General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medihub Pharmacy, 84 St. Teilo Street, Pontarddulais, Swansea, Abertawe, SA4 8ST

Pharmacy reference: 9012258

Type of pharmacy: Community

Date of inspection: 01/07/2024

Pharmacy context

This pharmacy is on a high street in a small town in south west Wales. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy offers a range of services including provision of emergency hormonal contraception, treatment for minor ailments and a seasonal influenza vaccination service. 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	N/A	N/A	N/A
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	N/A	N/A	N/A
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 take action to help reduce the chance of similar mistakes from happening again. But they do not always record or review all their mistakes, so they may miss some opportunities to learn and improve. 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. Pharmacy team members know how to keep people's private information safe. And they 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 a recording process for dispensing errors and near misses. The most recent near miss records had been made in May 2023. However, dispensing team members explained that the pharmacist discussed near misses with them at the time they came to light. And that any patterns or trends that emerged were discussed with the whole team. Action had been taken to reduce some risks that had been identified. For example, different strength of zopiclone tablets had been distinctly separated on dispensary shelving following some near misses with these medicines.

A range of electronic standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Pharmacy team members had digitally signed the SOPs to show that they had read and understood them. Members of the team were able to describe their roles and responsibilities. A pharmacy technician who worked as an accuracy checker explained that she could check most prescription items that had been marked as clinically checked by a pharmacist, except for medicines supplied in compliance packs, methotrexate and controlled drugs requiring safe custody. There were two responsible pharmacist notices on display, which was confusing. The pharmacist removed the incorrect notice as soon as this was pointed out. The pharmacy team were able to describe activities that could not take place in the absence of the responsible pharmacist.

The pharmacy team explained that verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place, and this was advertised in the pharmacy's practice leaflet, which was displayed in the retail area.

Evidence of current professional indemnity insurance was available. Most records were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug records. Running balances for controlled drugs were typically checked monthly. However, 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. So, there was a risk that it would not be possible to identify the pharmacist in charge if something went wrong. And emergency supply records did not always include the nature of the emergency. This might make it difficult for the pharmacy team to resolve queries or investigate errors.

Pharmacy team members had signed confidentiality agreements. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. The pharmacists and a pharmacy technician had undertaken advanced formal

safeguarding training. All other team members had undertaken in-house safeguarding training. They had access to guidance and local safeguarding contact details that were available in the SOP file.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are appropriately trained for the jobs they do or are enrolled on a suitable training course for their role. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The regular pharmacist worked at the pharmacy every day. He was assisted by a locum pharmacist on Wednesdays and Thursdays. The superintendent pharmacist also sometimes worked at the pharmacy, providing services. The pharmacy team consisted of two dispensing assistants, one of whom was employed as the pharmacy supervisor and oversaw the operational running of the branch, a pharmacy technician who was a qualified accuracy checker and another pharmacy technician who was the pharmacy's technical lead. Pharmacy team members were able to safely manage the workload and the staffing level appeared adequate for the services provided.

Members of the pharmacy team working on the medicines counter were observed using 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. Pharmacy team members had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They explained that much of their learning was via informal discussions with the pharmacists. They had recently completed mandatory training provided by NHS Wales on mental health awareness and improving the quality of services provided. The pharmacy technician understood the revalidation process and based her continuing professional development entries on training she had undertaken and on issues she came across in her day-to-day working environment. However, the lack of a structured training programme meant that individuals might not keep up to date with current pharmacy practice. All members of the pharmacy team were subject to annual performance and development reviews. And they could informally discuss issues with the pharmacists or the pharmacy supervisor whenever the need arose.

Targets were set for some services, but these were managed appropriately, and the pharmacist gave assurances that they did not affect his professional judgement or compromise patient care. Pharmacy team members worked well together. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists, including the superintendent pharmacist. A whistleblowing policy was available in the staff handbook and described the pharmacy's internal process for raising concerns. On discussion, the team understood that they could contact the GPhC or the local health board if they wished to raise a concern outside the organisation.

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 medicines and dispensed medicines awaiting collection were being temporarily stored on the floor, but they did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use. Two lockable consultation rooms were available for private consultations and counselling, although signs on the doors did not clearly indicate this. So people might not know they could be used for this purpose. Two other rooms had been fitted out to accommodate a clinic run by a dental therapist. External healthcare practitioners who used the pharmacy’s consultation rooms to provide services did not have access to the pharmacy out of hours. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy for people to access. Its working practices are generally safe and effective. But members of the pharmacy team do not always know when higher-risk medicines are being handed out. So they might not always be able to check that medicines are still suitable, or give people advice about taking them. The pharmacy stores medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy team offered a range of services. These were advertised in the pharmacy's practice leaflet that was displayed in the retail area. There was wheelchair access into the pharmacy and consultation rooms. The pharmacy had an internet-based telephone system with multiple handsets that allowed more than one person to make calls to its number at the same time. This meant that people had good access to the pharmacy team by phone. A signposting file provided by the local health board was available. The pharmacy team also signposted people requesting services they could not provide to nearby pharmacies or other providers such as the local council, which offered a needle and sharps collection service.

Dispensing staff used colour-coded baskets to ensure that medicines did not get mixed up during the dispensing process and to differentiate between different prescriptions. Dispensing labels were usually initialled by the dispenser and accuracy checker to provide an audit trail. However, labels for compliance packs did not always bear the dispenser's initial, which might prevent a full analysis of any dispensing incidents. Controlled drugs requiring safe custody and fridge lines were dispensed in clear bags to allow pharmacy team members to check these items at all points of the dispensing process and reduce the risk of a person receiving the wrong medicine.

Stickers were placed on prescription bags to alert team members to the fact that a CD requiring safe custody or fridge item needed to be added. Prescriptions for schedule 3 or 4 CDs awaiting collection were not routinely identified, so there was a risk that these items might be supplied past the 28-day validity period. However, all pharmacy team members were suitably trained and those present said that they recognised prescriptions for Schedule 3 or 4 CDs and checked that they were still valid before handing them out.

Prescriptions for high-risk medicines such as warfarin, lithium and methotrexate were not routinely highlighted, so there was a risk that counselling opportunities could be missed. Pharmacy team members were aware of the risks of valproate use during pregnancy. They were also aware of the requirement to supply valproate products in original packs. They confirmed that anyone prescribed valproate who met the risk criteria would be counselled and provided with educational information at each time of dispensing.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. Compliance packs were labelled with descriptions of the medicines they contained. However, the descriptions did not always include enough detail to enable identification of individual medicines, with many described simply as 'round white tablet'. So, there was a risk that patients might not always be able to make informed decisions about their own treatment. Patient information leaflets

were routinely supplied. Each patient had a clear plastic wallet that included their personal and medication details and details of any messages or queries for communication purposes. An original pack and medication administration record (MAR) dispensing service was provided to some care home residents.

The pharmacy made some supplies using an automated collection point that was situated offsite in a local GP surgery. The collection point was accessed externally which meant that people could retrieve their dispensed medicines at any time, including outside surgery hours. Controlled drugs and fridge lines were not included in the automated collection point. The machine's integrated software system allowed the pharmacy team to see which dispensed medicines were loaded and the time at which they had been collected. If a person wished to use the automatic collection point, they could give the pharmacy their details or sign up to the service online. They were then sent a unique PIN code by text as soon as their medicines were loaded into the machine. The PIN remained valid for five days. Any medicines not collected after this time were returned to storage in the pharmacy for the patient to collect.

The pharmacy's services were managed using a digital appointment system. A technician-led discharge medicines review service was provided, although uptake of this was low. Uptake of the common ailments service and the sore throat test and treat service was high, as the pharmacy received frequent referrals from nearby GP surgeries and other local healthcare professionals. The regular pharmacist and the superintendent pharmacist were independent prescribers and were able to provide the extended common ailments service. Demand for the emergency supply of prescribed medicines service was low, as the pharmacy kept similar opening hours to local surgeries, so people were usually able to obtain a valid prescription from a GP in an emergency. The pharmacy also offered an EHC (emergency hormonal contraception)/bridging contraception service, a smoking cessation service (supply and monitoring), and a seasonal influenza vaccination service.

The regular locum pharmacist ran a private vaccination and travel clinic on two days each week, supplying and administering vaccinations and travel medicines against patient group directions (PGDs). He also supplied Wegovy and Mounjaro injections for weight loss against private PGDs following face-to-face consultations. People receiving this service had their weight and blood pressure checked and recorded regularly to monitor their progress and treatment was adjusted where necessary. Uptake of these services was steady. One record for the supply and administration of a whooping cough vaccine by the locum pharmacist incorrectly named the regular pharmacist as the person carrying out the consultation. On discussion, the regular pharmacist said that this was an oversight. He explained that the error had probably occurred as his name had recently been registered with the PGD package and so was available for selection on the recording software, although he was not yet accredited to provide the services. The superintendent pharmacist offered free ear health checks to people over 18, with a charge for any subsequent removal of ear wax using microsuction. He was able to send digital images to an audiologist or ear, nose and throat specialist for support, advice and guidance when required. A nurse rented one of the pharmacy's consultation rooms every Tuesday to provide an eczema clinic. A dental therapist also rented two of the pharmacy's specially adapted consultation rooms to provide a dental hygiene and minor dental treatment clinic every Wednesday.

The pharmacy provided a prescription collection service from six local surgeries. It also offered a free medicines delivery service. Each prescription for delivery was scanned into an electronic device, and patients or their representatives signed the device to acknowledge receipt of the delivery as an audit trail. The device alerted the delivery driver if a controlled drug or a fridge line was included in the delivery so that they could notify the recipient. 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. The pharmacy

used an electric delivery van, which the superintendent pharmacist explained helped to reduce the environmental impact of providing the delivery service.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in two well-organised medical fridges. Maximum and minimum temperatures for the fridges were recorded daily and were consistently within the required range. CDs were stored in two well-organised CD cabinets and obsolete CDs were kept separately from usable stock.

There was some evidence to show that regular expiry date checks were carried out, although the frequency and scope of these checks were not documented. This created a risk that out-of-date medicines might be overlooked, although none were found. 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, but the pharmacy team were in the process of ordering a bin from their waste contractor and explained that they would separate out any cytotoxic waste they received in the meantime. The pharmacy received safety alerts and recalls via wholesalers and its NHS email account. The pharmacy team were able to describe how they would deal with a medicine recall by contacting patients where necessary, quarantining affected stock, and returning it to the supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities it needs to provide the services they offer. And its team members use these 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 loose tablets. The triangles were dusty, but the dispensing team confirmed that they were washed before each use. The pharmacy had a range of up-to-date reference sources.

All equipment was in good working order, clean and appropriately managed. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the consultation rooms were used for private conversations and counselling. Some dispensed medicines could be seen from the retail area, but no confidential information was visible. The pharmacy software system was protected with a password and computer screens were not visible to people using the pharmacy.

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.