General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: St. Athan Pharmacy, The Square, St Athan, BARRY, South Glamorgan, CF62 4PF

Pharmacy reference: 1043658

Type of pharmacy: Community

Date of inspection: 17/11/2023

Pharmacy context

This is a village pharmacy. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a very limited range of services including a local prescription collection 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 record their mistakes so they can learn from them. But they do not always 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. Very few near misses had been recorded in recent months but the pharmacist said he was confident that most incidents had 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 they came to light. And that any patterns or trends that emerged were discussed with the whole team. Members of the pharmacy team were able to describe some recent action they had taken to reduce risk. For example, they had used a shelf marker to highlight different pack sizes of codeine tablets following some near misses involving incorrect quantities. A range of written Standard Operating Procedures (SOPs) underpinned the services provided and these had been read and signed by the pharmacy team. However, the SOPs were overdue for review and so there was a risk that they might not always accurately reflect the activities currently carried out by the pharmacy.

The pharmacist said that verbal feedback they had received about the services provided by the pharmacy was mostly positive. He explained that a formal complaints procedure was in place, but he was in the process of reviewing it and so it was not available during the inspection. The pharmacy's complaints procedure was not advertised, so people might not always understand the best way to raise concerns. However, a leaflet that provided information about the NHS complaints procedure 'Putting Things Right' was available in the consultation room.

Evidence of current professional indemnity insurance was available. Pharmacy records were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. However, the pharmacist had not made a record in the RP register that day to show the time at which he had taken charge of the safe and effective running of the pharmacy. He rectified this immediately. Most CD running balances were checked every three to four weeks. However, some controlled drugs that were not frequently dispensed were not checked as often. Which meant that any discrepancies might not be identified promptly. Three random balances were checked and one was found to be incorrect. The pharmacist quickly identified the error and corrected it.

Pharmacy team members had signed confidentiality agreements as part of their contracts. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. They had undertaken formal safeguarding training and had access to local guidance and contact details in the SOP file and via the internet.

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. His absences were covered by a regular locum pharmacist. The support team consisted of five part-time dispensing assistants. 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. Pharmacy team members had the necessary training and qualifications for their roles.

There were no specific targets or incentives set for the services provided. Pharmacy team members 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. A whistleblowing policy was available in the staff handbook, although this only included information about the company's internal whistleblowing procedures. However, pharmacy team members understood that they could contact the GPhC or the local health board 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. 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. A suite of rooms above the pharmacy was occupied by a private therapist who ran an aesthetics clinic. The clinic was sometimes open for longer hours than the pharmacy. It had a separate entrance to prevent unauthorised access to the pharmacy by the therapist or her clients. The sinks had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff and patient use. A consultation room was available for private consultations and counselling. Its availability was clearly advertised. A semi-private screened area of the medicines counter was used for quiet conversations and counselling. 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 medicines appropriately.

Inspector's evidence

The pharmacy offered a very limited range of services that were not advertised. The pharmacy team signposted people requesting services they could not provide to other nearby pharmacies or healthcare services, such as local GP surgeries. There was wheelchair access into the pharmacy and consultation room. A section of the medicines counter had been lowered to make it easier to use for people in wheelchairs. Some health promotional material was on display in the retail area.

Dispensing staff used a colour-coded 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. Prescriptions were usually attached to dispensed items awaiting collection, but some prescriptions had not been retained. This meant that the pharmacy team might not always have full information about what had been prescribed. 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. The pharmacy dispensed medicines against some faxed prescriptions from local surgeries. There were mechanisms in place to ensure that Schedule 2 or 3 CDs were only ever supplied against the original prescription.

Controlled drugs (CDs) requiring safe custody and fridge lines were not dispensed until the patient or their representative arrived at the pharmacy to collect them. Prescriptions for these items were stored in a designated area of the dispensary and dispensing labels were attached to show that the CD or fridge item was outstanding. Notes were attached to prescriptions awaiting collection to alert staff to the fact that the pharmacist wished to speak to the patient or their representative at the point of handout. There was no strategy in place to routinely identify Schedule 3 or 4 CDs that were awaiting collection. Which meant that members of the pharmacy team might not always be able to check that the prescription was still valid at the time of supply.

People on high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified so some counselling opportunities might be missed. 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, and shelves containing these products were marked as a reminder. The superintendent pharmacist said that two patients prescribed valproate who met the risk criteria had been identified. He explained that their representatives 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 number of people. Compliance aids were labelled with descriptions to enable identification of individual medicines. Patient information leaflets were not always supplied. This meant that people might not always have all the information they needed for them to make informed decisions about their own treatment. People receiving compliance aids had a section in either a dedicated file or a labelled basket

that included their personal details, current prescriptions, and any other relevant documents such as hospital discharge letters. A progress log was available for reference and showed the status of each person's compliance aid at any given time.

The pharmacy provided a prescription collection service from two local surgeries. It did not offer a routine prescription delivery service, but members of the pharmacy team could deliver urgent prescriptions when necessary. The pharmacist had recently undergone accreditation to provide the common ailments service, the EHC service, the Emergency Supply of Prescribed Medicines service and the influenza vaccination service. He explained that the pharmacy would soon be able to offer these services to the public pending authorisation from the local health board. The pharmacy currently provided a private dispensing service to a nearby Ministry of Defence air force base.

Stock medicines were obtained from licensed wholesalers and were 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.

Stock was subject to regular documented expiry date checks. Date-expired medicines were disposed of appropriately, as were patient returns. The pharmacy received drug alerts and recalls via its NHS email account. These were printed and filed for reference. 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 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. Triangles and a capsule counter were used to count tablets and capsules. These were washed after being used to count loose cytotoxics. The pharmacy had a range of up-to-date reference sources. All electronic equipment was in good working order, although it had not been tested since 2018. 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.

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.