General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Sheppards Pharmacy, Goodwick Square, Goodwick, FISHGUARD, Dyfed, SA64 0BP

**Pharmacy reference:** 1043251

**Type of pharmacy:** Community

**Date of inspection:** 12/08/2024

## Pharmacy context

This pharmacy is in a small coastal town in Southwest 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, a smoking cessation service and treatment for minor ailments. Substance misuse services are also available.

## 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 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 the recording of dispensing errors and near misses. The pharmacist carried out a monthly review of patient safety incidents. Dispensing team members explained that near misses were discussed 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, shelf edge stickers had been used to alert team members to the risk of selection errors with sildenafil and sitagliptin tablets following some near misses. And these two medicines had been distinctly separated on dispensary shelving. The pharmacy team received a regular patient safety newsletter produced by the superintendent's team, and the most recent edition was displayed on the staff noticeboard. It included case studies and key learning points from company-wide patient safety incidents to help prevent further errors.

A range of standard operating procedures (SOPs) underpinned the services provided and these had been regularly reviewed. Pharmacy team members had signed the SOPs to show that they had read and understood them. 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, as long as she had not been involved in dispensing or labelling these. The pharmacy team were able to describe activities that could not take place in the absence of the responsible pharmacist. The responsible pharmacist notice displayed was incorrect, but the pharmacist remedied this as soon as the inspection began.

A touch screen in the retail area was used to obtain customer feedback about people's experience of the pharmacy's services. The pharmacist explained that this feedback was relayed directly to the superintendent's team and was mostly positive. A formal complaints procedure was in place and was advertised in the pharmacy's practice leaflet. A poster that provided information about the NHS complaints procedure 'Putting Things Right' was displayed near the medicines counter.

Evidence of current professional indemnity insurance was available. Records were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and electronic controlled drug (CD) records. However, emergency supply records did not always include the nature of the emergency. This meant that it might be difficult for the pharmacy team to demonstrate why the supply was appropriate. CD Running balances were typically checked fortnightly.

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. A privacy notice displayed in the retail area signposted people to the pharmacy's website for information on the way in which personal data was used and managed by the company. The pharmacists and pharmacy technicians had undertaken advanced formal safeguarding training. All other team members had undertaken basic formal safeguarding training. They had access to guidance and local safeguarding contact details that were available in the SOP file. A chaperone policy was also available in the SOP file and a summary of the policy was displayed near the medicines counter. Leaflets that included Information about support groups and services for carers were displayed in the retail area.

## 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. And they feel comfortable speaking up about any concerns they have.

### Inspector's evidence

The pharmacist manager worked at the pharmacy between two and five days per week. His absences were covered by locum pharmacists. The pharmacy team consisted of two pharmacy technicians, one of whom was a qualified accuracy checker (ACT), two dispensing assistants (DAs), a medicines counter assistant (MCA) and a pharmacy student. Another DA was absent on long-term leave and was due to return to work at the branch in a few weeks' time. The pharmacy student 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 pharmacy team working on the medicines counter were observed asking 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 a transaction. The team had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They also had access to an online training programme provided by the company, which included modules on seasonal healthcare, such as hay fever remedies and the management of colds and flu, as well as health and safety training. All pharmacy team members had recently completed mandatory training provided by NHS Wales on mental health awareness and improving the quality of services provided. 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 was allowed eight hours of protected learning time each year to spend completing revalidation work. The company had recently introduced an appraisal process. The pharmacy team had not yet received their first performance and development review but understood that they could informally discuss issues with the pharmacist whenever the need arose.

There were no specific targets or incentives set for the services provided. Pharmacy team members worked well together. The pharmacy served a small and close-knit community and staff had an obvious rapport with customers. They said that they felt comfortable making suggestions or raising concerns with the pharmacists or regional manager. A whistleblowing policy was available in the SOP file and included a confidential helpline for raising concerns outside the company.

## 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 helps to protect 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.

A consultation room was available for private consultations and counselling and its availability was clearly advertised. It was kept locked when not in use. 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 room. Pharmacy team members signposted people requesting services they could not provide to nearby pharmacies or other healthcare providers such as the local GP surgery. Some health promotional material was on display in the retail area.

Dispensing staff used a basket system to help ensure that medicines did not get mixed up during the dispensing process when assembling prescriptions for compliance packs. However, baskets were not routinely used during the assembly of other types of prescriptions. The pharmacist and dispensing staff explained that they always ensured that enough space was left between individual prescriptions being assembled on the workbench to reduce the risk of medicines becoming mixed up. This was achievable at the time of the inspection as there was ample workbench space and the pharmacy was quiet. However, it was unclear if this was still the case during busy periods. Dispensing labels were initialled by the dispenser and accuracy checker to provide an audit trail.

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.

Prescriptions for higher risk medicines such as warfarin, 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 dispensed medicines against some faxed prescriptions from local surgeries due to its rural location. There were mechanisms in place to ensure that Schedule 2 or 3 CDs were only ever supplied against the original prescription.

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 not labelled with descriptions of the medicines they contained. So, there was a risk that people might not always be able to make informed decisions about their own treatment. However, patient information leaflets which included descriptions of these medicines were routinely supplied. Details of any messages or changes were recorded on the individual's patient medication record. An original pack

and medication administration record (MAR) dispensing service was provided to some care home residents.

Uptake of 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. Uptake of the pharmacy's discharge medicines review service and the common ailments service was steady. Demand for the emergency supply of prescribed medicines service and EHC (emergency hormonal contraception)/bridging contraception service was usually relatively low, as the pharmacy did not open at weekends. However, there was a rise in demand during the summer months when numbers of visitors to the area increased. The pharmacy offered a smoking cessation (supply and monitoring) service, a supervised consumption service and a needle and syringe disposal service for people receiving treatment for chronic conditions. The local health board (LHB) had recently commissioned a new MAR chart service. The pharmacist said that the team had received training and would soon be providing this service to people referred to them by the LHB.

The pharmacy provided a prescription collection service from three local surgeries. It also offered a free medicines delivery service. The delivery driver used a delivery sheet to record each delivery that was made. Signatures were obtained for deliveries of controlled drugs. In the event of a missed delivery, the delivery driver usually put a notification card though the door and brought the prescription back to the pharmacy. But medicines had been posted through a letterbox on at least one occasion. The delivery driver explained that this deviation from the delivery SOP had been discussed in advance and agreed with the pharmacist. And a record had been made on the pharmacy's software system. However, the practice of posting medicines through letterboxes may compromise confidentiality and increases the risk of errors.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in a well-organised medical fridge. 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 well-organised CD cabinets and obsolete CDs were kept separately from usable stock.

Medicine stock was subject to regular expiry date checks. These were documented, and 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 company emails and its NHS email account. These were printed out and filed for reference. 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. Triangles and a capsule counter were used to count loose tablets and capsules. A separate triangle was available for use with loose cytotoxics to prevent cross-contamination. 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 room was 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. Some dispensed medicines awaiting collection could be seen from the retail area, but no confidential information was visible.

## 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. |