General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Elders Chemist, St Anne's Road, Hakin, MILFORD HAVEN, Dyfed, SA73 3LL

Pharmacy reference: 1043300

Type of pharmacy: Community

Date of inspection: 26/10/2023

Pharmacy context

This is a neighbourhood pharmacy. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It supplies medicines in multi-compartment compliance aid packs to a large number of people living in the local community. It offers a range of services including emergency hormonal contraception, treatment for minor ailments and a seasonal 'flu vaccination service for NHS patients. Substance misuse services are also available.

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 record some of their mistakes so they can learn from them. But they do not always record or review everything that goes wrong. So they may miss some opportunities to learn. 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 errors and near misses. However, near miss records had not been completed for several months and it was likely that some incidents had not been captured. There was no evidence available to show that near misses were regularly reviewed. The pharmacist explained that he tended to discuss near misses with relevant staff at the time and that any patterns or trends that emerged were discussed with the whole team. Records of dispensing errors were historic, and the pharmacist said that he could not remember the last time an error had been made. Members of the pharmacy team were able to describe some recent action that had been taken to reduce risk. They had used a shelf marker to highlight different pack sizes of codeine tablets after some near misses involving incorrect quantities. And some 'look-alike, sound-alike' or LASA drugs had been distinctly separated in the dispensary to reduce the risk of selection errors.

A range of written Standard Operating Procedures (SOPs) underpinned the services provided. The pharmacist said that he had recently reviewed the SOPs, although there was no clear audit trail to show when this had been carried out or when the next review would take place. Members of staff were in the process of reading and signing the reviewed SOPs.

The pharmacist said that verbal feedback about the services provided by the pharmacy was mostly positive. A formal complaints procedure was in place but was not advertised. A current certificate of professional indemnity insurance was on display. Pharmacy records were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. However, electronic emergency supply records did not always include the nature of the emergency. And it was sometimes unclear if the supply had been made at the request of the patient or the prescriber, as these entries were simply annotated 'script to follow'. This meant that it might be difficult for the pharmacy team to fully resolve queries or deal with errors effectively. CD running balances were typically checked monthly.

Staff had signed to show that they understood the patient confidentiality SOP. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. The pharmacist had undertaken formal safeguarding training and had access to local guidance and contact details via the internet. Staff had received in-house safeguarding training.

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 superintendent pharmacist worked at the pharmacy on most days. The support team consisted of five part-time dispensing assistants and a part-time medicines counter assistant. There were enough suitably qualified and skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. Certificates were displayed as evidence that pharmacy team members had the necessary training and qualifications for their roles.

There were no specific targets or incentives set for the services provided. Staff worked well together. The pharmacy served a small and close-knit community and staff had an obvious rapport with customers. They were happy to make suggestions within the team and felt comfortable raising concerns with the superintendent and locum pharmacists. There was no whistleblowing procedure in place, but staff understood that they could contact the GPhC if they wished to raise a concern outside the company.

Members of the pharmacy team were observed to use appropriate questions when selling over-the-counter medicines to people. They referred to the pharmacist on several occasions for further advice on how to deal with transactions. There was no structured training programme in place. However, pharmacy team members had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. Much of their learning was via informal discussions with the pharmacist. They had recently completed some mandatory training provided by NHS Wales on mental health awareness and improving the quality of service provision. There was no formal appraisal system, but team members could discuss 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 meant 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 clean, tidy and well-organised, with enough space to allow safe working. Some dispensed prescriptions were being temporarily stored on the floor, but these 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 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. It was visible from the retail area, but its availability was not clearly advertised. 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. 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, and it stores most medicines appropriately.

Inspector's evidence

There was a small step up to the pharmacy entrance, but the pharmacy team explained that they would go out to wheelchair patients and help them into the pharmacy if necessary. There was wheelchair access into the consultation room. The pharmacy offered a range of services that were appropriately advertised. Staff signposted people requesting services they could not provide to other nearby pharmacies. Some health promotional material was on display near the pharmacy entrance. Posters advertising local community support groups and services were displayed in the pharmacy window.

Dispensing staff used a basket system to ensure that medicines did not get mixed up during dispensing. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Prescription bags were marked to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. Prescriptions were not always retained for dispensed items awaiting collection. This meant that an accurate and complete record of the prescription details might not be available for reference at the time of supply. Most prescriptions were scanned into the pharmacy's computer system, and the image remained available for reference. However, this was not the case for all prescriptions. There was no strategy in place to routinely identify Schedule 3 or 4 CDs that were awaiting collection, and there was a risk that these medicines might be supplied against a prescription that was no longer valid.

People on high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified and there was a risk that counselling opportunities might be missed. The pharmacist said that the pharmacy team usually asked people about relevant blood tests and dose changes when they ordered their medicines, or at the point of handout, but did not record these conversations. He explained that methotrexate products were not usually prescribed on a repeat basis: the local surgery would only issue a prescription on receipt of an appropriate blood test result.

The pharmacy team were aware of the risks of valproate use during pregnancy. They were also aware of the requirement to provide all valproate products in original packs wherever possible. The superintendent pharmacist said that one patient prescribed valproate who met the risk criteria had been identified. He explained that they were routinely counselled and provided with information. Educational material was available in the dispensary.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a large number of people. Compliance aids were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied. Each patient had a section in a dedicated file that included their personal and medication details and current prescriptions. It was marked using a sticker if the person was known to be in hospital. A progress log for all patients was available for reference at the front of the file. It showed the status of each person's compliance aid at any given time.

The pharmacy provided a prescription collection service from three local surgeries. It also offered a prescription delivery service for a small charge. Signatures were not routinely obtained for prescription deliveries, which meant that the pharmacy team might have difficulty dealing with any complaints or queries. In the event of a missed delivery, the delivery driver put a notification card though the door and brought the prescription back to the pharmacy.

The pharmacist was accredited to provide the discharge medicines review service but uptake of this was very low. Demand for the emergency supply of prescribed medicines service was also low, as the pharmacy kept similar opening hours to local surgeries and people were usually able to obtain a valid prescription from a GP in an emergency. There was a steady uptake of the common ailments service. The pharmacy offered a waste sharps disposal service, the All-Wales EHC service and an influenza vaccination service for NHS patients. It had also recently begun to provide a locally commissioned UTI service to symptomatic females between the ages of 60 and 64.

Stock medicines were obtained from licensed wholesalers and were generally 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. Controlled drugs were stored in a well-organised CD cabinet. Obsolete CDs were segregated from usable stock.

There was some evidence to show that expiry date checks were carried out, but the frequency and scope of these checks were not documented. This created a risk that out-of-date medicines might be overlooked, and some out-of-date medicines were found present in the dispensary. However, these had been highlighted using a marker pen, and the pharmacist said that the team always included an expiry date check as part of their dispensing and accuracy checking processes. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. There was no separate bin for disposing of cytotoxic waste, but the pharmacist said that he was in the process of ordering one from the pharmacy's waste contractor, as the previous bin had been collected but not replaced. He gave assurances that the team would segregate any cytotoxic waste they received in the meantime.

The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist also received MHRA alerts directly to his personal mobile phone. He was able to describe how he would deal with medicines or medical devices that had been recalled as unfit for purpose by contacting patients where necessary and returning quarantined stock to the relevant supplier or manufacturer.

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 and oral syringes were used to measure volumes below 10ml. One measure was potentially unsafe as it had a broken base. Separate measures were used for methadone. Triangles were used to count tablets and a separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. All electronic equipment was 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. Some dispensed prescriptions 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.