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:** 05/08/2020

## 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 treatment for minor ailments and injuries and a seasonal 'flu vaccination service. This inspection visit was carried out during the Covid-19 pandemic crisis.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

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 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 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. And it keeps 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, although these were overdue for review and did not include changes to processes that had been made as a result of the Covid-19 pandemic. A full range of reviewed SOPs that included these changes was due to be sent to the pharmacy in a few weeks' time. 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 the dispensing assistant at the time of each occurrence rather than analyse all patient safety incidents on a regular basis to identify patterns and trends. Recent near misses had involved medicines that had accidentally been moved into the wrong compartments of compliance aids following assembly, although the cause had not always been identified. However, some action had been taken to reduce risks: for example, quinine and quetiapine tablets and paroxetine and pantoprazole tablets had been separated on dispensary shelves following selection errors. Individual risk assessments had been carried out for all staff members in light of the Covid-19 pandemic.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey showed that this was mostly positive. A formal complaints procedure was in place, but was not advertised in the retail area.

Current professional indemnity insurance was in place. All necessary records were kept, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drugs (CD) records. The majority were properly maintained, although there were occasions on which the pharmacist had not signed out of the RP register to show the time at which he had relinquished responsibility for the safe and effective running of the pharmacy. There was a risk that there would not be enough information available to provide a complete audit trail in the event of an error or incident. CD running balances were typically checked every two months.

The trainee dispensing assistant said that she had signed a confidentiality agreement which was stored in the company's area office. She was aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. Individual staff members had unique passwords to access the pharmacy computer. A privacy notice displayed at the medicines counter explained the way in which data was used by the pharmacy and gave details of the pharmacy's Data Protection Officer.

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 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 usually covered her absences. However, at the height of the Covid-19 pandemic, she had been required to self-isolate for a short period and the extraordinary circumstances had meant that no cover was available. During this time the pharmacist had worked alone for three days. He said that this had been manageable as the pharmacy was normally very quiet, with little walk-in trade. When he had needed to take a short break, he had locked the entrance door and had displayed a notice informing customers when the pharmacy would re-open.

The pharmacy team could comfortably manage the workload during the inspection and the staffing level appeared adequate. 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, 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 understood 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. However, she said that much of her learning was via informal discussions with the pharmacist. The lack of a structured training programme increased the risk that staff might not keep up to date with current pharmacy practice. The dispensing assistant had recently received a formal appraisal and could informally discuss performance and development issues with the pharmacist whenever the need arose.

## 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. The dispensary was clean, tidy and well-organised. It was small, but there was enough space to allow safe working. There were some narrow areas at the rear of the dispensary in which it was not possible to maintain the current two-metre distancing requirements. However, only two staff members worked in the pharmacy at any one time and they ensured that they did not enter these areas together.

The sinks had hot and cold running water and soap and cleaning materials were available. Dispensary surfaces were wiped down with disinfectant just before the pharmacy closed for lunch at 1pm and at the end of each day. The shop till was disinfected after each transaction. A plastic screen at the medicines counter had been installed to reduce the risk of viral transmission between staff and customers. Contactless payments could be made through this screen. Hand sanitiser was available at the pharmacy entrance for customer use. Personal protective equipment was available for staff use but was not routinely worn.

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 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. Information about coronavirus and related safety procedures was displayed on the pharmacy entrance door and at the medicines counter. 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. The 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.

The demand for the delivery service had increased during the pandemic situation. Before the crisis, the delivery driver had obtained signatures for prescription deliveries. However, to reduce the risk of viral transmission, this procedure had been changed. The driver now placed a package on the patient's doorstep, knocked or rang the doorbell and waited until someone collected it. They then verbally confirmed the person's identity, recording this as an audit trail. In the event of a missed delivery, the delivery driver sometimes put a notification card though the door and brought the prescription back to the pharmacy. However, he also posted some medicines through letterboxes at the patient's request, which increased the risk of errors. The pharmacist said that this was always at his discretion after risks had been assessed and was a last resort rather than a routine occurrence.

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. Most compliance aids were supplied via the delivery service. Collection or delivery arrangements were recorded on individual patient medication records.

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 crisis. No discharge medicines reviews had been carried out in recent months. There had recently been an increased uptake of the Choose Pharmacy common ailments service and the Triage and Treat service, as many people had chosen to use their local pharmacy as their first port of call rather than visit other healthcare establishments. The pharmacist had conducted face-to-face consultations at the required two-metre distance or had worn personal protective equipment (PPE) where this was not possible. Some consultations for services had been carried out over the telephone where appropriate, in line with recommendations from Welsh Government. The pharmacist said that there had been a high demand for the Just in Case palliative care service in recent months, although this had not been as a direct result of the pandemic. The blood pressure measurement service was not currently being provided, as the pharmacist said that he was unable to disinfect the monitor's cuff effectively between consultations and felt that this might contribute to the risk of viral transmission. The pharmacy was planning to provide the influenza vaccination service during the 2020/21 season.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. However, some bottles containing loose tablets 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. The pharmacy team had experienced some difficulties in obtaining stocks of medicines during the pandemic crisis. However, they had worked collaboratively with local surgeries to ensure that an effective available substitute was prescribed where necessary.

Stock was checked monthly and date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. Staff used gloves when handling patient-returned medicines to reduce the risk of viral transmission. 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 these 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. |