General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Williams; J.R.G., 31 High Street, Llandybie, AMMANFORD, Dyfed, SA18 3HX

**Pharmacy reference:** 1043214

**Type of pharmacy:** Community

**Date of inspection:** 20/04/2022

## Pharmacy context

This is a rural village pharmacy. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a limited range of services including treatment for minor ailments and a basic smoking cessation service. This inspection was carried out during the COVID-19 pandemic.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

Follow this link to find out what the inspections possible outcomes mean

## 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 talk about things that go wrong and take action to help stop them 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's 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 the recording of dispensing incidents and near misses. Staff said that the pharmacist discussed near misses with them at the time of each occurrence. They said that they often shared examples of similar packaging that they thought might lead to selection errors and had recently separated different forms of metformin tablets on dispensary shelves for this reason. A range of written Standard Operating Procedures (SOPs) had been signed by all staff, although these were overdue for review. There were many slightly different versions of SOPs which was confusing. It was difficult to tell which SOPs were current and if they accurately reflected the activities carried out in the pharmacy. However, the pharmacy team were able to give appropriate descriptions of their roles and responsibilities. The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, but this process had been paused during the pandemic. The pharmacist said that verbal feedback was mostly positive. The pharmacy used the NHS formal complaints procedure 'Putting Things Right' to manage complaints. Information about how to make complaints was included in the practice leaflet, although this was not displayed in the retail area. Evidence of current professional indemnity insurance was available. 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. Some headings were missing from CD registers. Staff 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. The pharmacist and staff had undertaken formal safeguarding training and had access to local guidance and contact details via the internet.

## 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 from Monday to Friday each week. The pharmacy was very quiet at the time of the inspection and there were enough suitably qualified and skilled staff present to comfortably manage the workload. The staffing level appeared adequate for the services provided. The support team consisted of a dispensing assistant and a medicines counter assistant (MCA). Another dispensing assistant was absent. Staff had the necessary training and qualifications for their roles. Part of the MCA's role was to check dispensary stock against wholesaler invoices before putting it away and she had successfully completed an appropriate training course to allow her to do this. One dispensing assistant had been declared competent under the grandparent clause. She had trained as an accuracy checker but did not currently use this qualification. There were no specific targets or incentives set for the services provided. Staff worked well together and had an obvious rapport with customers since they served a small and close-knit community. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist owner. A whistleblowing policy in the Information Governance file advertised a confidential helpline for reporting concerns outside the organisation.

Members of staff were observed to use appropriate questions when selling over-the-counter medicines to patients. They referred to the pharmacist on several occasions for further advice on how to deal with transactions. Staff had access to informal training materials such as articles in trade magazines and information about new products from pharmaceutical representatives. There was no formal appraisal system in place, but all staff could discuss performance and development issues informally with the pharmacist 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 that opportunities to identify training needs could be missed.

## 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 housed in an old building but was clean, generally tidy and well-organised. The dispensary was small but had sufficient space to allow safe working. Some stock was being temporarily stored on the floor but it did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. A plastic screen had been installed at the medicines counter to reduce the risk of viral transmission between staff and customers. A consultation room was available for private consultations and counselling. But it was not visible from the retail area and it was not clearly advertised, so people may not have known it was available. The lighting and temperature in the pharmacy were adequate. One prescription retrieval area was not well-lit, which increased the risk of pharmacy team members picking up the wrong bag, but a torch was available for use if necessary.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy's services are easy for people to access. If it can't provide a service, it directs people to somewhere that can help. The pharmacy's working practices are generally safe and effective. It stores most medicines appropriately and carries out some checks to help make sure that they are in good condition and suitable to supply.

### Inspector's evidence

The pharmacy offered a limited range of services, some of which were advertised in the pharmacy window and in the practice leaflet, although this was not displayed in the retail area. There was wheelchair access into the pharmacy and consultation room. A signposting file provided by the local health board was available and staff said that they would signpost people requesting services they could not provide to nearby pharmacies or other providers such as the local surgery. Some health promotional material was available in the retail area. The pharmacy was located in a Welsh-speaking area. The pharmacist was a fluent Welsh-speaker and several transactions were observed to take place in Welsh.

The pharmacist said that the dispensing workload was easy to manage as most of it consisted of repeat prescriptions with very few walk-ins. The pharmacy offered a repeat prescription collection service from four local surgeries. Dispensing staff used a basket system for assembling repeat prescriptions to help ensure that medicines did not get mixed up during dispensing. Baskets were not used for walk-in prescriptions, but these were dispensed and bagged in the order that they were presented to reduce the risk of transposition of medicines. Dispensing labels were usually initialled by the dispenser and checker to provide an audit trail. However, some labels did not bear the dispenser's initial, which might prevent a full analysis of dispensing incidents. The print on some labels was a little faint and there was a risk that people with poor eyesight might find it difficult to read. The pharmacist said that this was due to a software issue with the laser printer which he would address as soon as possible. Some dispensed prescriptions were bagged up before they had been subject to an accuracy check by the pharmacist, and there was a risk that items that had not been checked might be handed out in error. However, these bags were kept in a separate dedicated area of the dispensary and staff understood that any items in this area would have to be checked by the pharmacist before handout.

Some prescriptions awaiting collection were no longer valid. The pharmacist admitted that this was an oversight and removed the prescriptions from the storage area immediately. However, he said that he would always check the date on a prescription before handing it out to the patient or their representative. Prescriptions were marked to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. Prescriptions for Schedule 3 and 4 CDs awaiting collection were also marked to remind staff that these should not be supplied more than 28 days after the date on the prescription. Patients on high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified and there was a risk that opportunities for counselling might be missed. However, staff referred all prescriptions to the pharmacist before handout. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that any patients prescribed valproate who met the risk criteria would be counselled appropriately and provided with information. The pharmacy carried out regular audits of high-risk medicines, which were 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 pharmacy did not provide a routine delivery service, but the pharmacist or the medicines counter assistant delivered about ten prescriptions to vulnerable and housebound patients each week. They asked recipients to sign the back of the prescription if a controlled drug was supplied.

Disposable compliance aid trays were used to supply medicines to a number of patients. Trays were labelled with descriptions to enable identification of individual medicines, although occasionally a description was missing. The pharmacist said that patient information leaflets were supplied monthly. Each patient had a section in a dedicated file that included their personal and medication details and details of any messages or changes. A list of patients and their collection or delivery arrangements was available for reference in the front of the file. A record of the date on which each patient's compliance aid had been collected was also kept for reference. A few dispensed compliance aids stored in the pharmacy had not been adequately labelled as either pre-packed or dispensed medicines. The pharmacist labelled these during the inspection.

The pharmacy provided a limited range of services. The pharmacist was accredited to provide discharge medicines reviews, but none had been carried out in recent months. The pharmacy provided the level two (supply only) smoking cessation service and the Choose Pharmacy common ailments service, although uptake of these was low.

Stock medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were stored in a well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored in a safe that was secured to the fabric of the building. There was not a great deal of stock, but different products were stored in piles on top of one another and one box of out-of-date Matrifen 50mcg/hr patches had not been segregated from usable stock, increasing the risk of errors. Some poisons were stored appropriately in a locked cupboard in the dispensary away from other medicines.

There was some evidence to show that regular expiry date checks were carried out, but the frequency and scope of these checks were not documented and there was a risk that out-of-date medicines might be overlooked. This was reinforced by the discovery of two bottles of Daktarin powder and a pot of thiamine tablets that were found to be out of date. However, the pharmacist and dispensing assistant said that they always included an expiry date check in their dispensing and checking processes. Date-expired medicines were generally disposed of appropriately, as were patient returns and waste sharps. The pharmacy received drug alerts and recalls via NHS email. The pharmacist was able to describe how he had dealt with recalls for medicines 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. The pharmacy's 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. These were clean and a dispensing assistant said that they were washed after being used to measure methadone. Triangles were used to count tablets and staff said that these were washed after use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. Personal protective equipment was available for staff use and the pharmacy team were wearing face masks.
All equipment was clean and in good working order, although there was no evidence to show 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 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. |