General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Lansbury Chemist, 42 Maxton Court, Lansbury Park, CAERPHILLY, Mid Glamorgan, CF83 1QN

Pharmacy reference: 1043538

Type of pharmacy: Community

Date of inspection: 31/05/2019

Pharmacy context

This is a pharmacy in a council estate on the outskirts of a large town. Most people who use the pharmacy are residents of the estate. The pharmacy sells a range of over-the-counter medicines, dispenses NHS and private prescriptions and provides treatment for minor ailments.

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 always record or review their mistakes. So it is likely that some chances to learn from them might be missed. 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 know 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. The pharmacist said that near misses were not recorded. He said that he discussed any errors with staff at the time of each occurrence. Some action had been taken to reduce risk: amoxicillin 125mg/5ml and 250mg/5ml granules for reconstitution had been separated to reduce the incidence of picking errors. The pharmacist said that after some near misses involving amlodipine and amitriptyline tablets, he had given dispensing staff some extra training about the risks of picking errors with 'Look-Alike, Sound-Alike' or 'LASA' drugs. He said that in this case he had trained staff to notice the difference in spelling at the end of the drug name, i.e. 'IPINE' or 'YLINE', which had reduced the number of errors.

A range of written Standard Operating Procedures (SOPs) underpinned the services provided; these were overdue for review and there was a risk that they might not always reflect current practice. The pharmacy received regular customer feedback from annual patient satisfaction surveys; the results of the most recent survey displayed in the retail area 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, although this was not on display.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and generally properly maintained, including Responsible Pharmacist (RP), private prescription, emergency supply and Controlled Drug (CD) records. However, records of patient-returned CDs were not normally made until destruction was carried out and so there was no record of the medicines currently held. This meant that instances of diversion might go unnoticed. CD running balances were typically checked at the time of dispensing, although some items that were not frequently dispensed had not been subject to a balance check for two years. This increased the risk that concerns such as diversion or dispensing errors might be missed.

Staff had signed confidentiality agreements. They were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. A privacy notice displayed at the pharmacy entrance advertised the way in which data was used by the pharmacy and gave details of the pharmacy's Data Protection Officer. Leaflets displayed in the retail area explained how NHS Wales used prescription information to help them make better informed decisions about medicines and patient services.

The pharmacist and staff had undertaken formal safeguarding training and had access to guidance and local contact details that were displayed in the dispensary. Leaflets displayed in the retail area advertised a local organisation that provided respite for people suffering from dementia.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are properly trained for the jobs they do. They can speak up about the way the pharmacy works.

Inspector's evidence

The superintendent pharmacist oversaw all professional activities. 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 staff members had the necessary training and qualifications for their roles. One dispensing assistant had been declared competent under the grandparent clause.

There were no specific targets or incentives set for the services provided. Staff worked well together and had an obvious rapport with customers since they served a small and very close-knit community. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist. A whistleblowing policy advertising a confidential helpline for reporting concerns outside the organisation was available in the SOP file.

A member of staff working on the medicines counter gave a coherent explanation of the WWHAM questioning technique and referred to the pharmacist on several occasions for further advice on how to deal with transactions.

Staff had access to informal training materials such as articles in trade magazines and information about new products. They had recently completed training provided by NHS Wales on improving the quality of services provided. However, much of their learning was via informal discussions with the pharmacist and there was a risk that the lack of a structured training programme might restrict their ability to keep up to date with current pharmacy practice. There was no formal appraisal system in place and there was a risk that opportunities to identify training needs might be missed. However, all staff could discuss performance and development 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 clean, tidy and well-organised. The dispensary was small, but there was enough space to allow safe working, although some prescriptions were stored on the floor. The sinks had hot and cold running water and soap and cleaning materials were available. A consultation room was available for private consultations and counselling and its availability was clearly advertised.

The pharmacy was lockable and protected by external shutters and a security alarm. Some prescription only medicines were stored in the consultation room and these were protected from unauthorised access by a locked shutter. The lighting was a little dim and the temperature a little cool in some areas of the pharmacy, but the dispensary workbench was well-lit and heaters were being used for warmth.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access easily. If it can't provide a service it directs people to somewhere that can help. Its working practices are generally safe and effective. And it generally manages medicines well.

Inspector's evidence

The pharmacy offered a limited range of services which were appropriately advertised. There was a step up to the pharmacy entrance and staff said that they would go out to patients in wheelchairs and help them into the pharmacy if necessary. There was no wheelchair access into the consultation room, but the pharmacist said he could arrange appointments in the retail area during the two-hour lunch break for anyone who could not access the room. He said he could also conduct private consultations over the telephone.

Staff said that they would signpost patients requesting services they could not provide to other nearby pharmacies. A poster in the retail area advertised the local NHS Health Courier Scheme, which offered a sharps collection service. An array of health promotional material was on display in the retail area. The pharmacy took part in a local on-call palliative care rota scheme. The pharmacist explained that he was on call 24 hours a day for a period of a week approximately once every three months.

The pharmacy dispensed an average of 4000 prescription items each month. It supplied medicines in monitored dosage system trays to about 10 patients. It had no substance misuse clients.Baskets were not used for assembling prescriptions, but these were dispensed and bagged one at a time to avoid the risk of transposition of medicines. The pharmacist self-checked many prescriptions. He was aware that self-checking could increase the risk of errors but said that he always took a mental break between the dispensing and checking processes. He demonstrated that he labelled and dispensed items in one area of the dispensary and then moved these items to a separate area before checking them. The 'checked by' box on dispensing labels was initialled to provide an audit trail, but the 'dispensed by' box was not always initialled. This meant that it was unclear whether another dispenser had been involved or if the pharmacist had self-checked the item. There was a risk that the lack of a complete audit trail might prevent a full analysis of dispensing incidents.

Prescriptions were not always retained for dispensed items owed to patients and there was a risk that an accurate and complete record of the prescription details would not be available for reference at the time of supply. However, most prescriptions were scanned and the image remained available for reference. Dispensing labels were attached to 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.

The pharmacist said he asked walk-in patients prescribed high-risk medicines such as warfarin, lithium or methotrexate for relevant information about blood tests and dose changes. He said that warfarin was not prescribed on a repeat basis locally and explained that these prescriptions were only issued by clinical staff after blood test results had been received.

The pharmacy carried out regular high-risk medicines audits commissioned by the Local Health Board. The pharmacist was aware of the risks of valproate use during pregnancy. He said that one patient prescribed valproate who had met the risk criteria had received counselling and relevant patient information. He demonstrated that this intervention was logged on the patient information record (PMR). The information pack for valproate patients was available in the dispensary.

The pharmacy did not routinely provide a delivery service but the pharmacist said that he personally delivered MDS trays to a few patients in the local area. Staff collected repeat prescriptions on behalf of patients from three local surgeries. Disposable MDS trays were used to supply medicines to a number of patients. Trays were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied.

Medicines were obtained from licensed wholesalers and stored appropriately including those requiring cold storage. CDs were stored in a tidy, well-organised CD cabinet that was open with the key in the door when the inspection began, compromising the security of these medicines. The pharmacist locked the cabinet as soon as this was pointed out and stored the key on his person. Obsolete CDs were segregated from usable stock.

Stock was regularly date-checked, although there was no audit trail to show who had conducted the check. Date-expired medicines were disposed of appropriately, as were patient returns.
The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist 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. Drug recalls were printed, filed and signed to show that they had been actioned.
The pharmacy was fully compliant with the Falsified Medicines Directive.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services. Its 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. Triangles were used to count tablets and staff said they would be washed after use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources.All equipment was clean and in good working order, although there was no evidence to show 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.