General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Vale of Neath Pharmacy, Chain Road, Glynneath, Neath, Castell-nedd Port Talbot, SA11 5HP

Pharmacy reference: 9011163

Type of pharmacy: Community

Date of inspection: 06/05/2021

Pharmacy context

This is a pharmacy located in the grounds of a medical centre near a rural town. 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 NHS and private patients. Substance misuse services are also available. This inspection visit was carried out during the COVID-19 pandemic.

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	3.1	Good practice	The pharmacy premises is purpose-built and has been designed to provide services effectively
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 things that go wrong so that 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. But some details are missing, so it may not always be able to show exactly what has happened if any problems arise. The pharmacy 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

A range of written standard operating procedures (SOPs) underpinned the services provided. The pharmacy had some systems in place to identify and manage risk, including the recording and analysis of dispensing errors and near misses. Most medicines were stored in an automated dispensing robot, apart from controlled drugs, fridge items, liquids and bulky products. Use of the robot had reduced the pharmacy's near miss rate and the pharmacist said that there had been no dispensing errors since the robot had been installed the previous year. Some action had been taken to reduce risk when selecting medicines stored outside the robot. For example, morphine sulphate oral solution and a branded version had been separated in the dispensary following a recent picking error.

The pharmacy received regular customer feedback from annual patient satisfaction surveys, although these had been suspended during the pandemic. Verbal feedback from people using the pharmacy since its relocation had been very positive. A formal complaints procedure was in place although this was not advertised.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and most were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. However, there were occasions on which a pharmacist had not signed out of the RP register to show the time at which they had relinquished responsibility for the safe and effective running of the pharmacy. In addition, electronic emergency supply records were not always made in line with legal requirements as some did not include the nature of the emergency. CD records were electronic. Each dispensary staff member had their own pin number, or in the case of another registrant, could use their registration details to log in.

Confidentiality agreements signed by staff were not available. However, staff had completed GDPR training and were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. The pharmacists and pre-registration pharmacist had undertaken formal safeguarding training. They had access to guidance and local contact details that were available via the internet. Some staff members had also received training, but this was not recent. They were able to identify basic safeguarding concerns and said that they would refer these to the pharmacist, who confirmed that he would report concerns via the appropriate channels where necessary. The Safe Spaces initiative for victims of domestic abuse was advertised on a poster in the retail area and in the main consultation room.

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, assisted by the pharmacist owner. The support team consisted of a pharmacy technician, three dispensing assistants (DAs) and two medicines counter assistants (MCAs). An accuracy checking technician (ACT), a trainee pharmacy technician and a DA who manned the medicines counter at weekends were absent. The pharmacy was part of a pilot pre-registration pharmacist scheme and accommodated a different pre-registration pharmacist every four months. The current pre-registration pharmacist had already completed two four-month placements in secondary and primary care respectively and was due to sit the pre-registration examination in July 2021. He appeared confident and competent in his role. 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 pharmacist and trained members of 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 felt comfortable raising concerns with the pharmacists. Staff had signed a whistleblowing procedure available in the SOP file which provided details of how to raise a concern outside the company.

Staff members 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 a transaction. The ACT had been trained to provide the smoking cessation services, which had helped reduce the pharmacists' workload. Staff had access to online modules from a training provider, articles in training magazines and information about new products, but there was no formal training programme in place. Most learning was self-motivated, or 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 increases the risk that individuals might not keep up to date with current pharmacy practice and that opportunities to identify training needs could be missed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and secure. It has enough space to allow safe working. And the pharmacy layout has been designed to provide services effectively and to protect people’s privacy.

Inspector's evidence

The pharmacy had recently relocated into spacious purpose-built premises. It was very clean, tidy and well-organised. Some stock was being temporarily stored on the floor of the retail area but did not constitute a trip hazard. The sinks had hot and cold running water and soap and cleaning materials were available. Personal protective equipment and hand sanitiser were available for staff use and the pharmacy team were wearing face masks. Pharmacy surfaces were wiped down regularly and the consultation rooms were disinfected after each use.

Floor markings at two-metre intervals in the retail area encouraged customers to adhere to social distancing requirements. Two well-appointed lockable consultation rooms and a larger treatment room were available for private consultations and counselling, although only one was currently being used for this purpose. Its availability 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 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. But it doesn't always keep prescription forms with dispensed medicines. This means that the pharmacy's team members may not always have all the information they need when they hand out the medicines. The pharmacy generally manages medicines well. But it does not always remove out-of-date medicines from its dispensing stock. This could result in pharmacy team members supplying medicines when they are no longer safe to use.

Inspector's evidence

The pharmacy offered a range of services that were clearly and appropriately advertised at the pharmacy entrance. 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 other nearby pharmacies. The pharmacy had four telephone lines to deal with the increased number of calls they had begun to receive as a result of the pandemic. Two telephone headsets and microphones enabled staff members to take calls in any part of the dispensary. Some health promotional material was displayed in the retail area. Three large video screens at the medicines counter were linked directly to the internet and could also be used to display healthcare information videos as well as counselling messages for over-the-counter medicines. The pharmacists worked closely with the local surgery to discuss and promote services. They provided services for two hours on Sundays and for varying hours on bank holidays. This ensured that people living within the local area had access to a pharmacy each day.

Most prescriptions were assembled with the aid of an automated dispensing robot which had seven workstations. The dispensing robot had an automated stock input feature which reduced the amount of time staff spent putting goods away. Dispensing staff used baskets to ensure that medicines did not get mixed up during dispensing. Dispensing labels were usually initialled by the dispenser and checker to provide an audit trail. However, this was not always the case for substance misuse clients' doses or compliance aids, 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.

Prescriptions were not always retained for dispensed items awaiting collection. This meant that prescriptions for some Schedule 3 CDs might not be marked with the date of supply at the time the supply was made, as required by law. Most prescriptions were scanned and the image remained available for reference. However, this was not the case for all prescriptions. The pharmacy dispensed medicines against some faxed signed prescriptions from the out-of-hours prescribing service. 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 dispensed items awaiting collection to alert staff to the fact that a fridge item was outstanding. Prescriptions for which a CD requiring safe custody was outstanding were stored in a separate area of the dispensary and the CD was not dispensed until the point of handout. Stickers were

used 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.

Stickers were used to routinely identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate so that they could be counselled. Evidence showed that relevant information about blood tests and dose changes was recorded on the patient medication record (PMR). The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that one patient prescribed valproate who met the risk criteria had been counselled appropriately and provided with information. 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 prescription delivery service was managed electronically. Each prescription was scanned into a handheld electronic device before it left the pharmacy. Prior to the pandemic, signatures had been obtained for prescription deliveries. However, to reduce the risk of viral transmission, the procedure had been changed. The driver now placed a package on the patient's doorstep, knocked or rang the doorbell and waited until it was collected, making a note of this on the handheld device as an audit trail. In the event of a missed delivery, a notification card was put though the door and the prescription was returned to the pharmacy.

Disposable compliance aid trays were used to supply medicines to many patients. Information about individual patients was available on the patient medication record (PMR). Messages and changes were added as alerts that flashed up when the person's PMR was selected for viewing. A list of patients was available in the dispensary for reference. Each weekly patient had an individually labelled basket that contained their stock medicines and included their personal details and collection or delivery arrangements. Compliance aids were labelled with descriptions, although these did not always include enough detail to enable identification of individual medicines. Patient information leaflets were not routinely supplied, which does not comply with legislation. Compliance aids were labelled using printed backing sheets, but these did not include precautions relating to the use of each medicine, which is a breach of legislation. There was a risk that people might not always have all the information needed for them to make informed decisions about their own treatment.

The pharmacy worked closely with the local health board (LHB), acting as a pilot branch for new services. There was a steady uptake of most enhanced and advanced services, including discharge medicines reviews (DMR), the common ailments service, the All-Wales EHC service and smoking cessation services. The pharmacy was not currently providing medicines use reviews, as this service had been suspended by the NHS during the pandemic. Some consultations for services had been carried out over the telephone where appropriate, in line with NHS recommendations. Pharmacists and the ACT conducted face-to-face consultations wearing appropriate PPE where this was not possible. There had been a high uptake of the seasonal influenza vaccination service during the 2020/21 season and the team had vaccinated about 600 people. The superintendent pharmacist and the pharmacist manager were independent prescribers (IPs) and the LHB had commissioned an IP service as part of the common ailments service. The pharmacists could prescribe medicines for urinary tract infections, sore throats, otitis media and externa and minor skin infections. It was likely that this service would soon be extended to include oral contraceptive prescribing.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. However, some medicines that had been removed from their original packaging were not adequately labelled as either patient-named medication or stock, and some loose tablets and blisters were found on

dispensary shelves. This increased the risk of error and did not comply with legislative requirements. Medicines requiring cold storage were stored in two well-organised drug fridges. Maximum and minimum temperatures were recorded daily and were consistently within the required range. However, there was no space for some bulky prescriptions, which were being temporarily stored in the staff fridge. Maximum and minimum temperatures for this fridge were not recorded. This made it difficult for the pharmacy team to know that these medicines were stored properly and were safe and fit for purpose. CDs were stored appropriately in two large, well-organised CD cabinets. Obsolete CDs were segregated from usable stock in a safe. The key was left in the door of the safe for most of the inspection, compromising the security of these medicines. The pharmacist removed the key and secured it on his person as soon as this was pointed out.

There was some evidence to show that expiry date checks were carried out. However, it was unclear how frequently checks took place as these were not documented. Several packs of out-of-date medicines were found on pharmacy shelves. Date-expired medicines were disposed of appropriately, as were patient returns, waste sharps and clinical waste. There was no separate bin for disposing of cytotoxic waste. However, the pharmacy was in the process of obtaining a new bin from its waste contractor and cytotoxic waste had been segregated pending its arrival. The pharmacy received drug alerts and recalls via its NHS email account. These alerts were also prominently displayed on the electronic CD register. The pharmacist was able to describe how he would deal with a drug recall by contacting patients where necessary, quarantining stock and returning it 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. Its 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. Trays were used to count out loose tablets and a triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was clean and in good working order. There was no evidence to show that it had recently been tested, but most equipment was quite new as it had been purchased when the pharmacy had relocated the previous year. 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 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.