselling. The lighting and temperature in the pharmacy were appropriate. However, the rear of the dispensary was quite cold, and heaters were being used to keep this area warm.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy promotes the services it provides so that people know about them. People can usually access services but there are sometimes long waits. If pharmacy team members can't provide a service they direct people to somewhere that can help. The pharmacy's working practices are generally safe. The pharmacy's team members take extra care with high-risk medicines to help make sure that people use these safely. But they do not always make sure that dispensed medicines are stored appropriately. And there is a risk that medicines for different patients could get mixed up.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room and a hearing aid loop was available. A signposting file provided by the local health board was available which included details of local services and support groups. Staff said that they would signpost patients requesting services they could not provide to nearby pharmacies or other providers such as the local surgery, which offered a sharps disposal service. Some health promotional material was on display in the retail area. The regular pharmacist had recently visited local surgeries to discuss and promote services as part of a health board-funded collaborative working initiative. Visits had involved discussions around high-risk medicines and the common ailments service.

A new pharmacy software system had recently been installed which allowed about 35% of the pharmacy's prescription items to be assembled at the company's hub pharmacy. The hub pharmacy could not assemble split packs, most controlled drugs or fridge lines 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. However, the Regional Development Manager said that processes were not consistently followed within branch and that many prescriptions that could be dispensed by the hub were not ready when people returned to collect them. In these cases, the prescriptions had to be re-dispensed in branch, which was time-consuming and led to very long waits.

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. However, some baskets containing dispensed medicines were piled up precariously on work benches and the floor. One pile of baskets was knocked over as the pharmacist was trying to locate a dispensed prescription for a waiting customer and some medicines fell into another person's basket. Staff rectified this immediately it was pointed out. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. 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.

Supplies had recently been made against two prescriptions that had not been signed by the prescriber. This calls the pharmacy's checking procedures into question and there is a risk that any supplies made are not in accordance with the directions of a prescriber. A dispensed prescription in the controlled drugs cabinet awaiting collection was also found not to have been signed by the prescriber. The responsible pharmacist remedied this immediately it was pointed out.

Each prescription awaiting collection could be 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 the patient's items were being stored, including the drug fridge or CD cabinet where applicable. However, many prescriptions were still at the processing stage or had not been received from the hub when people arrived at the pharmacy to collect them. This meant that staff were unable to use the scanning system to locate many prescriptions, leading to confusion and time-consuming searches.

Stickers were placed on bags to alert staff to the fact that a patient was eligible for an MUR, or that a CD requiring safe custody or fridge item was outstanding. Stickers were also used to identify some dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was invalid and could no longer be supplied. However, one prescription for gabapentin was found present that had not been marked in this way and was over 28 days old, so no longer valid. The ACT said this was an oversight and removed it from the prescription retrieval system.

Pre-printed slips were used to routinely identify prescriptions for patients prescribed warfarin. They included prompt questions to ensure that the member of staff handing out the prescription obtained all necessary information from the recipient. This information was recorded on the patient medication record (PMR). The pharmacist said that if a person received high-risk medicines as part of the free repeat prescription service, staff asked them for information about blood tests and dose changes when they telephoned them to take their prescription order. Staff demonstrated that 'therapy check' stickers were used to identify other high-risk medicines such as lithium and methotrexate. The pharmacy team were aware of the risks of valproate use during pregnancy. The regular pharmacist said that five patients prescribed valproate who met the risk criteria had been counselled and provided with appropriate information. He said that he had also contacted each patient's GP to make them aware of the prescribing risk. He demonstrated the valproate patient information was stored 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. 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.

Patients supplied substance misuse treatments against instalment prescriptions had a section in a dedicated file which included their prescription and signed contract if supervised. It also included their personal and medication details, emergency contact details, details of their prescriber and keyworker and any other relevant documents.

The pharmacy had carried out approximately 400 influenza vaccinations during the 2019/20 season. The majority of these had been as part of the NHS enhanced service. The ACT said that she and the pharmacist had held off-site vaccination clinics in a local primary school and the nearby police headquarters.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, some loose tablets and blister strips that had been removed from their original packaging were not adequately labelled either as stock or named-patient medication. This increased the risk of errors 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. However, storage space was limited, and some different products and different strengths of the same product were stored very closely together. This increased the risk of errors. CDs were stored appropriately in two large, well-organised CD cabinets and obsolete CDs were segregated from usable stock.

Stock was subject to regular documented date checks. However, some opened bottles of date-sensitive internal liquids had passed their expiry date, and some had not been marked with the date of opening, which increased the risk that out-of-date medicines might be supplied. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. An unsealed sharps bin containing used sharps was situated in the unlocked consultation room, which could be accessed from the retail area. The ACT moved the bin into the dispensary as soon as this was pointed out. A scheme run in association with GSK allowed the pharmacy to recycle returned inhalers. Staff were able to describe how they had recently dealt with a drug recall for ranitidine by quarantining affected stock and returning this to the supplier. They explained that the PMR software flashed up a real-time alert on the screen when a recall was received. 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 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. Liquid volumes below 10ml were measured using disposable oral syringes. Triangles and capsule counters were used to count tablets and capsules. Staff said that a separate triangle was available for use with loose cytotoxics, but this could not be located. They said that they would always wash other triangles or capsule counters after use with cytotoxics. The pharmacy had a range of up-to-date reference sources.

Equipment was clean and appropriate managed. Most was in good working order and evidence showed that it had recently been tested. However, staff said that there had recently been problems with the telephone lines, which had been working intermittently for the past few weeks. They had reported the issue to the superintendent's office and said that it was being investigated. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, 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.