General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sylvia Williams Chemist, 34 High Street, Cowbridge, South Glamorgan, CF71 7AG

Pharmacy reference: 1043768

Type of pharmacy: Community

Date of inspection: 02/07/2024

Pharmacy context

This pharmacy is on a high street in a market town in the Vale of Glamorgan. 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 influenza vaccination 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. And they take action to help reduce the chance of similar mistakes from happening again. The pharmacy 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. Pharmacy team members 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. There were no dispensing error records available to view, but the superintendent pharmacist explained that the pharmacy team had not made any errors since the pharmacy had changed ownership in May 2024. Near misses were recorded regularly. Dispensing team members explained that the pharmacists discussed any patterns or trends that emerged with the whole team. Action had been taken to reduce some risks that had been identified. For example, different strengths of quetiapine tablets and different forms of ramipril had been distinctly separated in dispensary storage drawers following some near misses with these medicines.

A range of standard operating procedures (SOPs) underpinned the services provided. However, these were overdue for review and there was a risk that they might not reflect the activities being undertaken in the pharmacy. The superintendent pharmacist explained that he was in the process of reviewing the SOPs and producing new versions where appropriate. Pharmacy team members had signed the SOPs to show that they had read and understood them. Members of the team were able to describe their roles and responsibilities. A dispensing assistant who worked as an accuracy checker explained that she could check any repeat prescription items that had been marked as clinically checked by a pharmacist, provided she had not been involved in dispensing or labelling these. She did not check prescriptions for children under the age of 12, or prescriptions that included new medicines or dosage changes. A trainee dispensing assistant was able to describe 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, although this was not advertised in the retail area. So people using the pharmacy might not understand the best way to raise concerns.

Evidence of current professional indemnity insurance was available. Records were generally properly maintained, including responsible pharmacist (RP), private prescription, unlicensed specials, emergency supply and controlled drugs (CD) records. The pharmacist had not completed the RP record on the day of the inspection but did so as soon as this was pointed out to her. Electronic emergency supply records did not always include the nature of the emergency. This might make it difficult to resolve queries or investigate errors. Running balances for CDs were typically checked monthly by two members of the dispensing team. Records of patient-returned CDs were not always made at the time they were received by the pharmacy and there was no record of the medicines currently held. This meant that diversion might go unnoticed. A dispensing assistant said that this was an oversight and gave assurances that she would make a record of these medicines as soon as possible.

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

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are appropriately trained for the jobs they do or are enrolled on a suitable training course for their role. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacy was run using several regular locum pharmacists. The superintendent pharmacist was also present at the pharmacy on most days. The pharmacy team consisted of three dispensing assistants (DAs), two trainee DAs, a medicines counter assistant (MCA) and an untrained member of staff who worked in the retail area. Two of the DAs were enrolled on a pharmacy technician and accuracy checker training course, and one was a qualified accuracy checker. Trainees worked under the supervision of the pharmacist and other trained members of staff. The untrained member of staff worked at the till on the medicines counter but explained that her main role was to supervise sales of toiletries and gifts. She was always accompanied by a trained MCA and referred all requests for medicines or advice. Pharmacy team members were able to safely manage the workload and the staffing level appeared adequate for the services provided.

The MCA was able to provide a coherent explanation of the WWHAM questioning technique and gave appropriate examples of situations she would refer to the pharmacist. Pharmacy team members had access to informal training materials such as articles in trade magazines, information about new products from manufacturers and learning updates from NHS Wales. The dispensing team were members of an electronic pharmacy discussion group and shared information about pharmacy topics with each other for learning purposes. They explained that much of their learning was via informal discussions with the pharmacists. Pharmacy team members had recently completed mandatory training provided by NHS Wales on mental health awareness and improving the quality of services provided. However, 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 pharmacy team members could informally discuss performance and development issues with the pharmacists 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 pharmacists, including the superintendent pharmacist. The superintendent pharmacist explained that the company had a whistleblowing policy, but this could not be found during the inspection. On discussion the pharmacy team understood that they could contact the GPhC or the local health board if they wished to raise a concern outside the organisation. The superintendent pharmacist agreed to locate the policy and display a copy in the pharmacy for reference.

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 and well-organised. The dispensary areas were small, but there was enough space to allow safe working. The sink had hot and cold running water and soap and cleaning materials were available. A consultation room was available for private consultations and counselling, and this was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. It stores medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply. But members of the pharmacy team do not always know when higher-risk medicines are being handed out. So they might not always be able to check that medicines are still suitable, or give people advice about taking them.

Inspector's evidence

The pharmacy team offered a range of services, which were clearly advertised in the pharmacy window. There were steps up to the pharmacy entrance, but no structural changes could be made, as the premises was a Grade 2 listed building. A portable ramp was available inside the pharmacy, but this was not advertised. So people finding it difficult to access the pharmacy, such as wheelchair users, might not be aware of its availability. A low-level buzzer had been installed outside the pharmacy so people could attract the team's attention if they needed assistance. There was wheelchair access into the consultation room. The pharmacy team signposted people requesting services they could not provide to nearby pharmacies or other providers, such as the local council, which provided a needle and sharps collection service.

Dispensing staff used colour-coded baskets to ensure that medicines did not get mixed up during the dispensing process and to differentiate between different prescriptions. Dispensing labels were usually initialled by the dispenser and accuracy checker to provide an audit trail. However, labels for compliance packs did not always bear these initials, which might prevent a full analysis of any dispensing incidents. And there is a risk that compliance packs might be supplied before they have been checked for accuracy. On discussion, the pharmacy team understood the risks and agreed to review their dispensing processes going forward. A text messaging service was available to let people know that their medicines were ready for collection.

Prescriptions were annotated to alert team members to the fact that a CD requiring safe custody or fridge item needed to be added before handout. Prescriptions for schedule 3 and 4 CDs awaiting collection were marked with the date after which the prescription was invalid and could no longer be supplied. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

Prescriptions for high-risk medicines such as warfarin, lithium and methotrexate were not routinely highlighted and there was a risk that counselling opportunities could be missed. Pharmacy team members were aware of the risks of valproate use during pregnancy. They were also aware of the requirement to supply valproate products in original packs. Members of the dispensing team explained that people prescribed valproate who met the risk criteria were routinely counselled and provided with information at each time of dispensing.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. People requesting the service were risk-assessed for suitability. Compliance packs were labelled with descriptions of the medicines they contained. However, the descriptions did not always include enough detail to enable identification of individual medicines. And patient information

leaflets were not always supplied. So, there was a risk that patients might not always be able to make informed decisions about their own treatment. On discussion, the pharmacy team understood the risks and agreed to review their dispensing processes going forward. Each patient had a clear plastic wallet that included their personal and medication details and details of any messages or queries for communication purposes. An original pack and medication administration record (MAR) dispensing service was provided to some care home residents.

There was a steady uptake of the pharmacy's discharge medicines review service, common ailments service and emergency hormonal contraception (EHC)/bridging contraception service. Uptake of the sore throat test and treat service was low. Demand for the emergency supply of prescribed medicines service was high as the pharmacy was open at weekends when the GP surgery was closed. The pharmacy also offered free blood pressure and blood glucose measurement services and a seasonal influenza vaccination service. A regular locum pharmacist, who was the pharmacy's previous owner, was able to supply medicines privately against patient group directions (PGDs) on two days each week. These included antibiotics for urinary tract infections, ear infections and impetigo.

The pharmacy provided a prescription collection service from two local surgeries. It also offered a free medicines 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 usually put a notification card though the door and brought the prescription back to the pharmacy. However, the pharmacy team explained that medicines were occasionally posted through a person's letterbox on request. They gave assurances that the associated risks had been assessed in advance on each occasion by the pharmacist, although risk assessments were not documented. This practice may compromise confidentiality and it increases the risk of errors.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in two well-organised medical fridges. Maximum and minimum temperatures for the fridges were usually recorded daily, although there were occasional gaps in the records. Members of the dispensing team said that these were an oversight and gave assurances that temperatures were checked every day. Recorded temperatures were consistently within the required range. CDs were stored in two CD cabinets and obsolete CDs were kept separately from usable stock.

Stock was subject to regular documented expiry date checks and short-dated items were highlighted. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received safety alerts and medicine recalls via wholesalers and its NHS email account. The pharmacy team were able to describe how they would deal with a medicine recall 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 team has the equipment and facilities it needs to provide the services they offer. And it makes sure that these are safe and suitable for use. The pharmacy's 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 were used to count loose tablets. A separate triangle was available for use with 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 electrical equipment 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. Bags of dispensed medicines awaiting collection 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.