

# Registered pharmacy inspection report

**Pharmacy Name:** Glyn Pharmacy, New Road, Glyn Ceiriog,  
LLANGOLLEN, Clwyd, LL20 7HE

**Pharmacy reference:** 1043124

**Type of pharmacy:** Community

**Date of inspection:** 24/06/2019

## Pharmacy context

The pharmacy is located in a village. The pharmacy sells a range of over-the-counter medicines and dispenses both private and NHS prescriptions. The pharmacy opening hours are 9am – 5pm on a Monday, Tuesday, Thursday and Friday, and 9am -12.30pm on a Wednesday.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. The pharmacy keeps the records that are needed by law and protects peoples' information. Members of the pharmacy team record things that go wrong, so that they can learn from them. But they do not record all of their mistakes, so they may miss some opportunities to learn.

### Inspector's evidence

There were up-to-date Standard Operating Procedures (SOPs) for the services provided, with signature sheets showing that members of staff had read and accepted them. Roles and responsibilities of staff were set out in SOPs. The trainee dispenser was seen to be following the SOPs that were relevant to her role and she was able to clearly describe her duties.

Dispensing incidents were reported on incident report forms and learning points were included. These were sent to the superintendent for review. The pharmacist said near miss errors were discussed with the trainee dispenser at the time, but said they were not recorded.

The correct responsible pharmacist (RP) notice was displayed prominently in the pharmacy. A complaints procedure was in place. The pharmacist explained that he aimed to resolve complaints at the time they arose, and he would involve the superintendent if necessary. A customer satisfaction survey was carried out annually. The pharmacist explained that because of some patients highlighting that there was nowhere to have a private conversation, a consultation room had been added.

The company had appropriate professional indemnity insurance in place. The private prescription record, emergency supply record, specials procurement record, responsible pharmacist (RP) record and the CD registers were in order. Patient returned CDs were recorded and disposed of appropriately.

Confidential waste was shredded. Confidential information was kept out of sight of the public. An information governance SOP was in place. Staff members had signed confidentiality agreements, with copies of these present. The computer was password protected and faced away from the customers. Assembled prescriptions awaiting collection were being stored in the dispensary in a manner that protected patient information.

The local contact numbers for raising safe guarding concerns were available in the pharmacy. The pharmacy had no safe guarding SOP in place and the pharmacist said he had not completed any safe guarding training, which may make it more difficult for staff to understand the correct procedure to follow in the event of a concern arising.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough staff to manage its workload safely. The pharmacy enables its team members to act on their own initiative and use their professional judgement, to the benefit of people who use the pharmacy's services.

### Inspector's evidence

There was pharmacist manager and a trainee dispenser on duty. The staff appeared to manage the workload adequately. The trainee dispenser was aware of a process to deal with whistle blowing concerns and understood how to report a concern if needed. e.g. she said she would speak to the superintendent in the first instance.

The trainee dispenser was given informal feedback from the pharmacist. e.g. about near miss errors. The trainee dispenser explained that she was currently undertaking a dispensing course. She said the pharmacist was supporting her through the course and she provided a copy of one of her workbooks. She said with exception of the dispenser course, no other training material was provided.

The trainee dispenser was clear about her role. She knew what questions to ask when making a sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if she suspected a customer might be abusing medicines such as co-codamol. i.e. she would refer the patient to the pharmacist for advice. The pharmacist explained that there were no targets or incentives set in the pharmacy.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean and tidy. It is a suitable place to provide healthcare.

### Inspector's evidence

The pharmacy was clean and tidy. It was free from obstructions and had a waiting area. The pharmacist said that the dispensary benches, sink and floors were cleaned regularly. The temperature in the pharmacy was controlled by heating units. Lighting was adequate.

The pharmacy premises were maintained and in an adequate state of repair. Maintenance problems were reported to the superintendent and dealt with accordingly. Staff facilities included a microwave, kettle and WC with wash hand basin and antibacterial hand wash. There was a consultation room available which was uncluttered and clean in appearance.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's services are generally well managed. But the pharmacy team may not always know when higher risk medicines are being handed out. So, they may not always make extra checks to be sure that they are needed. The pharmacy stores medicines safely and carries out checks to help make sure that medicines are in good condition and suitable to supply.

### Inspector's evidence

The pharmacy, consultation room and pharmacy counter were generally accessible to people. There was an entrance step and four internal stairs which led from the entrance to the retail area. The trainee dispenser explained that people with mobility difficulties were assisted into the pharmacy and up the stairs when necessary.

There was a selection of healthcare leaflets in the retail area for customers. Staff were clear about what services were offered and where to signpost to a service if this was not provided. e.g. needle exchange. The opening hours were displayed near the entrance to the pharmacy.

The work flow in the pharmacy was organised into separate areas – an area for dispensing and a designated checking area for the pharmacist. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Baskets were to separate prescriptions to reduce risk of medicines becoming mixed up during dispensing.

The trainee dispenser explained that schedule 2 CDs awaiting collection had a CD sticker attached to the bag. She explained that this was to act as a prompt and ensure that it was not handed out after 28 days of the prescription date. Examples of this were present, including a schedule 2 CD stored in a CD cabinet. The pharmacist said that schedule 3 and 4 CDs had the wording "CD" written in a triangle on the prescription and an example of this was present for a pregabalin prescription. However, an assembled prescription for zopiclone had not been highlighted which may increase the possibility of supplying a CD on a prescription that had expired.

The pharmacist said that prescriptions for warfarin, methotrexate and lithium were not routinely highlighted prior to collection. The pharmacy had patient information resources for the supply of valproate, including, patient cards, patient information leaflets and warning stickers. The pharmacy had carried out a clinical audit for patients prescribed valproate and had not identified any female patients who met the risk criteria. The pharmacist said any female patients prescribed valproate who met the risk criteria would be counselled by him and referred to their GP if necessary.

The pharmacist provided a detailed explanation of how the monitored dosage system (MDS) service was provided which was in accordance with the SOP. MDS was well organised with an audit trail for changes to medication added to a handwritten list of medications for the patient and the patient medication record (PMR) on the computer being updated. Disposable equipment was used. The pharmacist explained that patient information leaflets were routinely included and that hospital discharge summaries were kept for him to refer to. The assembled MDS packs awaiting collection had tablet descriptions included and patient information leaflets for all medicines.

There were a number of assembled prescriptions awaiting collection stored in sealed bags directly on the dispensary floor, which may become a trip hazard for staff and increase the possibility of medicines becoming damaged prior to supply. Stock was kept in an orderly manner. Date checking was carried out and documented. Short dated medicines were highlighted with a red dot sticker. No out of date stock medicines were seen from a number that were sampled. The date of opening for liquid medicines with limited shelf life was seen added to the medicine bottles.

CDs were stored appropriately. Patient returned CDs were destroyed using denaturing kits and records made in a designated book. A balance check for MST 5mg tablets was carried out and found to be correct. There was a clean fridge for medicines, equipped with an external thermometer. The minimum and maximum temperature was being recorded daily and the record was complete. The temperature of the fridge was usually kept within normal range.

The pharmacist said he was aware of the Falsified Medicines Directive (FMD). The pharmacy had signed up with an FMD supplier and had a 2D barcode scanner installed at the computer terminal. All FMD compliant medicines were scanned and verified at the point of receipt. Staff training had been carried out on FMD. Alerts and recalls etc. were received via email. These were acted on by the pharmacist or pharmacy team member and a record was kept.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide the service safely.

### Inspector's evidence

A paper copy of the up to date BNFC was available. The staff used the internet to access websites for up to date information. i.e. BNF, medicines complete. Any problems with equipment were dealt with by the pharmacist manager or superintendent. All electrical equipment appeared to be in working order. It was not PAT tested for safety.

There was a selection of liquid measures with British Standard and Crown marks. The pharmacy had equipment for counting loose tablets and capsules, including tablet triangles and a capsule counter. The computer was password protected and the screen was positioned so that it was not visible from the public area of the pharmacy. A mobile telephone was available in the pharmacy and the pharmacist said he would use this to hold private conversations with patients if required.

### 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.