General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Fairwater Pharmacy, 7 Fairwater Square, Fairwater, CWMBRAN, Gwent, NP44 4TA

Pharmacy reference: 1043366

Type of pharmacy: Community

Date of inspection: 30/09/2024

Pharmacy context

This pharmacy is in a suburb of Cwmbran in South East Wales. It sells a range of over-the-counter medicines and dispenses both 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. 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 for its team members to follow to help make sure they work safely. Team members record and review their mistakes so they can learn from them. And they take action to help reduce the risk of similar mistakes happening again. The pharmacy keeps the records it needs to by law. Pharmacy team members 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. Dispensing team members explained that the pharmacist 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. Action had been taken to reduce some risks that had been identified. For example, different strengths of Epilim tablets had been separated on dispensary shelves following some near misses. And a bottle of methadone mixture had been clearly labelled and distinctly separated from sugar-free methadone oral solution in the CD cabinet to help reduce the incidence of selection errors. The superintendent pharmacist had assessed the risks of needlestick injury associated with the influenza vaccination service. A poster describing the process to follow in the event of needlestick injury was displayed in the consultation room.

A range of standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Members of the pharmacy team had signed the SOPs to show that they had read and understood them. A dispensing assistant described the activities that could not take place in the absence of the responsible pharmacist (RP). And she explained that if the RP was absent, a notice was displayed at the medicines counter to inform the public that certain services could not be provided.

The pharmacy team explained that verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place, and this was advertised in a notice displayed near the pharmacy entrance. The NHS Wales complaints procedure 'Putting Things Right' was also clearly advertised in the retail area.

Evidence of current professional indemnity insurance was available. Records were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. Running balances for controlled drugs were checked regularly.

Members of the pharmacy team had signed confidentiality agreements. They were aware of the need to protect 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. A privacy notice near the pharmacy entrance described the way in which data was used and managed by the pharmacy and included details of the pharmacy's Data Protection Officer. The pharmacist had undertaken advanced formal safeguarding training. All other team members had undertaken basic formal safeguarding training and had read and signed the pharmacy's safeguarding SOP. They had access to guidance and local safeguarding contact details that were displayed in the dispensary. A summary of the pharmacy's chaperone policy was advertised in a poster 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 superintendent pharmacist worked at the pharmacy on most days. The pharmacy team consisted of four dispensing assistants (DAs) and a trainee DA. The trainee 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 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. A computer terminal was situated at the medicines counter which allowed team members to access patient medication records to help them make decisions about sales of medicines or provision of advice. 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 pharmacist. All pharmacy team members had recently completed mandatory training provided by NHS Wales on mental health awareness. And they had online access to other training modules provided by NHS Wales on clinical topics and pharmacy services. There was a formal appraisal system in place and team members received a documented performance and development review each year. They could also discuss performance and development issues informally with 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 were happy to make suggestions and raise concerns with the superintendent pharmacist. A whistleblowing policy displayed in the staff area 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 and tidy. It is secure and has enough space to allow for safe working. There is a room where people can have conversations with team members in private.

Inspector's evidence

The dispensary was clean, tidy and well-organised, with enough space to allow for safe working. 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. A plastic screen at the medicines counter had been installed to reduce the risk of viral transmission between staff and customers.

A consultation room was available for private consultations and counselling and its availability was 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. Its working practices are mostly safe and effective. The pharmacy 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, and these were appropriately advertised at the pharmacy entrance and the medicines counter. There was wheelchair access into the pharmacy and consultation room. Team members signposted people requesting services they could not provide to nearby pharmacies or other providers such as the local council, which offered a needle and sharps collection service. Some health promotional material and information about local community groups was on display in the retail area.

Dispensing staff used colour-coded baskets to ensure that medicines did not get mixed up during the dispensing process and to differentiate between different types of prescriptions. 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. Prescriptions were marked 'CD' to identify dispensed Schedule 3 and 4 CDs awaiting collection. Pharmacy team members checked that these prescriptions were still valid before handing out the dispensed medicines. Post-dated prescriptions were highlighted to help reduce the chance of medicines being handed out too early.

Prescriptions for higher risk medicines such as warfarin, lithium and methotrexate were not routinely highlighted. However, pharmacy team members were suitably trained and explained that they would recognise these medicines and refer to the pharmacist before handing them out. The pharmacist said that he asked people about relevant blood tests and dose changes and recorded these conversations on the patient medication record. The pharmacy team were aware of the risks of using valproate-containing medicines and topiramate during pregnancy. They were also aware of the requirement to supply valproate products in original packs. They confirmed that anyone prescribed valproate or topiramate who met the risk criteria would be counselled and provided with educational information at each time of dispensing. Steroid cards, valproate information, alitretinoin information and lithium, methotrexate and warfarin monitoring booklets were available to provide to patients.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. The superintendent pharmacist explained that the service was currently at capacity and so the pharmacy was not currently accepting new patients. Compliance packs were not always labelled with descriptions to enable identification of individual medicines. So, there was a risk that people might not always be able to make informed decisions about their own treatment. On discussion, the pharmacy team understood the risks and agreed to review their dispensing processes going forward. Patient information leaflets were routinely supplied. Each patient had a clear plastic wallet that included their personal and medication details and current prescriptions. A list of people receiving their medicines in compliance packs that included their collection or delivery arrangements was displayed in the dispensary for reference. A progress tracker was also available and showed the status of each person's compliance pack at any given time. The pharmacy team also provided an NHS-

commissioned original pack and medication administration record (MAR) dispensing service for people with carers. People were referred to the pharmacy by the local health board.

The superintendent pharmacist explained that the pharmacy provided a discharge medicines review service, but local hospitals did not always send electronic copies of discharge letters to the pharmacy through the Choose Pharmacy software platform. So, the pharmacy team was often reliant on patients bringing paper copies of their discharge letters to the pharmacy. This meant that uptake of the service was relatively low. Uptake of the common ailments service was high, as it was an established service and the pharmacy also received frequent referrals from nearby GP surgeries and other local healthcare professionals. Demand for the emergency supply of prescribed medicines service was also high, as the pharmacy was open on Saturdays when the GP surgery was closed. The pharmacy offered a smoking cessation (supply only) service, an EHC (emergency hormonal contraception) and bridging contraception service and a seasonal influenza vaccination service. A supervised consumption service was also available. People supplied substance misuse treatments against instalment prescriptions were allocated a section in a dedicated file, which included their personal details and current prescriptions. The superintendent pharmacist was a qualified independent prescriber but explained that he did not currently provide any prescribing services.

The pharmacy provided a prescription collection service from six local surgeries. It also offered a medicines delivery service. Signatures were obtained for deliveries. Highlight stickers were attached to the delivery sheet if a controlled drug or a fridge line was included, and the delivery driver notified the recipient. 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.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. However, some aspirin tablets and doxycycline capsules that had been removed from their original packaging and packed into smaller quantities for supply against prescriptions had not been labelled according to legal requirements. A member of the team labelled the medicines appropriately as soon as this was pointed out using the information from the original packs. On discussion, the superintendent pharmacist understood the risks and agreed to label pre-packed medicines as soon as they were assembled going forward. Medicines requiring cold storage were kept in a well-organised medical fridge. Maximum and minimum temperatures for the fridge were recorded daily and were consistently within the required range. Controlled drugs were stored in two CD cabinets and obsolete CDs were kept separately from usable stock. Three prescriptions for dispensed CDs awaiting collection were no longer valid, as more than 28 days had elapsed since the date on the prescription. However, team members said that they would always check such a prescription with the pharmacist before handing it out. The pharmacist gave assurances that he would return the prescriptions to the GP surgery and deal with the medicines appropriately.

Medicine stock was subject to regular documented expiry date checks. 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 pharmacy team were in the process of ordering a bin from their waste contractor and explained that they separated out any cytotoxic waste they received. The pharmacy received safety alerts and recalls via its software system. A list of historic alerts was available for reference. Pharmacy team members 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. Separate measures were used for methadone to prevent cross-contamination. Triangles were used to count loose tablets and a separate triangle was available for use with loose cytotoxics. 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.

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.