General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Village Pharmacy, Unit 1; Station Road, Pontardulais, SWANSEA, West Glamorgan, SA4 8TL

Pharmacy reference: 1043892

Type of pharmacy: Community

Date of inspection: 19/09/2024

Pharmacy context

This pharmacy is next door to a medical centre in a small town in South West Wales. It sells a range of over-the-counter medicines and dispenses both 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. 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	4.1	Good practice	The pharmacy is good at promoting the services it provides so that people know about them and can access them easily.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures that team members follow to help make sure they team work effectively. Its team members record and review their mistakes so they can learn from them. And they take action to help reduce the risk of similar mistakes happening again. The pharmacy generally 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. A root cause analysis had been conducted following a recent dispensing error to help identify the cause and subsequent learnings. Dispensing team members explained that the pharmacists discussed near misses with them at the time they came to light. And that any patterns or trends that emerged were discussed with the whole team. The superintendent pharmacist conducted monthly reviews of errors and near misses. He used learning points from these incidents to produce a monthly patient safety bulletin which was shared with all colleagues and filed in the dispensary for reference. Action had been taken to reduce some risks that had been identified. For example, shelf edge stickers had been used to alert pharmacy team members to the risks of selection errors with different strengths of colecalciferol, codeine and diazepam tablets. Stickers had also been used for the same reason to highlight the LASA (look-alike, sound-alike) medicines clobazam, clonazepam and azathioprine, azithromycin, following some near misses. Notices provided by the local health board alerting team members to the risks of selection errors with gabapentin and pregabalin were displayed in the dispensary.

A range of standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Members of the pharmacy team had signed the SOPs to show that they had read and understood them. They were able to describe their roles and responsibilities. A pharmacy technician 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, as long as she had not been involved in dispensing or labelling these. A dispensing assistant and a pharmacy student described 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 positive. A formal complaints procedure was in place, and this was advertised in the retail area. Information about the NHS complaints procedure 'Putting Things Right' was also clearly displayed.

Evidence of current professional indemnity insurance was available. Records were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply and controlled drug (CD) records. Running balances for controlled drugs were checked frequently. However, there were occasions on which pharmacists had not signed out of the RP register to show the time at which they had relinquished responsibility for the safe and effective running of the pharmacy. So, there was a risk that it would not be possible to identify the pharmacist in charge if something went wrong.

Members of the pharmacy team had signed confidentiality agreements. The pharmacy technician had recently undertaken information governance training. All team members were aware of the need to protect confidential information, for example by offering the use of the consultation room for private conversations and by identifying confidential waste and disposing of it appropriately. A privacy notice displayed in the retail area described the way in which data was used and managed by the pharmacy and gave details of the pharmacy's Data Protection Officer. The pharmacist, the pharmacy technician and three other team members 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 displayed in the dispensary. Information about local services and support groups for people with dementia and their carers was available in the retail area.

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 superintendent pharmacist (SI) worked at the pharmacy on at least four days each week. His absences were covered by another pharmacist, who was also a director of the company, and a regular locum pharmacist who worked on Saturdays. The SI and the director occasionally worked together during busy periods, and this was the case on the day of the inspection. The pharmacy team consisted of a pharmacy technician who was a qualified accuracy checker (ACT), two dispensing assistants (DAs), two pharmacy students and a trainee pharmacist. A part-time medicines counter assistant (MCA) and a part-time trainee MCA were also employed by the pharmacy. Trainees worked under the supervision of the pharmacists or other trained members of the pharmacy team. Pharmacy team members were able to safely manage the workload and the staffing level appeared adequate for the services provided.

Members of the pharmacy team working on the medicines counter were observed to ask 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 computer terminal which allowed team members to access patient medication records to help them make decisions about sales of medicines or provision of advice was situated at the medicines counter. Team members had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They explained that much of their learning was via informal discussions with the pharmacists. The pharmacy technician was trained to provide the discharge medicines review service and the smoking cessation service. She understood the revalidation process and based her continuing professional development entries on training she had undertaken and on issues she came across in her day-to-day working environment. She had online access to training modules provided by NHS Wales on clinical topics and pharmacy services. All pharmacy team members had recently completed mandatory training provided by NHS Wales on mental health awareness and improving the quality of services provided. Team members were subject to annual performance and development reviews and could discuss issues informally 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 were happy to make suggestions and raise concerns with the superintendent pharmacist and other pharmacists. A whistleblowing policy was displayed in the dispensary. It included details of organisations that could be contacted if team members wished to raise a concern outside the company.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy. It is secure and has enough space to allow for safe working. There is a room where people can have conversations with team members in private.

Inspector's evidence

The dispensary was clean, tidy and well-organised, with enough space to allow for safe working. Some stock medicines and dispensed medicines awaiting collection were being temporarily stored on the floor, but they did not pose a trip hazard. The sinks had cold running water, but there was no hot water available. The superintendent pharmacist explained that the boiler had recently been serviced and he had arranged for a plumber to investigate the problem. The team were using a kettle to provide hot water in the meantime. Soap, hand sanitiser and cleaning materials were available. A plastic screen at the medicines counter had been installed to reduce the risk of viral transmission between staff and customers.

A consultation room was available for private consultations and counselling and its availability was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy effectively promotes the services it provides so that people know about them and can access them easily. Its working practices are generally safe and effective. The pharmacy stores medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy team offered a range of services, and comprehensive details of these were displayed at the pharmacy entrance and in the retail area. The pharmacy team had been trained to promote services and were observed to do so on several occasions during the inspection. There was wheelchair access into the pharmacy and consultation room. Push pads labelled 'Press to Open' were situated either side of the entrance door to allow people to access and exit the pharmacy easily. A signposting file provided by the local health board was available and team members signposted people requesting services they could not provide to nearby pharmacies or other NHS and private healthcare providers. Contact details for local sexual health and pregnancy advisory services were displayed in the dispensary for reference. An array of health promotional material and healthy lifestyle advice was on display in the retail area, as was information about local self-help and support groups and local healthcare services.

The pharmacy team had a good relationship with local GP surgery teams, which meant that queries and problems were usually dealt with quickly and effectively. The atmosphere in the pharmacy was calm and professional. Dispensing staff used baskets to ensure that medicines did not get mixed up during the dispensing process. Dispensing labels were usually initialled by the dispenser and accuracy checker to provide an audit trail. However, some dispensing labels were not initialled by the dispenser, which might prevent a full analysis of any dispensing incidents. On discussion, the pharmacy team understood the risks and agreed to review their dispensing processes going forward.

Prescriptions were not always retained for dispensed medicines awaiting collection, except for prescriptions for controlled drugs and any prescriptions that could not be scanned. However, most prescriptions were scanned, and the image remained available for reference. Dispensed medicines awaiting collection were marked to alert team members to the fact that a CD requiring safe custody or fridge item needed to be added. Prescriptions for schedule 3 or 4 CDs awaiting collection were not routinely identified so there was a risk that these items might be supplied past the 28-day validity period. However, all pharmacy team members were suitably trained and those present said that they recognised prescriptions for Schedule 3 or 4 CDs and checked that they were still valid before handing them out. The pharmacist explained that the prescription storage area was checked every month and that any invalid prescriptions would be removed and dealt with appropriately at this point.

Prescriptions for higher risk medicines such as warfarin, lithium and methotrexate were routinely highlighted for counselling. The pharmacist explained that he asked people about relevant blood tests and dose changes and recorded these conversations on patient medication records. The pharmacy team were aware of the risks of using valproate-containing medicines and topiramate during pregnancy. They were also aware of the requirement to supply valproate products in original packs. They confirmed that anyone prescribed valproate or topiramate who met the risk criteria would be counselled and provided with educational information at each time of dispensing.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. Compliance packs were labelled with descriptions of the medicines they contained. However, these did not always include enough detail to enable identification of individual medicines, with many described simply as 'white round tablet'. So, there was a risk that people 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. Patient information leaflets were routinely supplied. Each patient had a clear plastic wallet that included their personal and medication details, collection or delivery arrangements and details of any messages or changes. A list of people receiving their medicines in compliance packs was available in the dispensary for reference. The pharmacy team also provided an NHS-commissioned original pack and medication administration record (MAR) dispensing service for people with carers. People were referred to the pharmacy by the local health board.

Uptake of the pharmacy's common ailments service was high, as it was an established service and the pharmacy also received frequent referrals from nearby GP surgeries and a local optician. Demand for the emergency supply of prescribed medicines service was also high, as the pharmacy was open at weekends when the GP surgery was closed. The superintendent pharmacist was able to provide the sore throat test and treat service and the UTI (urinary tract infection) service, and demand for these was steady. Uptake of the blood borne virus testing service was low, as two local drug and alcohol teams also offered this service. The pharmacy offered a smoking cessation (supply and monitoring) service, a discharge medicines review service, an EHC (emergency hormonal contraception) and bridging contraception service and a seasonal influenza vaccination service. A supervised consumption service and a needle and syringe provision service were also available, as was a needle and syringe disposal service for people receiving treatment for chronic conditions.

The pharmacy provided a prescription collection service from five local surgeries. It also offered a free medicines delivery service, although demand for this was low. The delivery driver used a delivery sheet to record each delivery that was made. Signatures were obtained for deliveries of controlled drugs. 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. But medicines had been posted through a letterbox on at least one occasion. The pharmacy team gave assurances that this was not a routine occurrence and that the associated risks had been assessed in advance by a pharmacist. However, they understood that this practice could compromise confidentiality and increase the risk of errors, and agreed to review their delivery process going forward.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in a large fridge. Maximum and minimum temperatures for the fridge were recorded daily and were consistently within the required range. Controlled drugs were stored in three well-organised CD cabinets and obsolete CDs were kept separately from usable stock. However, some daily doses of methadone and buprenorphine being stored in the CD cabinet had not been labelled. The pharmacy technician explained that this was an oversight and labelled the doses as soon as this was pointed out. On discussion, the pharmacy team understood the risks and agreed to review their dispensing processes going forward.

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 pharmacy was able to accept patient-returned inhalers and plastic insulin pens for recycling. It received safety alerts and recalls via its NHS email account. These were printed and filed for reference. 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 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, and these were washed after being used to measure methadone. However, some plastic measures in the dispensary were not validated, and a member of the team removed these from use as soon as this was pointed out. On discussion, team members understood the risks and agreed to use validated glass measures to measure liquids going forward. Triangles were used to count loose tablets and 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.

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.