General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Knights Danescourt Pharmacy, 2 Rachel Close, Danescourt, CARDIFF, South Glamorgan, CF5 2SH

Pharmacy reference: 1043736

Type of pharmacy: Community

Date of inspection: 26/07/2024

Pharmacy context

This pharmacy is next door to a medical centre in a western suburb of Cardiff. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy offers a range of services including provision of emergency hormonal contraception, treatment for minor ailments and a seasonal flu vaccination service for both NHS and private patients. Substance misuse services are also available.

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 its team members work safely. They record and review their mistakes so they can learn from them. And they take action to help stop mistakes from happening again. The pharmacy keeps the records it needs to by law. But details are missing from some of the records, so it may not always be able to show exactly what has happened if any problems arise. 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 systems in place to identify and manage risk, including an electronic platform for recording dispensing errors and near misses. The pharmacist was unable to access records of patient safety incidents during the inspection. However, she explained that the superintendent's team could view all records for analysis. And they regularly shared learning points from patient safety incidents with all branch teams via email. The pharmacist was observed recording a near miss that was identified during the inspection. She confirmed that she discussed near misses with relevant team members at the time they came to light. And that any patterns or trends that emerged were discussed with the whole team. Action had been taken to reduce some risks that had been identified. For example, following near misses involving colchicine and cyclizine tablets and sertraline and sildenafil 25mg tablets, these items had been distinctly separated on dispensary shelves. This helped to reduce the risk of selection errors.

A range of standard operating procedures (SOPs) underpinned the services provided and these had recently been reviewed. Pharmacy team members had not yet signed the reviewed SOPs to show that they had read and understood them. However, a note from the superintendent pharmacist confirmed that there had been no changes. And team members were observed following SOPs relevant to their role. An appendix of the Staff Roles and Responsibilities SOP showing the tasks that each team member was expected to perform had not been completed. However, members of the pharmacy team were able to clearly describe their roles and responsibilities. And they were able to describe the activities that could not take place in the absence of the responsible pharmacist.

The pharmacy team explained that verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place and was advertised in the retail area. A notice near the medicines counter advertised the NHS complaints procedure 'Putting Things Right' and gave details of other local and national organisations that provided independent advice and support for people making a complaint.

Evidence of current professional indemnity insurance was available. All necessary records were up to date, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed medicines and controlled drug (CD) records. Most records were properly maintained. However, electronic records of emergency supplies did not always include the nature of the emergency. This meant that it might be difficult for the pharmacy team to demonstrate why the supply was appropriate. Running balances for controlled drugs were typically checked monthly.

Members of the pharmacy team understood the need to protect confidential information, for example,

by offering people the use of the consultation room for private conversations. They were able to identify confidential waste and demonstrated how they would dispose of this appropriately. Two privacy notices displayed in different parts of the retail area included information about the ways in which personal information was used and managed. However, the details of the pharmacy's data protection officer were different for each notice, which was misleading. The pharmacist agreed to find out which details were correct and remove the incorrect notice.

The pharmacist had undertaken advanced formal safeguarding training. Most other team members had undertaken basic formal safeguarding training. They had access to guidance and local safeguarding contact details that were available in a safeguarding file in the dispensary. A summary of the pharmacy's chaperone policy was advertised in a notice displayed on the consultation room door. Pharmacy team members were aware of the Ask for Ani and Safe Spaces domestic violence schemes but said that as far as they were aware there had not yet been any requests for these services. Posters advertising the services were displayed in the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are properly trained for the jobs they do. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacist manager worked at the pharmacy on most days. The pharmacy team consisted of two part-time dispensing assistants (DAs), a part-time medicines counter assistant (MCA) and a recently recruited member of staff who worked on the medicines counter. The pharmacist explained that this team member always worked under supervision and was shortly to be enrolled on an accredited training course. Another DA was absent on long-term leave. However, the staffing level appeared adequate for the services provided and the team were able to manage the workload effectively. The pharmacist explained that relief dispensers employed by the company or locum DAs were used to cover absences or help manage the workload if needed.

Members of the pharmacy team working on the medicines counter were observed using appropriate questions when selling over-the-counter medicines to people. And they referred to the pharmacist on several occasions for further advice on how to deal with transactions. A list of WWHAM questions was displayed on the medicines counter for reference. The team had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They said that much of their learning was via informal discussions with the pharmacists. The lack of a structured training programme meant that individuals might not keep up to date with current pharmacy practice. There was no formal appraisal system in place, which meant that development needs might not always be identified or addressed. But all team members could informally discuss performance and development issues with the pharmacist whenever the need arose.

There were no specific targets or incentives set for the services provided. Pharmacy team members worked well together and had an obvious rapport with customers. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist and area manager. A whistleblowing policy was available on the pharmacy's intranet system and described the pharmacy's internal process for raising concerns. On discussion, team members understood that they could contact the GPhC if they wished to raise a concern outside the organisation.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and well-organised. It is secure and has enough space to allow safe working. Its layout protects people’s privacy.

Inspector's evidence

The pharmacy was clean, tidy and well-organised, with enough space to allow for safe working. Some stock medicines and dispensed prescriptions awaiting collection were being temporarily stored on the floor, but they did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. A poster illustrating hand washing techniques was displayed above the dispensary sink.

A consultation room was available for private consultations and counselling, and its availability was clearly advertised. The lighting and temperature in the pharmacy were generally appropriate. One area of the dispensary was quite dark as a light bulb had broken that morning. The pharmacy team gave assurances that they would replace the bulb later in the day. A medicines fridge was situated in the area and there was not enough light to see its contents clearly. Pharmacy team members explained that they used a torch when accessing the fridge and would do so until the bulb was replaced.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally easy for people to access. The pharmacy's working practices are generally safe and effective. It largely stores medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised in the pharmacy window. There was flat access into the pharmacy and consultation room. However, wheelchair access to the pharmacy entrance was impeded by three large dustbins. The pharmacist agreed to re-site these away from the pharmacy entrance. A signposting file provided by the local health board was available and pharmacy team members said that they signposted people requesting services they could not provide to other nearby pharmacies. Some health promotional material was displayed in the pharmacy window and in the retail area.

Dispensing staff used colour-coded baskets to help ensure that medicines did not get mixed up during dispensing and to differentiate between different types of prescriptions. The dispenser and accuracy checker initialled dispensing labels to provide an audit trail. Controlled drugs requiring safe custody and fridge lines were dispensed in clear bags to allow staff members to check these items at all points of the dispensing process. This helped to reduce the risk of a person receiving the wrong medicine. Stickers were placed on prescription bags to alert team members to the fact that a CD requiring safe custody or fridge item was outstanding. There was no strategy in place to routinely identify Schedule 3 or 4 CDs that were awaiting collection, so there was a risk that these items might be supplied past their 28-day validity period. On discussion, the pharmacy team understood the risks and agreed to review their dispensing processes going forward.

Prescriptions for people prescribed higher-risk medicines such as warfarin, lithium and methotrexate were usually marked with stickers to identify the patient for counselling. However, one prescription for methotrexate was seen that had not been marked in this way. The pharmacist said that she asked people prescribed higher-risk medicines about relevant blood tests and dose changes and demonstrated that she recorded these conversations. The pharmacy team were aware of the risks of using valproate-containing medicines during pregnancy. They were also aware of the requirement to supply valproate products in original packs. The pharmacist confirmed that any people prescribed valproate who met the risk criteria would be counselled appropriately and provided with information at each time of dispensing.

The pharmacy provided medicines in disposable multi-compartment compliance packs to a few people in the community. Compliance packs were labelled with descriptions of the medicines they contained so that individual medicines could be easily identified. Patient information leaflets were routinely supplied. Each person was allocated a clear plastic wallet 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 repeat prescription order forms and hospital discharge letters. The pharmacy also provided an original pack and MAR (medication administration record) chart service to some people in a local assisted living facility.

Uptake of the common ailments service was steady, as the pharmacy had been providing the service for many years and the community were aware that they could access treatment in this way. The pharmacy also received referrals for the service from the adjacent GP surgery. Uptake of the discharge medicines review (DMR) service and the emergency hormonal contraception (EHC) service was low. Demand for the emergency supply of prescribed medicines service was also relatively low, as the pharmacy was not open at weekends and kept similar opening hours to local surgeries on weekdays, so people were usually able to obtain a valid prescription from a GP in an emergency. The pharmacy offered a seasonal influenza vaccination service. And a supervised consumption service was available, although the pharmacy currently had no people using this service.

The pharmacy provided a prescription collection service from three local surgeries. It also offered a free medicine delivery service. The delivery driver used a delivery sheet to record each delivery that was made. Patients or their representatives signed to show if they had received a controlled drug as an audit trail. In the event of a missed delivery, the delivery driver put a notification card though the door and brought the medicines back to the pharmacy.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in a medical fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. Controlled drugs were stored in two CD cabinets. However, large quantities of obsolete CDs awaiting destruction were stored in two separate lockable cupboards which did not comply with controlled drug regulations. The pharmacist gave assurances that these CDs would be destroyed as soon as possible. Following the inspection, the regional manager confirmed that he was in the process of arranging for the obsolete CDs to be destroyed appropriately.

Medicine stock was subject to regular expiry date checks. These were documented, and short-dated items were highlighted. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacist explained that an expiry date check was also part of her final accuracy check. A scheme run in association with NHS Wales allowed the pharmacy to recycle returned inhalers. The pharmacy received drug alerts and recalls via its NHS email account which was checked daily. The pharmacy team described how they would deal with a drug recall appropriately by contacting patients where necessary, quarantining affected stock and returning it to the supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide the services that it offers. And it makes sure these are always safe and suitable for use. Its team members use the 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 were used to count loose tablets. A separate triangle was available for use with loose cytotoxics to prevent cross-contamination. The pharmacy had a range of up-to-date reference sources. All equipment was in good working order, clean and appropriately managed. Evidence showed 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 consultation room was used for private conversations and counselling. The pharmacy software system was protected with a password and computer screens were not visible to people using the pharmacy. Dispensed prescriptions could be seen from the retail area, but no confidential information was visible.

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.