General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: The Pharmacy Rhosneigr, The Pharmacy, High Street, RHOSNEIGR, Gwynedd, LL64 5UX

Pharmacy reference: 1043993

Type of pharmacy: Community

Date of inspection: 11/12/2019

Pharmacy context

The pharmacy is situated amongst a small number of other retail shops, in Rhosneigr, on the Isle of Anglesey, North Wales. The pharmacy premises are accessible to most people, with adequate space in the retail area and a waiting area. It has a consultation room available for private conversations. The pharmacy sells a range of over-the-counter medicines and dispenses private and NHS prescriptions. And it supplies medication in multi-compartment compliance aids for some people, to help them take the medicines at the right time.

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	1.2	Good practice	The pharmacy records and analyses adverse dispensing incidents to identify learning points which are then incorporated into day to day practice to help manage future risk.
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 manages the risks associated with its services and protects peoples' information. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. They record their mistakes so that they can learn from them. And they act to help stop the same sort of mistakes from happening again.

Inspector's evidence

There were up-to-date standard operating procedures (SOPs) for the services provided. The members of the pharmacy team were in the process of re-reading the SOPs that were relevant for their role, as they had been updated recently. Roles and responsibilities of the pharmacy team were set out in SOPs. The member of the pharmacy team working on the medicines counter was able to clearly describe her duties. Dispensing incidents were recorded on the computer patient medication record (PMR) system and were reviewed by the pharmacist. Near miss errors were discussed with the member of the pharmacy team at the time and recorded in the near miss error log. Detailed near miss records were kept and reviewed by the pharmacist for trends and patterns. Due to several near miss errors with different strengths of Fostair inhaler, the stock had been separated in the fridge.

The incorrect responsible pharmacist (RP) notice was displayed. This was changed immediately to the correct RP notice once the pharmacist was prompted. A complaints procedure was in place. But details about it were not on display so people may not always know how they can raise concerns. The pharmacist explained that she aimed to resolve complaints in the pharmacy at the time they arose. A copy of the NHS "Putting Things Right" poster outlining how people were able to raise concerns with the NHS was displayed. A customer satisfaction survey was carried out annually. The pharmacist explained that some patients had previously provided negative feedback regarding having somewhere to hold a private conversation, and how a clearly signposted consultation room had been constructed in the last year for this purpose.

The pharmacy had professional indemnity insurance in place, with a copy of the certificate displayed. The private prescription record, emergency supply record, unlicensed specials record and the electronic CD register were in order. Records of CD running balances were kept and audited regularly. A balance check of a random CD was found to be correct. Patient returned CDs were recorded and disposed of appropriately. The responsible pharmacist (RP) record was up-to-date but had the time the RP ceased their duty missing on some occasions.

Confidential waste was shredded. Confidential information was kept out of sight of patients and the public. An information governance policy was in place and the team had read and signed confidentiality agreements as part of their training. The computer was password protected, with the screen facing away from the customer and assembled prescriptions awaiting collection were stored so that patient information was not visible There was no privacy notice displayed. So, people may be unaware how the pharmacy intended to use their personal data.

The pharmacist had completed level 2 safe guarding training and all staff had read the safeguarding policy. The local contact details for raising a concern were present for the team to refer to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. And the team members are comfortable about providing feedback to the pharmacist. But the lack of formal ongoing training could mean their skills and knowledge may not always be up to date.

Inspector's evidence

There was the pharmacist pharmacy owner and a member of the team who worked on the medicines counter on duty. The team member had commenced her role in the last two months and was working through a three-month probationary period, prior to being enrolled on an accredited training course. The other team members who were not present had completed accredited training courses for their roles or had been placed on suitable courses. The pharmacist and team member were busy providing pharmacy services. They appeared to work well together and manage the workload adequately.
The member of the pharmacy team said the pharmacist was supportive, approachable and was more than happy to answer any questions she had. She was aware of a process for whistle blowing and knew how to report concerns if needed. And the pharmacist provided the team with informal updates when necessary. The pharmacy team members were provided with copies of counter skills booklets covering various topics such as the digestive system. The team members were provided with time to read through these during working hours.

The member of the pharmacy team was clear about her role. She knew what questions to ask when making a sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as co-codamol, which she would refer to the pharmacist for advice. The pharmacist explained that there were no formal targets set for professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy. It is a suitable place to provide healthcare. It has a consultation room so that people can have a conversation in private.

Inspector's evidence

The pharmacy was clean and tidy. It was free from obstructions and had a waiting area. The pharmacist said that dispensary benches, sink and floors were cleaned regularly, and a cleaning rota was displayed. The temperature in the pharmacy was controlled by heating units. Lighting was adequate.

The pharmacy premises were maintained and in an adequate state of repair. Pharmacy team facilities included a microwave, kettle, toaster, WC with wash hand basin and antibacterial hand wash. There was a consultation room available which was uncluttered and clean in appearance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people and it manages them appropriately, so people receive their medicines safely. The pharmacy takes extra care when supplying some higher-risk medicines. It sources and stores medicines safely and carries out some checks to help make sure that medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchairs. There was a selection of healthcare leaflets. The team were clear about what services were offered and where to signpost to a service if this was not provided. The opening hours were displayed near the entrance.

The work flow in the pharmacy was organised into separate areas, with adequate dispensing bench space and a checking area for the pharmacist. Baskets were used in the dispensary to separate prescriptions to reduce the risk of medicines becoming mixed up during dispensing.

The pharmacist demonstrated that prescriptions containing schedule 2 CDs had a CD sticker included on the assembled bag. She explained that this was to act as a prompt for members of the team to take the CD from the CD cabinet and include it with the rest of the assembled prescription at the time of supply. She said prescriptions containing schedule 3 and 4 CDs were also highlighted with a CD sticker, and an example of this was present for a pregabalin prescription awaiting collection.

Prescriptions containing high-risk medicine such as warfarin were highlighted prior to collection. The patient medication records (PMR) for several people prescribed warfarin were reviewed and included INR records. The pharmacist was aware of the people prescribed methotrexate and lithium and had provided counselling, but these medicines were not routinely highlighted prior to collection. The team was aware of the risks associated with the use of valproate during pregnancy. The pharmacist had carried out an audit for patients prescribed valproate and had not identified any patients who met the risk criteria. The pharmacy had patient information resources for the supply of valproate.

The pharmacist provided a detailed explanation of how the multi-compartment compliance aid service was provided. Disability Discrimination Act (DDA) assessments were carried out by the pharmacist on people who requested compliance aids, and examples of these were provided. The Details of any changes to medication were added to the printed list of medicines and the computer patient medication record (PMR) was updated. Non disposable equipment was used. Individual medicine descriptions were added to some but not all medicines supplied. So, people may not be able to easily identify their medicines. Patient information leaflets were included when people were commenced on compliance aids or when there was a change of dose or new medicine. Therefore, people may not always have the most up-to-date information about their treatment. There was no dispensing audit trail included with the assembled compliance aid packs. So, it may be more difficult to establish who was responsible in the event of an error occurring.

The pharmacy offered an influenza vaccination service for NHS and private patients. Copies of the signed patient group directives (PGD) and SOP were present. The pharmacist explained how the service

was provided and records were kept. The necessary equipment for the service was available, including, in-date influenza vaccinations, in-date adrenaline ampoules, sharps bin, alcohol gel and swabs. The pharmacist explained that she had been given permission from the NHS Betsi Cadwaladr University Health Board to provide the service offsite. She said she had visited three care homes to immunise all staff with influenza vaccinations. She had received positive feedback from different staff in these homes, who stated they may not have received an influenza vaccination if the pharmacist had not carried out the service.

The pharmacy provided a discharge medicine review (DMR) service for people who had been discharge from hospital. This involved the pharmacist reviewing the hospital discharge prescription and speaking to the patient. The pharmacist explained that due to an error picked up during the DMR process, she had contacted the patients GP to clarify the dose of bisoprolol, who had agreed that the dose was incorrect, and the patients repeat prescription was updated.

The PMR record for a person who had presented as feeling unwell and was seen by the pharmacist was reviewed. The pharmacist had checked the patient's blood pressure and they were immediately referred and reviewed by their GP on the same day. Due to the intervention, the patient had various blood tests, was commenced on medication and was diagnosed with type 2 diabetes.

Stock medications were sourced from licensed wholesalers and specials from a licensed manufacturer. Stock was stored tidily. Date checking was carried out each week as part of a three-month rolling schedule for all stock and a record was kept. No out-of-date stock medicines were present from a number that were sampled. Patient returned CDs were destroyed using denaturing kits and a record was kept. There was a clean fridge for medicines, equipped with a thermometer. The minimum and maximum temperature was being recorded daily and the record was complete.

The pharmacy team were aware of the Falsified Medicines Directive (FMD). The pharmacy had FMD software installed and a 2D barcode scanner. The team were not decommissioning FMD compliant medication packs due to software glitches at present. Therefore, the pharmacy was not complying with legal requirements. Alerts and recalls were received via MHRA email and NHS email. These were actioned on by the pharmacist, but no record was kept. So, the pharmacy may not be able to provide a robust audit trail.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. The team uses it in a way that protects privacy. And electrical equipment is regularly tested to make sure it is safe.

Inspector's evidence

The pharmacy had up-to-date copies of the BNF and BNFc. The pharmacy team used the internet to access websites for up to date information. For example, Medicines Complete. Any problems with equipment were reported to the pharmacist. All electrical equipment appeared to be in working order and was PAT tested in October 2018.

There was a selection of liquid measures with British Standard and Crown marks. The pharmacy had equipment for counting loose tablets and capsules, including tablet triangles. The computer screen was positioned so that it wasn't visible from the public area of 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.