General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Kilgetty Pharmacy, Carmarthen Road, KILGETTY, Dyfed, SA68 0UE

Pharmacy reference: 1043264

Type of pharmacy: Community

Date of inspection: 28/08/2024

Pharmacy context

This pharmacy is in a rural village in West 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.

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	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 take action to help reduce the chance of similar mistakes from happening again. But they do not always record or review all their mistakes, so they may miss some opportunities to learn and improve. 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. Pharmacy team members know how to keep people's private information safe. And they can 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. The most recent near miss records had been made in 2023. However, dispensing team members explained that the pharmacists 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. They agreed to record near misses going forward. Action had been taken to reduce some risks that had been identified. For example, some medicines that looked and sounded alike, such as sildenafil and sumatriptan tablets and rosuvastatin and rivaroxaban tablets, had been distinctly separated on dispensary shelving following some near misses. And shelf edge stickers had been used to alert team members to the risk of selection errors with these medicines.

A range of up-to-date standard operating procedures (SOPs) underpinned the services provided. Pharmacy team members were in the process of signing the latest versions of the SOPs to show that they had read and understood them. Members of the team were able to describe their roles and responsibilities. A dispensing assistant was able to describe activities that could not take place in the absence of the responsible pharmacist. The responsible pharmacist notice was not conspicuously displayed, but the pharmacist remedied this as soon as it was pointed out to him.

The pharmacy team explained that verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place, although 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 generally properly maintained, including responsible pharmacist (RP), private prescription, unlicensed specials, emergency supply and controlled drugs (CD) records. However, there was a missing entry in the RP register for 7th August 2024. This meant that it might not be possible to identify the pharmacist accountable in the event of an error or incident. Running balances for CDs were typically checked monthly by a regular locum pharmacist.

Members of the pharmacy team confirmed that they had signed confidentiality agreements, although no evidence of this was available. However, they understood how to protect privacy and confidential information, for example by offering the use of the consultation room for private conversations and by identifying confidential waste and disposing of it appropriately. The pharmacists had undertaken advanced formal safeguarding training. Other team members explained that they had undertaken safeguarding training in the past, although no evidence of this was available. However, they were able

to give examples of how they had identified and supported potentially vulnerable people, which had resulted in positive outcomes. They had access to guidance and local safeguarding contact details which were displayed in the dispensary. The pharmacy's chaperone policy was advertised in a notice displayed on the consultation room door.

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 pharmacy operated using several regular locum pharmacists. The superintendent pharmacist also worked at the pharmacy on one or two days each month. However, the pharmacy team explained that the company had recently recruited a full-time pharmacist, who was due to start work at the branch in the next few weeks. The pharmacy team consisted of a medicines counter assistant (MCA), who was employed as the pharmacy manager and oversaw the operational running of the branch, two full-time dispensing assistants (DAs), a trainee MCA and an untrained member of staff who worked in the retail area. One of the DAs was due to leave the business in the next few months and the superintendent pharmacist was currently recruiting for another team member to replace her. The trainee MCA worked under the supervision of the pharmacist and other trained members of staff. The untrained member of staff worked in the retail area supervising sales of toiletries, gifts and other non-medicinal retail items. She referred all requests for medicines or advice to team members at the medicines counter, which was situated at the opposite end of the pharmacy. 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 using appropriate questions when selling over-the-counter medicines to people. And they referred to the pharmacist on several occasions for further advice on how to deal with transactions. Pharmacy team members had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They explained that much of their learning was via informal discussions with the pharmacists. However, the lack of a structured training programme meant that individuals might not keep up to date with current pharmacy practice. There was no formal appraisal system in place, which meant that development needs might not always be identified or addressed. But pharmacy team members informally discussed performance and development issues with the pharmacists, including the superintendent pharmacist, whenever the need arose.

There were no specific targets or incentives set for the services provided. Pharmacy team members worked well together and had an obvious rapport with customers. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists, including the superintendent pharmacist and pharmacy owner. A whistleblowing policy was available in the dispensary and described the pharmacy's internal process for raising concerns. On discussion, team members understood that they could contact the GPhC if they wished to raise a concern outside the organisation.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and secure. It has enough space to allow for safe working. There is a room where people can have conversations with team members in private. But it is not advertised and cannot be seen from the retail area, so people may not know that it is available.

Inspector's evidence

The pharmacy was clean and well-organised, with enough space to allow for safe working. A separate room off the main dispensary was used for the assembly of compliance packs. 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. But its availability was not clearly advertised, and it was not visible from the retail area. The room could only be accessed by walking a short distance through the dispensary. No confidential information was visible, and the pharmacist gave assurances that people using the room were always accompanied by a team member. The lighting and temperature in the pharmacy were appropriate.

The pharmacy was one of very few shops in the area. It had a large gift section and a separate room housing pet products to meet customer demand. These were clearly separated from the area in which pharmaceutical services were provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally easy for people to access. Its working practices are safe and effective. It generally 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, although these were not advertised in the retail area. There was wheelchair access into the pharmacy and consultation room. The pharmacy team signposted people requesting services they could not provide to nearby pharmacies or other healthcare providers, such as local GP surgeries.

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 baskets to ensure that medicines did not get mixed up during the dispensing process. 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.

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 supplied against the original prescription.

Prescriptions were marked to alert team members to the fact that a CD requiring safe custody or fridge item needed to be added before handout. Prescriptions for schedule 3 and 4 CDs awaiting collection were marked with the date after which the prescription was invalid and could no longer be supplied. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

Stickers were used to routinely identify people prescribed higher-risk medicines such as warfarin, lithium and methotrexate so that they could be counselled. The pharmacist said that he asked people about relevant blood tests and dose changes but did not record these conversations. 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. Compliance packs were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied. A list of people receiving their medicines in compliance packs with their collection or delivery details was displayed in the compliance pack room for reference. Details of any current messages or queries were also displayed and were subsequently recorded on the individual's patient medication record for communication purposes. An original pack and medication administration record (MAR) dispensing service was provided to some care home residents.

The locum pharmacist was unable to provide NHS-commissioned services on the day of the inspection, except for the NHS Wales Stop Smoking level two service (supply only). The pharmacy team explained that the superintendent pharmacist and other regular locum pharmacists were able to provide a range of services on most days. Uptake of the common ailments service was steady, as the pharmacy received referrals from the nearby GP practice. Uptake of the emergency supply of prescribed medicines service was also steady. However, the team explained that there was a rise in demand for this service during the summer months when numbers of visitors to the area increased. The pharmacy also provided a discharge medicines review service, an emergency hormonal contraception (EHC)/bridging contraception service, a needle and syringe disposal service for people receiving treatment for chronic conditions and a seasonal influenza vaccination service for NHS and private patients. The superintendent pharmacist was able to provide the sore throat test and treat service and the UTI (urinary tract infection) service when he worked at the pharmacy, but this was usually only on one or two days each month.

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. The sheet was marked to notify the driver if a controlled drug or a fridge line was included in the delivery so that they could inform the recipient. In the event of a missed delivery, the delivery driver put a notification card though the door and brought the medication back to the pharmacy.

Medicines were obtained from licensed wholesalers and were mostly stored appropriately. However, some different medicines and different strengths of the same medicines were stored very closely together in the compliance pack room, increasing the risk of selection errors. Medicines requiring cold storage were kept in a well-organised medical fridge. Maximum and minimum temperatures for the fridges were recorded daily and were consistently within the required range. CDs were stored in two CD cabinets and obsolete CDs were kept separately from usable stock. Two prescriptions for dispensed CDs awaiting collection were no longer valid, as more than 28 days had elapsed since the date on the prescription. However, they were marked with the date after which the CD could no longer be supplied, and team members said that they would always check such a prescription with the pharmacist before handing it out. The pharmacy manager gave assurances that she would return the prescriptions to the GP surgery and deal with the medicines appropriately.

There was evidence to show that expiry date checks were carried out, but the frequency of these checks was not documented. This created a risk that out-of-date medicines might be overlooked, and two out-of-date medicines were found present in the pharmacy. One was stored in the room used to assemble compliance packs and the other was stored in the consultation room. The pharmacy team explained that these areas contained very small quantities of stock medicines and so were not subject to routine date-checks. On discussion, they understood the risks and agreed to review their date-checking processes going forward. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received safety alerts and medicine 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 that these are 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 were used to count loose tablets. A separate triangle was available for use with 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 electrical equipment 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.

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.