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: 18/10/2022

Pharmacy context

This is a busy 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 both NHS and private patients. Substance misuse services are also available.

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	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 effectively 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.
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 some things that go wrong so that they can learn from them. 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. But some details are missing, so it may not always be able to show exactly what has happened if any problems arise. The pharmacy keeps people's private information safe. And its team members are good at recognising and reporting concerns about vulnerable people to help keep them safe.

Inspector's evidence

The pharmacy had some systems in place to identify and manage risk, including the electronic recording of dispensing errors. Near misses were not recorded but were discussed with relevant staff at the time of the occurrence. The pharmacist said that he and the accuracy checking technicians (ACTs) held weekly meetings to discuss the types of near misses they had come across and used these discussions to flag up any patterns or trends. Use of an automated dispensing robot had reduced the pharmacy's near miss rate and the pharmacist said that there had been no recent dispensing errors. Some action had been taken to reduce the risk of patient safety incidents: a laminated card provided by the local health board was displayed in the dispensary to remind pharmacy team members of the risk of errors with gabapentin and pregabalin products. Oramorph concentrated oral solution 20mg/ml had been separated from other liquids in the CD cabinet and an elastic band had been used to mark it as a product with which staff members should take extra care due to the risk of overdose.

A range of written standard operating procedures (SOPs) underpinned the services provided. These had been signed to show that they had been read and understood by all staff apart from the newest team member, who was in the process of reading and signing SOPs relevant to her role. A weekly rota was available in the dispensary and different members of staff were assigned different tasks each week, such as labelling, dispensing compliance aid trays or manning the medicines counter. This meant that all staff members gained regular experience of the different tasks they were required to perform as part of their role. The accuracy checking technicians (ACT) were able to accuracy check any prescriptions that had been clinically checked by a pharmacist. The ACT present explained that the pharmacists stamped and initialled prescriptions to show when these had been clinically checked, and the ACTs then initialled these prescriptions as an audit trail to show that they had performed the accuracy check.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, although these had been suspended during the pandemic. Several cards were displayed which thanked the pharmacy team for providing good and caring service. The pharmacist said that recent verbal feedback from people using the pharmacy had been 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 were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. However, electronic private prescription and emergency supply records were not always made in line with legal requirements as prescriber details were not always recorded correctly, and some emergency supply

records did not include the nature of the emergency. Some records of unlicensed specials did not include patient details. CD records were electronic. Each dispensary staff member had their own pin number to access the register, or in the case of another registrant, could use their registration details to log in. CD running balances were typically checked every one to two weeks.

Confidentiality agreements had been signed by most of the pharmacy team. A new member of staff who had not yet signed an agreement explained that she had undertaken information governance training as part of her previous job in another pharmacy. All staff were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. The pharmacy team had undertaken formal safeguarding training and had access to guidance and local contact details that were available via the internet. A part-time administrative staff member was a trained social worker with expertise in safeguarding children and vulnerable adults. The Ask for ANI and Safe Spaces initiatives for victims of domestic abuse were advertised on posters in the retail area and in the main consultation room. The team were able to give examples of how they had identified and supported potentially vulnerable people, which had resulted in positive outcomes.

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 owner worked at the pharmacy on most days, assisted by a second regular pharmacist. Another regular pharmacist worked every Wednesday and the superintendent pharmacist worked on some Sundays. The pharmacy also employed a full-time newly registered pharmacist in her first year of a two-year post-registration foundation pharmacist training programme. The support team consisted of an accuracy checking technician (ACT), a dispensing assistant (DA) with an NVQ level three qualification, three other DAs and a medicines counter assistant (MCA) who also had a DA qualification. A member of part-time staff who did not have any formal pharmacy training carried out an administrative role. Another ACT, a pharmacy technician and another with DA with an NVQ level three qualification 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. 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. A 'Wellbeing at Work' scheme that allowed staff members to access free help and advice about various issues was advertised in a leaflet available in the staff area.

A member of staff 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 transactions. The registered technicians had been trained to provide the smoking cessation services, and this had helped reduce the pharmacists' workload. One ACT said that she had recently undertaken training provided by HEIW that would soon allow her to provide the discharge medicine use review service. She understood the revalidation process and based her continuing professional development entries on her formal training as well as on situations she came across in her day-to-day working environment. The foundation pharmacist had a day of protected study time once a week. There was a plan to introduce protected training time for all staff, but this was not currently in place. Pharmacy team members 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 increased the risk that individuals might not keep up to date with current pharmacy practice, and opportunities to identify training needs could be missed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is very 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 was purpose-built and was very clean, tidy, spacious 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. Hand sanitiser was available for staff and customer use. Pharmacy surfaces were wiped down regularly and the floor was mopped and disinfected daily. Two well-appointed lockable consultation rooms and a larger treatment room were available for private consultations and counselling. Their 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. The pharmacy 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. There was wheelchair access into the pharmacy and consultation rooms. Hearing aid loops were available in the consultation rooms and at the medicines counter and their availability was advertised on a poster in the retail area. The team said that they would signpost patients requesting services they could not provide to nearby pharmacies or to other local healthcare providers such as GP surgeries. The pharmacy had four telephone lines to deal with the volume of calls received, and telephone headsets and microphones enabled staff members to take calls in any part of the dispensary. Some health promotional material was displayed at the medicines counter. The pharmacist owner was the local health board's primary care cluster lead for the area. He worked closely with 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 enhanced common ailments service and the sore throat test and treat service.

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, some dispensed items that were seen had not been initialled to show who had dispensed them, 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.

Prescriptions were not retained for dispensed items awaiting collection, apart from prescriptions that could not be scanned and prescriptions for Schedule 2 or 3 controlled drugs. All other prescriptions were scanned, and the image remained available for reference. 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.

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. Notes were attached to bags of dispensed items awaiting collection to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. Prescriptions for Schedule 3 or 4 CDs which did not require safe custody were stored in a separate area of the dispensary and staff had been trained to check that these were not supplied to the patient or their representative more than 28 days after the date on the prescription. Some bags of dispensed medicines awaiting collection were marked with stickers to alert staff to the fact that the pharmacist wished to speak to the patient or their representative at the point of handout. Each bag label attached to a prescription awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail.

Stickers were used to routinely identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate so that they could be counselled. Relevant information about blood tests and dose changes was sometimes, but not always, 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 was counselled appropriately and provided with information at each time of dispensing. 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. Patients or their representatives signed electronically to acknowledge receipt of delivery and were required to provide a separate signature on receipt of a CD delivery. 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 aids were used to supply medicines to many people. Compliance aids were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied. Each person had an individual file that included their personal and medication details as well as their collection or delivery arrangements, current prescriptions and details of any messages or changes. The file also included weekly collection slips, which were signed by a patient or their representative when collecting compliance aids. The slips included the collector's name, the date of collection and the name of the staff member involved in the handout as an audit trail. A list of compliance aid patients was available in the dispensary for reference, as was a list of people who were supplied original packs and MAR charts as part of a locally commissioned MAR chart service.

The pharmacy worked closely with the local health board (LHB), acting as a pilot branch for new services. The discharge medicines review service had a high uptake as most patient discharge information was sent directly to the pharmacy electronically via the Choose Pharmacy software platform. Uptake of the emergency supply of prescribed medicines service and the common ailments service was also high, and many people were referred to these services from the adjacent medical centre and by local optometrists. Most of the regular pharmacists were pharmacist independent prescribers (PIPs) and the LHB had commissioned an IP service as part of the common ailments service. The PIPs could prescribe oral contraceptives and treatments for gout. They could also prescribe medicines for urinary tract infections, upper respiratory tract infections, otitis media and externa and minor skin infections. The local primary care cluster had funded a C-reactive protein (CRP) assay machine that used a finger prick test to help diagnose bacterial infection and which could flag up high CRP levels that might indicate sepsis. The machine could also be used to perform an HbA1c test to measure a person's blood glucose control. Uptake of the needle exchange service was low. There was a steady uptake of the All-Wales EHC service and the technician-led smoking cessation services. There

had been a high uptake of the seasonal influenza vaccination service so far and the team had vaccinated about 800 people. The pharmacy also offered COVID booster vaccination clinics, appointments for which were centrally arranged via the local health board. The pharmacy team were able to access the central booking database and could rearrange appointments to better suit customers who lived close to the pharmacy but had been given appointments at a vaccination centre further away, or at a time that did not suit them. They were also able to book walk-in appointments for over-50s who were eligible for the vaccination. The pharmacy had recently resumed provision of the sore throat test and treat service that had been suspended during the pandemic and provided an ear syringing service for a charge.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. Most stock medicines were stored in the automated dispensing robot, apart from controlled drugs, fridge items, liquids and bulky products. Medicines requiring cold storage were stored in two well-organised drug fridges. Maximum and minimum temperatures for these fridges were recorded daily and were consistently within the required range. A fridge in one of the consultation rooms was used solely to store COVID vaccines. Maximum and minimum temperatures for this fridge were recorded daily on the Welsh Immunisation System software. CDs were stored appropriately in three large, well-organised CD cabinets. Obsolete CDs were segregated from usable stock. The ACT had possession of the CD keys during the inspection, which might compromise the security of these medicines. The pharmacist secured the keys on his person as soon as this was pointed out.

Most stock was subject to regular expiry date checks, which were documented. However, records showed that the compliance aid stock area had not been recently checked, which the pharmacist said was an oversight. Several packs of out-of-date medicines were found in this area and a staff member said that the items were medicines that were no longer prescribed. They were removed from stock and dealt with appropriately. 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 and kept an electronic record of these. Alerts were also prominently displayed on the electronic CD register. The pharmacist was able to describe how he would normally deal with drug recalls by contacting patients where necessary 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. Separate measures were used for controlled drugs, and these were clearly marked. Triangles and a capsule counter were used to count tablets and capsules, and these were washed after use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. There was suitable equipment available for providing the pharmacy's clinical services, including a pulse oximeter and a stethoscope. All equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. The automated dispensing robot was regularly serviced. A quick troubleshooting reference guide and a helpline contact number were displayed on the robot for reference. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the computer system 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.