General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: E P Parry Pharmacy, Tenby Road, CRYMYCH, Dyfed, SA41 3QG

Pharmacy reference: 1043246

Type of pharmacy: Community

Date of inspection: 17/10/2022

Pharmacy context

This is a village pharmacy in a rural area. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a wide range of services including emergency hormonal contraception, smoking cessation, treatments for minor ailments and a seasonal 'flu vaccination service for both 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	N/A	N/A	N/A
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 their mistakes so they can learn from them. But they do not always review everything that goes wrong. So they may miss some opportunities to learn. The pharmacy keeps the records it needs to by law. And it keeps people's private information safe. The pharmacy's 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 recording of dispensing errors and near misses. The superintendent pharmacist said that near misses were discussed with relevant staff at the time of each occurrence but patient safety incidents were not regularly analysed to identify patterns and trends. He was able to describe some recent action that had been taken to reduce risk: after some near misses with the 'LASA' or 'look-alike, sound-alike' drugs amlodipine and amitriptyline, these had been separated in the dispensary and highlight stickers had been used to alert staff to the risk of selection errors with these products.

The pharmacy team understood their roles and responsibilities and worked in accordance with written Standard Operating Procedures (SOPs). The SOPs were overdue for review and there was a risk that they might not adequately reflect the current activities undertaken by the pharmacy. New and trainee staff members were in the process of reading and signing SOPs relevant to their role. Staff were able to clearly describe their roles and responsibilities when questioned, and they understood which tasks could and could not be performed in the absence of the responsible pharmacist. The accuracy checking technician (ACT) was able to accuracy check all prescriptions that had been clinically checked by a pharmacist, apart from controlled drugs requiring safe custody. She demonstrated that the superintendent pharmacist initialled each prescription once he had conducted a clinical check and the words 'clinically checked by' and his registration number were then printed on the bag label as an audit trail. Other pharmacists working at the pharmacy also initialled prescriptions to indicate that these had been clinically checked, but their registration numbers were not recorded on the bag label, so the same system was not always followed.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, but these had been suspended during the pandemic. However, the pharmacist said that verbal feedback from people using the pharmacy was generally positive. A formal complaints procedure was in place although this was not advertised.

Evidence of current professional indemnity insurance was available. All necessary records were kept and these were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records.

The pharmacist had discussed the importance of confidentiality with all staff members and the ACT had received information governance training in her previous workplace. Members of the pharmacy team understood the need to protect confidential information, for example by offering people the use of the consultation room for private conversations. They were able to identify confidential waste and disposed of it appropriately. Individual staff members had unique passwords to access the PMR system. The

pharmacist and ACT had undertaken formal safeguarding training and had access to local guidance and contact details that were available via the internet. The newest members of staff understood basic safeguarding concerns and said that they would always refer these to the pharmacist. However, they had not received any formal safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. Pharmacy team members are properly trained for the jobs they do. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The superintendent pharmacist worked at the pharmacy regularly and was usually assisted by a second pharmacist every Tuesday. The support team consisted of an accuracy checking technician (ACT), a pharmacy technician who worked on Saturday mornings, a dispensing assistant and three trainee dispensing assistants, one of whom was also a trained medicines counter assistant. There were enough suitably skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. Staff members had the necessary training and qualifications for their roles. Trainees worked under the supervision of the pharmacist and other trained members of staff.

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 pharmacists. A whistleblowing policy was available in the staff handbook, although it did not include contact details for reporting concerns outside the organisation. However, the ACT understood that she could contact the GPhC or local health board if she wished to raise a concern externally.

A member of staff working on the medicines counter was 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. A poster near the medicines counter listed the WWHAM questions for reference. It also listed types of symptoms, patient categories and over-the-counter medicines that required referral to the pharmacist.

Staff had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They said that much of their learning was self-directed or via informal discussions with the pharmacist.

There was no formal appraisal system although staff members could discuss issues informally with the pharmacists whenever the need arose. However, 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 opportunities to identify training needs could be missed. The ACT and pharmacist said that they understood the revalidation process and based their continuing professional development entries on formal training as well as on situations they came across in their day-to-day working environment.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and tidy. It is secure and has enough space to allow safe working. Its layout generally protects people's privacy.

Inspector's evidence

The pharmacy was housed in an old building. Historic leaks had left some ceiling tiles stained and perished, the paintwork in some areas was in disrepair and the carpet was worn. However, the dispensary was generally clean, tidy and well-organised. The bathroom had hot and cold running water and soap and cleaning materials were available. The dispensary sink had only cold running water, but a thermos dispenser was used to supply hot water if necessary. A plastic screen had been installed at the medicines counter to reduce the risk of viral transmission between staff and customers. An automated verbal message played every two hours to remind staff to wash their hands at regular intervals.

A consultation room was available for private consultations and counselling and was advertised appropriately. Access to the room was through an area in which dispensed prescriptions were stored and there was a risk that people walking from the retail area to the consultation room might have unauthorised access to confidential information. However, the area was quite spacious and information was not easily visible. Staff said that they always escorted people through this area into the consultation room and back out into the dispensary. The pharmacy doubled as a general village store and although the pharmacy stocked items relevant to the healthcare setting, it also sold newspapers and magazines, trinkets, gifts and stationery. 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 generally safe and effective. It generally stores medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply. But members of the pharmacy team do not always know when higher-risk medicines are being handed out. So they might not always check that medicines are still suitable or give people advice about taking them.

Inspector's evidence

The pharmacy offered a wide range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. Staff said that they would signpost patients requesting services they could not provide to nearby pharmacies or other providers such as the local surgery. Some health promotional material was displayed in the retail area. The pharmacist visited local surgeries to discuss and promote services as part of a health board funded collaborative working initiative. Recent visits had involved discussions around the common ailments service. The pharmacy was in a Welsh-speaking area and most of the pharmacy team were able to speak to people in Welsh.

Dispensing staff used a colour-coded basket system to ensure that medicines did not get mixed up during dispensing and to differentiate between different prescriptions. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. A list of people for whom the surgery regularly issued post-dated prescriptions was displayed in the dispensary and included a reminder to staff that the pharmacist should be made aware if any of these prescriptions were requested or collected. The pharmacy received some faxed prescriptions from local surgeries due to its rural location. Staff gave assurances that medicines were not supplied against unsigned faxes and that Schedule 2 or 3 CDs were only ever supplied against the original prescription.

Stickers were attached to bags of dispensed medicines to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. However, there was no strategy in place to ensure that Schedule 3 or 4 CDs were not supplied to the patient or their representative more than 28 days after the date on the prescription. Trained dispensing staff could identify Schedule 3 or 4 CDs and said that they always checked the prescription date before supplying these. However, there was a risk that staff who were still in training might not recognise Schedule 3 or 4 CDs and could make a supply against a prescription that was no longer valid. Stickers were used to highlight prescriptions for lithium, a high-risk medicine. Prescriptions for other high-risk medicines such as warfarin and methotrexate were not highlighted and there was a risk that counselling opportunities could be missed. However, during the inspection one of the dispensing team asked a patient for their INR when processing a prescription for warfarin and made a note of this for referral to the pharmacist. Observation showed that INR results and dosage changes were usually recorded on the pharmacy's PMR. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacy supplied valproate to one person who met the risk criteria. The pharmacist explained that he counselled this person or their representative appropriately and provided them with information at each time of dispensing. 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.

Disposable multi-compartment compliance aids were used to supply medicines to a small number of patients. The pharmacist explained that he assessed all new patients and generally used a MAR chart and original pack service to help people who were finding it difficult to manage their medicines properly. He found that this initial approach was usually very successful. However, he supplied medicines in a compliance aid where he felt that this was a better solution. Compliance aids were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied. Information such as medication or dosage changes was recorded on the patient's PMR. Each person had a labelled basket that contained their personal and medication details, any notes or messages and current dispensed compliance aids.

The pharmacy was able to provide a wide range of services. Uptake of the common ailments service was steady, but there was relatively low uptake of both the discharge medicines review service and the influenza vaccination service. The pharmacy had recently resumed provision of the sore throat test and treat service that had been suspended during the pandemic, but there had not yet been much demand for this. It had also recently begun to provide a new UTI service to symptomatic females between the ages of 60 and 64. A 'triage and treat' minor injuries service was commissioned by the local health board but was not often used. The ACT was trained to provide the smoking cessation level 3 (supply and monitoring) service, although the pharmacy currently had no clients. She had also registered on a training course for a new health board-commissioned inhaler technique service. The pharmacy did not provide a delivery service.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, limited storage space meant that different products and different strengths of the same product were sometimes stored closely together in dispensary drawers, which might increase the risk of selection errors. Staff said that they were in the process of reorganising the dispensary to reduce this risk. Medicines requiring cold storage were stored in a large, tidy, well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in a tidy, well-organised CD cabinet and obsolete CDs were segregated from usable stock. Records showed that expired CDs had recently been destroyed in the presence of an authorised witness from the local health board. P medicines were stored in cabinets in an area near the dispensary which could be accessed from the retail area, although a 'no entry' sign discouraged this. A member of staff working on the medicines counter said that customers rarely attempted to enter this area to self-select medicines and if this happened they would intervene and refuse the sale if they felt that it was inappropriate.

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. No out-of-date medicines were found in the dispensary. Date-expired medicines were disposed of appropriately, as were patient returns. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist was able to describe how he would normally deal with drug recalls 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. Triangles were used to count tablets and staff said that these would be washed after use with cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was clean and in good working order. It was generally appropriately managed, although there was no evidence to show that it had recently been tested. However, the computer hardware used for dispensing had recently been replaced and so most electrical equipment was very new. A spill kit was stored conspicuously in the dispensary. Personal protective equipment was available and the pharmacist wore a mask. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the computer was password-protected 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.