General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Caerau Chemist, 68 Hermon Road, Caerau, Maesteg, BRIDGEND, Mid Glamorgan, CF34 0SU

Pharmacy reference: 1043506

Type of pharmacy: Community

Date of inspection: 08/09/2020

Pharmacy context

This is a village pharmacy. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. The inspection visit was carried out during the Covid-19 pandemic.

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. But its team members do not record all of their mistakes. And 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. It asks people to give their views about the services it provides. 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 some systems in place to identify and manage risk, including the recording of dispensing errors. However, the pharmacist and dispenser said that a recent error involving different forms of Epilim had not yet been documented, although the incident had been resolved. The pharmacist said that he would make a record of this incident as soon as possible. Records of near misses showed no entries in 2020. The dispenser said that there had been very few recent near misses and the pharmacist discussed these with her at the time of the occurrence. She said that she had recently made an error when selecting quetiapine and so she now made extra checks when dispensing different strengths and forms of this drug.

A range of written standard operating procedures (SOPs) underpinned the services provided, although these were overdue for review. Existing members of staff had signed the SOPs, but the locum dispenser had not. However, the dispenser said that the locum agency that employed her had required her to read and sign SOPs relevant to her role during her induction. She had also discussed her role and responsibilities with the pharmacist owner and understood the procedures she was required to follow.

The pharmacy received regular customer feedback from annual patient satisfaction surveys and the results of previous surveys showed that this was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in the practice leaflet displayed in the retail area. The leaflet encouraged patients to make comments and suggestions and provided contact details for the Community Health Council in Wales, which was able to facilitate the complaints process for customers who needed help with this.

Evidence of current professional indemnity insurance was available. All necessary records were kept and properly maintained, including Responsible Pharmacist (RP) records, electronic private prescription and emergency supply records, records of unlicensed specials and Controlled Drug (CD) records. CD running balances were typically checked at the time of dispensing, although some items that were not frequently dispensed were checked less often. One balance had not been checked for over a year. There is a risk that infrequent balance checks could lead to concerns such as dispensing errors or diversion being missed.

The dispenser said that she had signed a confidentiality agreement as part of her contract with the locum agency. She was aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. Information on the practice leaflet explained how and when patient information was recorded and shared. A privacy notice displayed near the consultation room advertised the way in which data was used by the pharmacy and gave details of

the pharmacy's Data Protection Officer, although this information was out of date.

The dispenser had undertaken formal safeguarding training and had access to local guidance and contact details that were available in a dedicated safeguarding file. The pharmacist confirmed that he would report concerns via the appropriate channels where necessary. The pharmacy was participating in the Safe Spaces initiative for victims of domestic abuse. Posters advertising the service were displayed on the consultation room door and inside the room itself.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy usually has enough staff to manage its workload safely. But it does not always have enough cover when staff members are absent. This means the pharmacy team might not be able to provide services as effectively as usual. Staff are properly trained for the jobs they do. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacist owner worked at the pharmacy on most days and his absences were covered by locum pharmacists. He explained that he was usually assisted by a team of four qualified dispensers, but two had recently left the pharmacy's employment and two were on a long-term leave of absence. He was in the process of recruiting to replace the staff who had left, but this was proving difficult, and for the last few weeks he had been assisted only by a full-time locum dispensing assistant. The dispensing assistant was a pharmacy student who had recently graduated and was waiting to sit an examination in order to register as a pharmacist. She said that she currently worked only as a dispenser and did not perform any tasks that were not in her job description. The pharmacist and dispensing assistant were able to manage the workload adequately during the inspection, although it was clear that it would have been managed more effectively if another trained member of staff had been present.

The pharmacist and dispenser worked well together, and the pharmacist had an obvious rapport with customers. There were no specific targets or incentives set for the services provided. The dispenser said that she was happy to make suggestions, discuss issues or raise concerns with the pharmacist owner. She said that she could also contact her current employer if she wished to report concerns externally. A whistleblowing policy in the pharmacy operations file included a confidential helpline for reporting concerns outside the organisation.

The dispenser gave a coherent explanation of the WWHAM questioning technique and gave appropriate examples of situations she would refer to the pharmacist. She said that she would feel confident refusing a sale and had done so in the past when dealing with what she considered to be an inappropriate request for a product containing codeine. Employee staff members were subject to annual performance and development reviews and could discuss issues informally with the pharmacist whenever the need arose.

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 housed in an old building and the interior décor needed refreshment. The dispensary was fairly clean and tidy, with sufficient space to allow safe working. However, some stock and prescriptions were being stored on the floor, which created a potential trip hazard. The dispenser moved these as soon as this was pointed out. The sink in the dispensary had hot and cold running water. Soap, cleaning materials and hand sanitiser were available. A digitally lockable consultation room was available for private consultations and counselling and its availability was clearly advertised. It was very cluttered but was tidied as soon as this was pointed out. 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. But it doesn't always keep prescription forms with dispensed medicines. This means that the pharmacy's team members may not always have all the information they need when they hand out the medicines. And they 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. The pharmacy stores medicines appropriately and carries out some checks to help make sure that they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a limited range of services and these were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. The dispenser said that she would signpost patients requesting services they could not provide to other nearby pharmacies. A list of local sexual health clinics was displayed in the consultation room and a list of pharmacies participating in the needle exchange service was displayed in the dispensary. An array of health promotional material was available in the retail area near the pharmacy entrance. Information about coronavirus and related safety procedures was displayed on the pharmacy entrance door.

Dispensing staff used baskets to ensure that medicines did not get mixed up during dispensing. Dispensing labels were initialled by the dispenser to provide an audit trail. However, labels did not always bear the checker's initial, which might prevent a full analysis of dispensing incidents. Insulin products were dispensed in clear bags to allow staff members to check these items at all points of the dispensing process and reduce the risk of a patient receiving the wrong medicine. Prescriptions were not always retained for dispensed items owed to patients. However, most prescriptions were scanned, and the image remained available for reference. Post-dated prescriptions were stored in a dedicated file in the dispensary to reduce the risk of these items being supplied before the appropriate date.

Stickers were used on prescriptions awaiting collection to alert staff to the fact that a CD or fridge item was outstanding. 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. Patients on high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified and there was a risk that opportunities for counselling might be missed. However, the pharmacist said that these medicines were not prescribed on a repeat basis: the surgery would only issue them as acute prescriptions when blood test results had been received. The pharmacy team were aware of the risks of valproate use during pregnancy. The dispenser said that any patients prescribed valproate who met the risk criteria would be counselled appropriately. She demonstrated that patient information was attached to original packs and said that this information would be printed from the internet and given to patients where an original pack was not supplied.

The pharmacist delivered prescriptions to vulnerable and housebound patients during his lunch hour. Prior to the pandemic, signatures had been obtained for prescription deliveries. However, to reduce the risk of viral transmission, this procedure had been changed. The pharmacist now placed a package on the patient's doorstep, knocked or rang the doorbell and waited until it was collected, verbally

confirming the person's identity. However, this information was not recorded, which meant that the pharmacy might have difficulty dealing with any complaints or queries. Any undelivered prescriptions were brought back to the pharmacy and delivery was attempted again later that day or the next.

Disposable compliance aid trays were used to supply medicines to a small number of patients. The pharmacist said that trays were labelled with descriptions to enable identification of individual medicines although there were no examples of this available during the inspection. Patient information leaflets were routinely supplied. A labelled basket for each patient contained their stock medicines and a sheet that included their personal and medication details, as well as other relevant documents such as current prescriptions and repeat order forms.

The pharmacy was not currently providing medicines use reviews, as this service had been suspended until April 2021 by Welsh Government in light of the Covid-19 pandemic. The pharmacist said that his workload currently prevented him from providing anything other than essential services.

Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were stored in two well-organised drug fridges. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in two tidy, well-organised CD cabinets. Large quantities of obsolete CDs were segregated from usable stock in one of the cabinets.

There was evidence to show that expiry date checks were carried out, although the frequency and scope of these checks were not documented and three out-of-date medicines were found. Laxity of date-checking procedures creates the risk that out-of-date medicines might be supplied. However, both the dispenser and the pharmacist said that a date-check of each item was part of their dispensing and checking processes. Date-expired medicines were disposed of appropriately, as were patient returns. The pharmacist said that he received notifications of drug alerts and recalls from his wholesalers. The dispenser said that an alert had been received that day and described how it had been dealt with appropriately. She was able to describe how she 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. The pharmacy had the necessary hardware to work in accordance with the Falsified Medicines Directive but the software had not been installed and so the pharmacy was not yet in a position to comply with legal requirements.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It uses 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 a separate triangle was available for use with loose cytotoxics. The pharmacy team had access to a range of up-to-date reference sources. They also had access to personal protective equipment (PPE) including masks, gloves and visors: the pharmacist was wearing gloves. All equipment was in good working order, clean and appropriately managed, 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 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.