General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Nelson's Pharmacy, The Bevan Health & Wellbeing Centre, Park Row, Tredegar, Blaenau Gwent, NP22 3NG

Pharmacy reference: 9012315

Type of pharmacy: Community

Date of inspection: 22/07/2024

Pharmacy context

This pharmacy is inside a medical centre in a small town in southeast 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	3.1	Good practice	The pharmacy premises is purpose-built and is very clean, tidy, spacious and well-maintained.
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 record and review their mistakes so they can learn from them. And they take action to help reduce the chance of similar mistakes happening again. The pharmacy keeps the records it needs to by law. Pharmacy team members know how to keep people's private information safe. And they 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. 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 strengths of perindopril 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 had been regularly reviewed. Most pharmacy team members had digitally signed the SOPs to show that they had read and understood them. Three recently recruited pharmacy apprentices had not yet signed the SOPs. However, they explained that they had been verbally trained on these procedures. They were observed following SOPs relevant to their role and were able to describe their roles and responsibilities. A pharmacy technician who worked as an accuracy checker (ACT) explained that she could check any prescription items that had been marked as clinically checked by a pharmacist. The pharmacy team were able to describe activities that could not take place in the absence of the responsible pharmacist.

A touch screen at the pharmacy entrance was used to obtain customer feedback. The superintendent pharmacist explained that this feedback was relayed directly to his mobile phone and was mostly positive. A formal complaints procedure was in place, but this was not advertised in the retail area. So, people using the pharmacy might not understand the best way to raise concerns.

Evidence of current professional indemnity insurance was available. Records were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and electronic controlled drug (CD) records. Running balances for most controlled drugs were checked at the time of dispensing. And running balances for methadone were checked monthly.

Pharmacy team members had signed confidentiality agreements as part of their induction programme. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. The pharmacists and pharmacy technicians had undertaken advanced formal safeguarding training. Most other team members had undertaken basic formal safeguarding training. They had access to guidance and local safeguarding contact details that were available via the internet. The pharmacist was able to give an example of how he had recently identified and referred a safeguarding concern appropriately.

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 superintendent pharmacist worked at the pharmacy every day. The pharmacy team consisted of two pharmacy technicians, four dispensing assistants (DAs), a trainee DA, a medicines counter assistant (MCA) and three apprentices who had worked at the pharmacy for about two months. One of the pharmacy technicians was a qualified accuracy checker (ACT) and another was a trainee ACT. The apprentices were due to be enrolled on an accredited hybrid MCA/DA training course during the next few weeks. Their progress was monitored and supported by an external apprenticeship company. Trainees worked under the supervision of the pharmacist or other trained members of the pharmacy team. Pharmacy team members were able to safely manage the workload and the staffing level appeared adequate for the services provided.

Members of the team who worked on the medicines counter were able to provide a coherent explanation of the WWHAM questioning technique and gave appropriate examples of situations they would refer to the pharmacist. All team members were allowed an hour’s protected learning time each week. They had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They had also recently completed training on health and safety procedures. A pharmacy technician understood the revalidation process and explained that she based her continuing professional development entries on training she had undertaken and on issues she came across in her day-to-day working environment. She had recently undertaken training on pharmacy services, including the discharge medicines review service and vaccination services. She explained that these services would eventually be technician-led, which would free up the pharmacist’s time. There was no formal performance and development system in place, which meant some opportunities to identify training needs could be missed. However, pharmacy team members understood that they could discuss issues with the pharmacist informally whenever the need arose.

There were no specific targets or incentives set for the services provided. Pharmacy team members worked well together. They said that they felt comfortable raising concerns with the superintendent pharmacist or pharmacy operations manager. A whistleblowing policy was available and included a confidential helpline for raising concerns outside the company. The pharmacist agreed to print this out and display it in the pharmacy for reference.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is very clean and tidy. It is secure and spacious. Its layout protects people’s privacy.

Inspector's evidence

The pharmacy had recently relocated into a new purpose-built premises. It was very clean and well-organised, with plenty of space to allow safe working. 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.

A semi-private hatch that opened into the dispensary from the retail area was used for quiet conversations. Three consultation rooms were available for private consultations and counselling and the availability of these was clearly advertised. 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 some 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, and these were advertised in the retail area. There was wheelchair access into the pharmacy and consultation rooms. Pharmacy team members used large print dispensing labels for people with poor eyesight. They 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.

The pharmacy team had a good relationship with local GP surgery teams, which meant that queries and problems were usually dealt with quickly and effectively. Dispensing staff used colour-coded baskets to ensure that medicines did not get mixed up during the dispensing process and to differentiate between different types of prescriptions. Dispensing labels were initialled by the dispenser and accuracy checker to provide an audit trail. 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. This helped to 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. Stickers were also attached to prescription bags to identify dispensed Schedule 3 and 4 CDs awaiting collection. These stickers were marked with the date after which the prescription was invalid and could no longer be supplied.

Stickers were used to routinely identify people prescribed warfarin so that they could be counselled. However, other higher-risk medicines, such as lithium and methotrexate, were not routinely highlighted. So there was a risk that counselling opportunities could be missed. The pharmacy team were aware of the risks of using valproate-containing medicines 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. People requesting the service were risk-assessed for suitability. 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 'tablet' or 'capsule'. So, there was a risk that people 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, collection or delivery arrangements and any relevant documents, such as repeat prescription order forms. Some individual sheets listing medication details were quite untidy. For example, some dosage changes had

been altered by obliteration and were difficult to read, which may increase the risk of errors. An original pack and medication administration record (MAR) dispensing service was provided to some care home residents and some people in the community.

The pharmacy's services were managed using an appointment system. A discharge medicines review service was provided. However, local hospitals did not automatically send electronic copies of patient discharge letters to the pharmacy via the service's software platform. Instead, the pharmacist was reliant on people bringing a paper copy of their discharge letter into the pharmacy within the required four-week timeframe. This meant that uptake of the service was low. Uptake of the common ailments service, the sore throat test and treat service and the UTI (urinary tract infection) service was high, as the pharmacy received frequent referrals from nearby GP surgeries and other local healthcare professionals. The superintendent pharmacist was an independent prescriber and was able to provide the extended common ailments service. Demand for the emergency supply of prescribed medicines service was steady. The pharmacy also offered an EHC (emergency hormonal contraception)/bridging contraception service, a smoking cessation (supply and monitoring) service, and a seasonal influenza vaccination service. A technician-led supervised consumption service and a needle exchange service were available. The superintendent pharmacist offered a private ear wax removal service using microsuction techniques. He was able to send digital images to an audiologist or ear, nose and throat specialist for support, advice and guidance when required.

The pharmacy provided a prescription collection service from four local surgeries. It also offered a free medicines delivery service. The delivery driver used a delivery sheet to record each delivery that was made. Highlight stickers alerted the 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.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in two large, well-organised medical fridges. Maximum and minimum temperatures for the fridges were recorded daily and were usually within the required range. Some discrepancies had been recorded but evidence showed these had been monitored appropriately. Controlled drugs were stored in two large, 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. Short-dated items were highlighted. Date-expired medicines were disposed of appropriately, as were patient returns, waste sharps and clinical waste. 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 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 methadone to prevent cross-contamination. Triangles were used to count loose tablets, and these were washed after being used to count loose cytotoxics. The pharmacy had a range of up-to-date reference sources.

All equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. 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. 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.