General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Neighbourhood Centre, Parc Derwen, Bridgend, Pen-y-bont ar Ogwr, CF35 6HB

Pharmacy reference: 9012039

Type of pharmacy: Community

Date of inspection: 27/07/2023

Pharmacy context

This is a neighbourhood pharmacy on a housing estate. 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. The pharmacy offers a range of services including emergency hormonal contraception, treatment for minor ailments and a seasonal 'flu vaccination service for NHS and private patients.

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	2.2	Good practice	Staff have the appropriate skills, qualifications and competence for their roles 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 generally 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 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 electronic recording and monthly analysis of dispensing errors and near misses. Action had been taken to reduce the risk of errors following some dispensing incidents involving compliance aids. Two members of the pharmacy team were now required to be involved in the assembly of each compliance aid: one team member selected the required stock items, and the second assembled the compliance aid using this stock. The dispensing process had been changed to ensure that assembly did not take place until all prescription items were in stock, reducing the risk of items being omitted in error. In addition, members of the pharmacy team were required to cross-check the number of tablets in each compliance aid with the number of items on the prescription to further reduce the risk of errors.

A range of electronic standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Members of the pharmacy team were required to complete an online declaration and assessment for each SOP. A dispensing assistant was able to describe activities that could not take place in the absence of the responsible pharmacist.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, but these had been suspended during the pandemic and had not yet resumed. The pharmacy technician said that verbal feedback from people using the pharmacy was mostly positive. However, customers had made it clear that they would prefer the pharmacy to remain open throughout the day, rather than shutting for an hour at lunchtime. The pharmacy team had reported this internally. A formal complaints procedure was in place and information about making complaints was included in the practice leaflet displayed near the medicines counter.

Evidence of current professional indemnity insurance was available. All necessary records were kept, including responsible pharmacist (RP), private prescription, emergency supply, specials procurement and electronic controlled drug (CD) records. Most records were properly maintained, but there were occasions on which the 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. This meant that it might not be possible to identify the pharmacist accountable in the event of an error or incident. Two records of emergency supplies did not include relevant dates and records of unlicensed specials did not always include patient details as required by law. CD running balances were checked weekly. Entries in the electronic register for patient-returned CDs did not include an audit trail to show who had been involved in the destruction process. This might make it difficult to resolve queries or investigate errors.

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. A privacy notice displayed near the medicines counter signposted people to the company's website for information about the way in which their personal data was used and managed.

The pharmacist had undertaken formal safeguarding training and members of the pharmacy team had received internal training. The safeguarding SOP included local contact details and guidance. The pharmacy had a chaperone policy which was normally advertised in a poster in the retail area, although this was not currently on display as the poster holder had broken. Leaflets and posters advertising help for carers and support for people with mental health issues were displayed in the retail area.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough staff to manage the workload effectively. But it does not always have enough cover when staff are absent. This means that the team sometimes has to work under pressure. Pharmacy team members complete regular training and understand their roles and responsibilities. They feel comfortable speaking up about any concerns they have.

Inspector's evidence

The regular pharmacist worked at the pharmacy from Monday to Wednesday and a relief pharmacist employed by the company covered her absences on Thursdays and Fridays. A trainee accuracy checking technician was employed as a team leader and oversaw the operational running of the pharmacy. The support team consisted of two dispensing assistants (DAs), one of whom was absent on long-term leave. Her role was being covered on a part-time basis by a relief DA employed by the company. The pharmacy technician explained that the team sometimes worked under pressure, as the relief DA was often needed elsewhere to support other branches. So it was not always possible to know when she would be working at the branch. And she was not always able to work there at the times when she was needed most. Trainees worked under the supervision of the pharmacist and other trained staff.

Targets were set for services, but these were managed appropriately and did not affect the pharmacist’s professional judgement or compromise patient care. Staff worked well together and said that they were happy to make suggestions within the team. They felt comfortable raising concerns with the pharmacists and the area manager. A whistleblowing policy was available on the company’s intranet system. It included information about how to report 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 people. Pharmacy team members referred to the pharmacist on several occasions for further advice on how to deal with transactions. The pharmacy technician said that she would feel confident refusing a sale and had done so in the past when dealing with what she considered to be an inappropriate request for a product containing codeine. Staff undertook regular online training provided by the organisation on new products, clinical topics, operational procedures and services. The team were in the process of completing a training module on mental health. The pharmacy technician said that she understood the revalidation process and based her continuing professional development entries on situations she came across in her day-to-day working environment. Staff were subject to six-monthly performance and development reviews and could discuss issues informally with the pharmacists 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. Some stock was being temporarily stored on the floor, but this did not pose a trip hazard. The sinks had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use. A lockable consultation room was available for private consultations and counselling and its availability was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

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. The pharmacy's working practices are safe and effective. It stores medicines appropriately and carries out checks to help make sure that they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services which were appropriately advertised. There was wheelchair access into the pharmacy and consultation room and hearing aid loops were available. Staff said that they would signpost patients requesting services they could not provide to nearby pharmacies or other providers, such as the local council, which provided a waste sharps collection service. Some health promotional material was on display in the retail area. The pharmacist and pharmacy technician held regular telephone meetings with staff from nearby surgeries and local opticians to discuss and promote services as part of a health board funded collaborative working initiative. Visits had included discussions about the repeat prescription service and the common ailments service.

About 60% of the pharmacy's prescription items were assembled offsite at the company's hub pharmacy. There was no notice on display in the retail area to explain that this arrangement was in place. This meant that people might not always be aware where their medicines are being assembled. The hub pharmacy could not assemble split packs, fridge lines, most controlled drugs or multi-compartment compliance aid trays and these continued to be dispensed at the branch. Prescription items sent to the hub before the end of the working day were generally returned to the branch within 48 hours, although there were occasional delays. The pharmacy team had a good relationship with the local surgery team, which meant that queries and problems were usually dealt with efficiently and effectively.

Dispensing staff used a colour-coded basket system to ensure that medicines did not get mixed up during dispensing and to differentiate between different types of prescriptions. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Controlled drugs requiring safe custody, fridge lines and compliance aid trays 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. A text messaging service was available to let patients know that their medicines were ready for collection.

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 prescription bags to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. Stickers were also used to identify 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. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

Prescriptions for patients prescribed high-risk medicines such as warfarin, lithium and methotrexate were usually marked with 'therapy check' stickers to identify the patient for counselling. The pharmacy technician said that members of the pharmacy team asked patients about relevant blood tests and dose changes but did not record these conversations. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacy did not currently have any patients prescribed valproate who met the risk criteria, but the pharmacist said that any such patients would be counselled and provided with information at each time of dispensing. The pharmacy team 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.

Medicines were supplied in disposable compliance aid trays for many people. The pharmacy technician explained that all new patients were assessed for suitability. She said that the regular pharmacist was in the process of setting up annual reviews for each patient to ensure that the compliance aid system was still suitable for their needs. Trays were labelled with descriptions of individual medicines and patient information leaflets were routinely supplied. A list of patients and their delivery or collection arrangements was available for reference. Each patient had a section in a file that included their personal and medication details, collection or delivery arrangements, details of any messages or changes and relevant documents, such as current prescriptions. A workload tracker for each patient was available and showed the status of each patient's tray at any given time. The pharmacy had a good relationship with the local health board's medicines management team and were in regular contact with them to resolve any problems involving compliance aid patients.

The pharmacy provided a range of services. There was a high uptake of the discharge medicines review service, as the pharmacy supplied medicines to many elderly and vulnerable people. Most patient discharge information was sent directly to the pharmacy via e-mail or through the Choose Pharmacy software platform. There was a steady uptake of the common ailments service, with referrals from local surgeries and opticians. The regular pharmacist had recently qualified as an independent prescriber but had not yet begun to provide any prescribing services. Demand for the emergency supply of prescribed medicines service was occasional, as the pharmacy was situated near to the local surgery, which kept similar opening hours, so people were usually able to obtain a valid prescription from a GP in an emergency. The pharmacy also offered a smoking cessation service (supply only) and an EHC/bridging contraception service. A relief pharmacist was able to provide the sore throat test and treat service every Thursday and Friday. The pharmacy team planned to provide an influenza vaccination service to NHS and private patients later in the year.

The pharmacy provided a prescription collection service from four local surgeries. It also offered a free prescription delivery service. Signatures were not obtained for prescription deliveries as an audit trail, but the pharmacist gave assurances that the delivery driver confirmed the identity of the recipient before each prescription was supplied. Controlled drugs were supplied in separate clear bags and marked 'CD' on the delivery list, which alerted the driver to notify the patient that they were receiving a controlled drug. 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.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. Stock and dispensed medicines requiring cold storage were stored in two drug fridges. There was limited space in the stock fridge which meant that different products were stored closely together, increasing the risk of errors. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored in one large, well-organised CD cabinet and obsolete CDs were segregated from usable stock. One dispensed prescription in the CD cabinet was no longer valid, as more than 28 days had elapsed since the date on the prescription: the pharmacy technicians said that

this was an oversight and dealt with it appropriately. The pharmacist had removed some antihistamines liable to misuse from display after receiving frequent requests for over-the-counter sales of these.

Stock was subject to regular expiry date checks. These were documented, and short-dated items were highlighted with stickers. Some out-of-date nutritional supplement drinks were found present in the dispensary. However, these were highlighted with stickers and pharmacy team members explained that they included a date check as part of their dispensing and checking procedures. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. There was no separate bin for disposing of cytotoxic waste, but the pharmacy technician said that a bin had been ordered from the pharmacy's waste contractor. She demonstrated that cytotoxic waste was currently segregated and explained that it would be disposed of appropriately when the bin was received. The pharmacy received drug recalls and alerts via its intranet system. The PMR software flashed up a real-time alert on the screen when a recall was received. The pharmacy technician was able to describe how the team would deal with medicines or medical devices that were unfit for purpose by contacting patients where necessary and returning quarantined stock to the relevant supplier. Drug recalls were printed, signed when actioned and then filed for reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities it needs to provide the services. And 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. 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 available. Equipment was in good working order, clean and appropriately managed. There was evidence to show that it had recently been tested. Staff had access to personal protective equipment such as face masks. 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.

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.