General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Tongwynlais Pharmacy, 17 Merthyr Road, Tongwynlais, CARDIFF, South Glamorgan, CF15 7LF

Pharmacy reference: 1043718

Type of pharmacy: Community

Date of inspection: 21/08/2020

Pharmacy context

This is a village pharmacy on the outskirts of Cardiff. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a range of services including emergency hormonal contraception and treatment for minor ailments. This 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	1.8	Good practice	Safeguarding is an integral part of the culture within the pharmacy
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 some of their mistakes. But 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 are good at recognising and reporting 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. There were no recent records of near misses. Staff said that the pharmacist tended to discuss near misses with them 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 risks that had been identified: for example, caution stickers had been used to alert staff to the risks of picking errors with imipramine, indapamide, amlodipine and amitriptyline following dispensing incidents. A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. At the start of the pandemic, staff had received informal risk assessments and one member of staff had been temporarily furloughed as a result. The Responsible Pharmacist notice displayed was incorrect, but the pharmacist owner remedied this as soon as it was pointed out to him.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. Staff said that the results of the most recent survey showed that this was mostly positive. They said that the pharmacy had recently had a great deal of positive feedback from village residents, who had thanked the pharmacy team for helping people during the difficult circumstances caused by the pandemic. The pharmacy used the NHS complaints procedure 'Putting Things Right' to deal with complaints and staff had read and signed a copy of this. A poster advertising the complaints procedure was displayed on the consultation room door, although this was not visible from the retail area. Information about how to make complaints was included in the practice leaflet which was on display at the front of the shop.

A current certificate of professional indemnity insurance was on display. Responsible pharmacist (RP), private prescription and unlicensed specials records were kept and properly maintained. No records of emergency supplies were available, but staff said that they could not remember the last time such a supply had been made. Some headings and entries in the CD register had been altered by obliteration, with no audit trail to show who had been responsible for the amendment. This meant that it might be difficult for the pharmacy team to fully resolve queries or deal with errors effectively.

Staff said that they had signed confidentiality agreements. They understood the importance of confidentiality and were aware of the need to protect confidential information. They were able to identify confidential waste and demonstrated that it was disposed of appropriately. The pharmacist and the two dispensing assistants had individual passwords to access the pharmacy computer system. A poster at the pharmacy entrance explained how NHS Wales used prescription information to help them make better informed decisions about medicines and patient services.

The pharmacist had undertaken level two safeguarding training and had access to guidance and local contact details via the internet. Staff had received in-house training and were able to identify different types of safeguarding concerns. They said that after having concerns about an elderly patient who lived alone and was confused, they had contacted her GP who had carried out a home visit. Arrangements had subsequently been made for the patient to be placed in a retirement home close to her family. Staff had also helped a vulnerable person who could not read or write and had run out of medication by contacting the surgery on his behalf and arranging for a prescription to be generated so that they could make a supply. A chaperone policy was advertised in a poster displayed on the consultation room door and inside the room itself. Information about support groups and services for carers was displayed in the consultation room and near the dispensary.

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

One of the pharmacist owners worked at the pharmacy on most days. He was assisted by two dispensing assistants and a medicines counter assistant. Certificates were displayed as evidence that staff members had the necessary training and qualifications for their roles. The pharmacy was quiet, and staff worked well together to manage the workload effectively. The pharmacy served a small and close-knit community and staff members had an obvious rapport with customers. There were no specific targets or incentives set for the services provided. Staff said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist owners. A whistleblowing policy in the SOP file had been signed by all staff and included details of a confidential helpline for reporting concerns outside the company. The GPhC's Guidance on Raising Concerns was also available in the SOP file.

A member of staff working on the medicines counter understood and demonstrated appropriate questioning techniques for selling over-the-counter medicines. She 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 articles in trade magazines, training modules on counter skills provided by suppliers and information about new products from manufacturers. They said that much of their learning was via informal discussions with the pharmacist. There was no formal appraisal system in place, but all staff could informally discuss performance and development issues 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 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, very tidy and well-organised, with enough space to allow safe working. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use. Dispensary surfaces were wiped down with disinfectant twice daily. Personal protective equipment (PPE) was available for staff use and the pharmacy team were wearing face masks and visors. A one-way system with floor markings at two-metre intervals had been implemented in the retail area to encourage customers to adhere to social distancing requirements. A consultation room was available for private consultations and counselling and its availability was clearly advertised. The room doubled as an office and access was at the entrance to the dispensary. Staff said that patients were escorted into the room and they made sure that no confidential information was visible. The lighting and temperature in the pharmacy were generally appropriate, although the area in which the CD cabinet was located was not well lit, increasing the risk of errors.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally 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. It stores medicines appropriately and carries out some checks to make sure they are in good condition and suitable to supply. But pharmacy team members 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.

Inspector's evidence

The pharmacy offered a range of services that were advertised in the practice leaflet. The entrance to the pharmacy was not flat, but staff said that people in wheelchairs were able to access it easily. There was no wheelchair access into the consultation room. However, the pharmacist said that as the pharmacy currently operated a 'one in, one out' restricted access policy, he was able to lock the entrance door and provide a private consultation in the retail area for people who could not access the room. He could also conduct private consultations over the telephone if necessary.

Staff said that they would signpost people requesting services they could not provide to other nearby pharmacies. A notice at the medicines counter advised people that the local GP practice was currently closed and signposted them to its sister surgery. Lists of pharmacies participating in the local health board's palliative care and needle exchange schemes were displayed in the dispensary. Some health promotional material and details of local community support groups were on display in the retail area. Information about coronavirus and related safety procedures was displayed on the pharmacy entrance door.

Baskets were used to assemble prescriptions. This helped 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 not always retained for dispensed items owed to patients. However, most prescriptions were scanned and the image remained available for reference. One prescription awaiting collection was over six months old and so no longer valid. A dispensing assistant removed it from the retrieval area as soon as this was pointed out. 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 that included CDs requiring safe custody were stored in a dedicated area of the dispensary. Staff said that these items were only added when the patient or their representative attended to collect the prescription. Stickers and notes were attached to prescriptions awaiting collection to alert staff to the fact that a fridge item was outstanding, or that the pharmacist wished to speak to the patient or their representative at the point of handout.

Patients prescribed 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. Staff said that walk-in patients prescribed these medicines were asked for relevant information about blood tests and dose changes. The pharmacy team were aware of the risks of valproate use during pregnancy. Staff said that any patients prescribed valproate who met the risk criteria would be counselled and provided with appropriate information. The information pack for valproate patients was available in the dispensary office. 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.

Demand for the prescription delivery service had increased as a result of the pandemic. The service was managed by members of staff. The delivery driver 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. If a controlled drug requiring a CD register entry was delivered, the delivery driver's name was recorded in the register as an audit trail. 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.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a number of patients. The trays were labelled with descriptions to enable identification of individual medicines. Staff said that patient information leaflets were supplied monthly. A list of patients was displayed in the dispensary for reference. Each patient had a labelled drawer that contained their stock medicines.

There was very little uptake of most enhanced and advanced services. 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 pharmacy was not planning to provide the influenza vaccination service during the 2020/21 season.

Medicines were obtained from licensed wholesalers and stored appropriately. Controlled drugs were stored in a safe that was securely bolted to the floor. Two boxes of patient-returned 10mg and 30mg MST Continus tablets had been segregated from usable stock but were not clearly marked to show that they were obsolete. There was a risk they could be confused with stock medicines, as they were in date and the dispensing labels had been removed. However, pharmacy team members said that they could identify the boxes as patient returns because they were stored on a shelf they knew should only be used for obsolete CDs. Two boxes of dexamphetamine tablets with an expiry date of February 2020 had not been segregated from usable stock. This created a risk that out-of-date medicines could be supplied in error. The pharmacist segregated these as soon as this was pointed out to him.

Medicines requiring cold storage were stored in a small, well-organised drug fridge. There was ice in the freezer compartment and staff said that the fridge was due to be defrosted. Maximum and minimum temperatures were recorded daily. A minimum temperature below two degrees Celsius had been recorded on one recent occasion. Staff could demonstrate how they read and reset the drug fridge thermometer. On discussion, they understood that if the temperature fell outside the range of two and eight degrees Celsius the pharmacist should be informed, and remedial action taken if necessary.

Stock was date-checked regularly, and a sticker was placed on each shelf to record the date on which stock was last checked. However, no historic records were kept, which meant the pharmacy might have difficulty dealing with any complaints or queries. Short-dated items were highlighted with stickers. Date-expired medicines were disposed of appropriately, as were patient returns. The pharmacy received drug alerts and recalls via its NHS email account. Staff were able to describe how they would deal with drug recalls 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 able 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. Its 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. One 10ml measure was not validated, but 10ml water measured in this also measured 10ml in a validated measure. Triangles and a tablet counter were used to count tablets and a separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. Equipment was clean and most was 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 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.