General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M W Phillips Chemists, 1 Iscoed Road, Hendy, Pontardulas, SWANSEA, West Glamorgan, SA4 0TP

Pharmacy reference: 1043848

Type of pharmacy: Community

Date of inspection: 27/11/2019

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 range of services including emergency hormonal contraception, treatment for minor ailments and a seasonal 'flu vaccination service for NHS and private patients.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards not all met	1.7	Standard not met	Confidential patient information is not disposed of appropriately.
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 not all met**

Summary findings

The pharmacy has written procedures to help make sure the team works safely. Its team members record and review some of 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. It asks people to give their views about the services it provides. But it does not always keep people's private information safe. The pharmacy's team members understand how to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. The pharmacy had some systems in place to identify and manage risk, including the recording and root cause analysis of dispensing errors. The pharmacist said that he tended to discuss near misses with staff at the time of each occurrence rather than analyse all patient safety incidents on a regular basis to identify patterns and trends. However, some action had been taken to reduce risks that had been identified: for example, quinine and quetiapine tablets had been separated on dispensary shelves following selection errors. Paroxetine and pantoprazole 20mg tablets had been separated for the same reason.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed behind the medicines counter showed that this was mostly positive. A formal complaints procedure was in place but was not advertised in the retail area. A poster at the medicines counter encouraged people to report adverse events involving pelvic implants, hormonal pregnancy tests or sodium valproate to the Independent Medicines and Medical Devices Safety Review.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. CD running balances were typically checked every two months. There was a risk that infrequent balance checks might lead to concerns such as dispensing errors or diversion being missed.

The trainee dispensing assistant said that she had signed a confidentiality agreement which was stored in the company's area office. She was able to give examples of ways in which patient confidentiality could be protected. However, confidential waste was not disposed of appropriately. Individual staff members had unique passwords to access the pharmacy computer.

The pharmacist had undertaken level two safeguarding training and had access to guidance and local contact details that were displayed in the dispensary. The trainee dispensing assistant said she had not yet undertaken any safeguarding training but she was able to identify different types of safeguarding concerns. She said that she would refer these to the pharmacist, who confirmed that he would report concerns via the appropriate channels where necessary. 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.

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 worked at the pharmacy on most days. He was assisted by a full-time trainee dispensing assistant, who worked under his close supervision. Staff members from a nearby branch covered the dispensing assistant's absences. The pharmacy was very quiet and the pharmacy team could comfortably manage the workload during the inspection. The staffing level appeared adequate for the services provided.

There were no specific targets or incentives set for the services provided. The pharmacist and trainee dispensing assistant worked well together. The pharmacy served a small and close-knit community and staff had an obvious rapport with customers. The trainee dispensing assistant said that she was happy to make suggestions and felt comfortable raising concerns with the pharmacist or deputy superintendent pharmacist. A confidential helpline for reporting concerns outside the organisation was available in the dispensary.

The trainee dispensing assistant gave a coherent explanation of the WWHAM questioning technique and gave appropriate examples of situations she would refer to the pharmacist. She had access to informal training materials such as counter skills modules, articles in trade magazines and information about new products from manufacturers. She said that much of her learning was via informal discussions with the pharmacist. She had not had a formal appraisal but said that she could informally discuss performance and development issues with the pharmacist whenever the need arose. The pharmacist said that a formal appraisal process was due to be implemented very soon. 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 and tidy. It has enough space to allow safe working and its layout generally protects people’s privacy.

Inspector's evidence

The pharmacy was housed in an old building and the décor was in need of refreshment. A ceiling tile in the pharmacy was missing and an adjacent light panel did not work as a result of a leak from the flat above the pharmacy. The pharmacist said that the flat was now unoccupied, and the water had been turned off. The dispensary was clean, tidy and well-organised, with enough space to allow safe working. The sinks had hot and cold running water and soap and cleaning materials were available. A consultation room at the rear of the pharmacy was available for private consultations and counselling but this was not advertised. The room could only be accessed through the dispensary. The pharmacist said that patients would be escorted to the room and that the team would ensure that no confidential information was visible. However, there was a risk that the privacy of patients receiving pharmacy services might be compromised. The lighting and temperature in the pharmacy were appropriate.

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 members of the pharmacy team 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 appropriately advertised. A leaflet in the retail area also advertised several private services that were not currently offered as the patient group directions underpinning them had expired. There was wheelchair access into the pharmacy. There was no wheelchair access into the consultation room, but the pharmacist said that he would arrange out-of-hours appointments for people who could not access the room and could also conduct private consultations over the telephone if necessary. The trainee dispensing assistant said that she would signpost people requesting services they could not provide to other nearby pharmacies.

The pharmacist said that he self-checked many prescriptions and understood that there was a risk that this might lead to errors. He said that to reduce this risk he worked slowly and methodically and always took a mental break between the dispensing and checking processes. There were very few walk-in prescriptions, and these were dispensed and bagged in the order that they were presented to avoid the risk of transposition of medicines. Staff said that they always ensured that enough space was left between repeat prescriptions being assembled on the workbench to reduce the risk of medicines becoming mixed up. This was achievable at the time of the inspection as there was ample workbench space and the pharmacy was quiet. However, it was unclear if it was still the case during busy periods. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Prescriptions awaiting collection were annotated or stickers were attached to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. The pharmacist said that stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection.

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. However, the pharmacist said that one local surgery did not prescribe these medicines on a repeat basis and would only issue prescriptions when blood test results had been received. He said that patients from another local surgery tended to present staff with their current INR results when ordering their prescriptions from the pharmacy. Some information about blood tests and dose changes was recorded on the patient medication record (PMR). The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that any patients prescribed valproate who met the risk criteria would be counselled and provided with appropriate information. A valproate information pack was available in the dispensary. 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.

Signatures were obtained for prescription deliveries. Separate signatures were obtained for deliveries of controlled drugs. 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. Trays were labelled with descriptions, although these did not always include enough detail to enable identification of individual medicines. Patient information leaflets were not routinely supplied. This created a risk that patients might not always have all the information they needed for them to make informed decisions about their own treatment. A list of patients was displayed in the dispensary for reference. Collection or delivery arrangements were recorded on individual patient medication records.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, some bottles containing loose tablets and some blister strips 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. 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. CDs were stored appropriately in a 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 of these checks was not documented. This created a risk that out-of-date medicines might be supplied, although none were found. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received drug alerts and recalls via email. 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. 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 its services. 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 tablets and the trainee dispensing assistant said that these would be 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, although there was no evidence to show 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 pharmacy software system was protected with a password and the consultation room was used for private consultations and counselling. 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.