General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Llandaff Pharmacy, 18a High Street, Llandaff, CARDIFF, South Glamorgan, CF5 2DZ

Pharmacy reference: 1043708

Type of pharmacy: Community

Date of inspection: 27/06/2019

Pharmacy context

This is a high street pharmacy in a residential area of north Cardiff. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a wide range of services including emergency hormonal contraception, treatment for minor ailments and a seasonal 'flu vaccination service for NHS and private patients. The pharmacy changed ownership in March 2018.

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	1.4	Good practice	The pharmacy is receptive to customer feedback and improvements have been made as a result of this feedback.
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	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
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. But details are sometimes missing, so some records may not be reliable or meet legal requirements. It asks people to give their views about the services it provides and uses this information to improve services. It keeps people's private information safe. And its 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 and some near misses. Records of dispensing errors were historic and the pharmacist said that she could not remember any errors having occurred since the pharmacy changed ownership in March 2018. The only records of near misses made since the change of ownership had been recorded over the period of a week as a short audit. The pharmacist said that she tended to discuss near misses with relevant staff at the time of each occurrence rather than analyse all patient safety incidents on a regular basis to identify patterns and trends.Some action had been taken to reduce risk: ramipril capsules and tablets had been separated to reduce the incidence of picking errors. However, a pack of quinine bisulphate 300mg tablets was stored with quinine sulphate 300mg tablets. Staff said that this was a mistake and moved the quinine bisulphate tablets to their correct storage position in a separate drawer as soon as this was pointed out.

A range of written standard operating procedures (SOPs) underpinned the services provided. Most had been signed by the regular staff members, although the signature sheets sometimes covered a suite of similar SOPs rather than individual procedures. This meant that if new versions or procedures were added it might not be clear if staff had been trained to follow them. Two recently-recruited pharmacy students had not signed to show they had read and accepted the procedures. However, the pharmacy student present was observed to follow SOPs relevant to her role and could describe her responsibilities. Some responsible pharmacist (RP) procedures had not been signed by all staff but staff present understood which activities could and could not take place in the absence of the RP.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The pharmacist said that recent feedback was mostly positive. However, customers had commented that the retail area needed updating and did not realise the pharmacy had a consultation room to allow them to talk to the pharmacist in private. She explained that as a result the superintendent pharmacist had decided to refit the pharmacy and the work had finished a few weeks previously. The refit had been carried out to a high standard and the consultation room was now more visible. 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, specials procurement and controlled drug (CD) records. However, there were occasions on which the pharmacist had not signed out of the RP register to show the time at which they

had relinquished responsibility for the safe and effective running of the pharmacy. In addition, specials procurement records were not always marked with patient details and some headings were missing from CD registers. 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 increased the risk that diversion might go unnoticed.

Most staff had signed confidentiality agreements. The pharmacist said that she had discussed the importance of patient confidentiality with the newest members of staff during their induction. Staff present, including one of the new members of staff, were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately.

The pharmacist and most staff apart from the pharmacy students had undertaken formal safeguarding training. They had access to guidance and local contact details that were available via the internet. Staff, including one of the pharmacy students, were able to identify different types of safeguarding concerns. They said that they would refer these to the pharmacist, who confirmed that she would report concerns via the appropriate channels where necessary.

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 regular pharmacist manager oversaw professional activities on three or four days each week. The superintendent pharmacist covered her absences. 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. Staff members had the necessary training and qualifications for their roles. Two pharmacy students and three trainee dispensing assistants worked under the pharmacist’s supervision. The trainee dispensing assistants were long-term members of staff who had originally been certified as competent under the grandparent clause. The pharmacist said that the company had recently recruited a pharmacy technician who would be starting work at the pharmacy in September 2019.

There were no specific targets or incentives set for the services provided. Staff worked well together and said that they were happy to make suggestions within the team. They said that they felt comfortable raising concerns with the pharmacist or superintendent pharmacist. A whistleblowing policy that included a confidential helpline for reporting concerns outside the organisation was available in the SOP file.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients and referred to the pharmacist on several occasions for further advice on how to deal with a transaction. Staff had access to informal training materials such as communications from the Local Health Board, articles in trade magazines and information about new products from manufacturers. They had recently completed training provided by NHS Wales on improving the quality of services provided. There was no formal appraisal system in place, but all staff could discuss performance and development issues informally with the pharmacist or superintendent pharmacist whenever the need arose. However, there was a risk that the lack of a structured training and development programme might restrict the ability of individuals to 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. The dispensary was small, but there was enough space to allow safe working. However, some stock was temporarily stored on the dispensary floor and there were some empty tote boxes on the floor of the retail area, although these did not constitute a trip hazard.

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 lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy promotes the services it provides so that people know about them and can access them easily. 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 generally manages medicines well. But it doesn't always keep prescription forms for the dispensed medicines waiting to be collected. This means that the pharmacy's team members will not always have all the information they may need when the medicines are handed out.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was a small step up to the pharmacy entrance, but the pharmacist said that a portable ramp was available. There was wheelchair access into the consultation room. A signposting file was available in the consultation room. Staff said that they would signpost patients requesting services they could not provide to other nearby pharmacies.

The pharmacist explained that she had recently visited the local surgery to discuss and promote services as part of a health board-funded collaborative working initiative. Recent visits had involved discussions around the repeat dispensing service, the common ailments service, the All-Wales EHC service and the DMR service.

The pharmacy dispensed an average of 9,000 prescription items each month. It supplied medicines in monitored dosage system trays for about 100 patients. 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. Prescriptions awaiting collection were annotated to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. However, 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.

Prescriptions were not always retained for dispensed items. Most prescriptions were scanned and the image remained available for reference. The pharmacist said that she usually retained prescription forms that could not be scanned as well as prescriptions for all Schedule 2 and 3 items. However, there was no evidence to confirm this and there was a risk that prescriptions for some Schedule 3 CDs might not be marked with the date of supply at the time the supply was made, as required by legislation. Supplies had recently been made against three private prescriptions that had not been signed by the prescriber. This called the pharmacy's checking procedures into question and there was a risk that supplies had not been made in accordance with the directions of the prescriber.

Patients prescribed high-risk medicines such as warfarin, lithium or methotrexate were not routinely identified and there was a risk that opportunities for counselling might be missed. The pharmacy carried out regular high-risk medicines audits commissioned by the Local Health Board. These audits were used to collect data about the prescribing, supply and record-keeping associated with high-risk medicines to flag up areas where risk reduction could be improved within primary care. Results from a recent audit showed that 24 patients prescribed warfarin did not have their INR result recorded on the patient medication record (PMR). The pharmacist said that as a result she had introduced a change in

procedure that week: prescriptions for warfarin would be routinely marked and patients or their representatives would then be asked for information about blood tests and dosage changes. This information would be recorded on the PMR. She produced documentary evidence of a staff meeting where this had been discussed.

The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that the pharmacy did not currently have any patients prescribed valproate who met the risk criteria. However, she understood that such patients should be counselled appropriately and provided with appropriate information. A valproate information pack was available in the consultation room. Both pharmacists were registered to supply clozapine against valid prescriptions and undertook annual training to ensure their knowledge was up to date. The pharmacist said that two patients currently received clozapine in MDS trays.

The pharmacist said that signatures were obtained for prescription deliveries, with separate signatures obtained for CDs, although there were no recent examples available. If a patient or their representative was not at home to receive a delivery, the delivery driver usually put a notification card though the door and brought the prescription back to the pharmacy. However, records showed that prescriptions were occasionally posted through letterboxes at the patient's request. The pharmacist said that this was always at her discretion after risks had been assessed and was a last resort rather than a routine occurrence.

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. Each patient had a section in one of several dedicated files that included their personal and medication details, collection or delivery arrangements, details of any messages or queries for communication purposes and any relevant documentation, such as current repeat prescriptions. It also included a slip that was marked to show who had assembled, checked and delivered or collected each MDS tray, with dates.

Medicines were obtained from licensed wholesalers and generally stored appropriately including those requiring cold storage. However, some medicines that had been removed from their original packaging were not adequately labelled either as stock or named-patient medication. This increased the risk of error and did not comply with legislative requirements. CDs were stored appropriately in a large, tidy, well-organised CD cabinet and obsolete CDs were segregated from usable stock.

There was some evidence to show that regular expiry date checks were carried out, but the frequency and scope of these checks were not documented. This created a risk that date-expired medicines might be supplied and some out-of-date medicines were found in the drug fridge and on dispensary shelves. The pharmacist said that an expiry date check formed part of her routine accuracy checking procedure.

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 they were in the process of ordering a bin from their waste contractor and would segregate any cytotoxic waste they received in the meantime.

The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist was able to describe how she had recently dealt with a drug recall for valsartan by quarantining affected stock and returning it to the relevant supplier. 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 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. Triangles and a capsule counter were used to count tablets and capsules. Staff said that these were 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. There was no evidence to show that it had recently been tested. However, the pharmacist said that most equipment was quite new as it had been purchased when the company took ownership of the pharmacy in March 2018.

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.