General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M W Phillips Chemists, 50 Nolton Street, BRIDGEND, Mid Glamorgan, CF31 3BP

Pharmacy reference: 1087252

Type of pharmacy: Community

Date of inspection: 31/01/2020

Pharmacy context

This is a high street pharmacy in a small town. 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. 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	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 review things that go wrong so that they can learn from them. But they do not record all of their mistakes. So they may miss some opportunities to learn. The pharmacy generally 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. Some of these were overdue for review and there was a risk that they might not reflect the activities carried out in the pharmacy. A few SOPs had not been signed by two staff members. However, they were able to clearly describe their roles and responsibilities relating to the SOPs when questioned. There were no records of dispensing errors available, but the accuracy checking technician (ACT) said that a recent incident had been reported to head office staff, who kept records centrally. The most recent records of near misses had been made in October 2019. However, the pharmacist said that he discussed near misses with relevant staff at the time of each occurrence. The ACT said that she reviewed records of incidents monthly and demonstrated that patient safety reports had been produced as a result. However, the reports were not detailed and in most cases there were no specific learning points other than to be more careful when dispensing. Staff were able to describe some recent action that had been taken to reduce risk: highlight stickers had been used in drawers storing Triapin tablets and felodipine tablets as one staff member had made several selection errors with these items.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. Staff said that the results of the most recent survey were mostly positive. Complaints were dealt with using the NHS complaints procedure 'Putting Things Right', although this was not advertised in the retail area.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and generally properly maintained, including Responsible Pharmacist (RP), private prescription, unlicensed specials and controlled drug (CD) records. There were no recent records of emergency supplies, but staff said that they could not remember the last time an emergency supply had been made. The web-based RP register included one recent incorrect entry made at the end of the working day, which the pharmacist said was an oversight. He explained that when the system was shut down at the end of the day, the programme automatically signed the RP out of the register. On this occasion he had needed to go back into the system for a few minutes and had signed into the register but had selected the first person on the list in error rather than himself. Some private prescription records did not include relevant dates and unlicensed specials records were not always marked with patient details. This creates a risk that the pharmacy team might not have all the information needed to investigate queries or errors. CD running balances were typically checked every two months.

Confidentiality agreements signed by staff were not available to view at the time of the inspection, but staff said they had signed a confidentiality clause as part of their contract. They were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. A summary of the company's confidentiality policy was displayed near the

medicines counter.

The pharmacist, ACT and NVQ3-qualified dispensing assistant had undertaken level two safeguarding training and had access to guidance and local contact details that were displayed in the dispensary. The full-time dispensing assistant had received in-house training provided by her previous employer. Staff were able to identify different types of safeguarding concerns and said that they would refer these to the pharmacist, who confirmed that he would report concerns via the appropriate channels where necessary. A summary of the chaperone policy was advertised at the medicines counter. A notice at the front entrance advertised a confidential helpline for women affected by domestic abuse.

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

A long-term locum pharmacist worked at the pharmacy on most days. The support team consisted of an accuracy checking technician (ACT) and a dispensing assistant. Another dispensing assistant was absent. There were enough suitably qualified and skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. Certificates were displayed as evidence that staff members had the necessary training and qualifications for their roles. One dispensing assistant had obtained an NVQ level 3 qualification.

Targets were set for MURs, but these were managed appropriately, and staff said that they did not affect the pharmacist's professional judgement or compromise patient care. Staff worked well together and had an obvious rapport with their regular customers. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist, regional office manager or superintendent pharmacist. Staff said that a whistleblowing policy was in existence, but it could not be located during the inspection. They said that they would contact an organisation such as the NPA if they needed to report concerns outside the company.

Members of staff were observed to use appropriate questions when selling over-the-counter medicines to patients. They referred to the pharmacist on several occasions for further advice on how to deal with a transaction. Staff had access to informal training materials such as counter skills training modules, articles in trade magazines and information about new products from manufacturers. The ACT said that she understood the revalidation process and based her continuing professional development entries on situations she came across in her day-to-day working environment. There was no formal appraisal system in place, but all staff could informally discuss performance and development issues with the pharmacist whenever the need arose. 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 generally clean and tidy. It is secure and has enough space to allow safe working. Its layout protects people’s privacy.

Inspector's evidence

The pharmacy was housed in an old building and the décor was in need of refreshment. Roof leaks had caused damage to the consultation room carpet and ceiling tiles after recent heavy rainfall. The pharmacist explained that work to repair the roof was ongoing and said that the superintendent pharmacist planned to refit the pharmacy after the work had finished. The dispensary was clean, tidy and well-organised, with sufficient space to allow safe working. Some stock and prescriptions were being temporarily stored on the floor but did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. A small consultation room was available for private consultations and counselling although its availability was not advertised. Substance misuse clients tended to use a semi-private hatch that opened into the dispensary from a quiet part of the retail area. The pharmacist said that they were always given the option to use the consultation room. The lighting and temperature in the pharmacy were generally appropriate. The lighting above the CD cabinet was a little dim. The dispensary was a little cold, but staff were using heaters to keep warm.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people. But the consultation room was not suitable for wheelchairs. So some people may not be able to access all of the pharmacy's services. If the pharmacy can't provide a service, it directs people to somewhere that can help. Its working practices are generally safe and effective. It stores most medicines appropriately and carries out checks to help make sure that they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. However, leaflets at the medicines counter advertised some private services that could not currently be provided as the patient group directions underpinning them had expired. The pharmacist removed the leaflets as soon as this was pointed out. There was a small step up to the pharmacy entrance, but staff said that a portable ramp was available for wheelchair users. During the inspection a staff member went out to a patient using a walking frame and helped her into the pharmacy. The consultation room could not accommodate a wheelchair as the door was too narrow and the room itself was too small. The pharmacist said that he offered to telephone patients who could not access the room if they wished to have a private conversation and had conducted telephone MURs in the past. A small section of the retail area at the rear of the shop could be closed off using a door and used as a quiet or even private consultation area if necessary. A list of local sexual health clinics was displayed in the consultation room and a list of needle exchange facilities was available in the dispensary. Staff said that they would signpost patients requesting services they could not provide to other nearby pharmacies. Some health promotional material, along with information about local support groups and community services, was displayed in the retail area.

Dispensing staff used a basket system to ensure that medicines did not get mixed up during dispensing. Dispensing labels were usually initialled by the dispenser and checker to provide an audit trail, although this was not the case for substance misuse clients' daily doses. There was a risk that the lack of a complete audit trail might prevent a full analysis of dispensing incidents.

Prescriptions awaiting collection were marked to identify patients eligible for an MUR. If a CD or fridge line was outstanding, the remainder of the assembled prescription was stored in a separate area and the item was not dispensed until the patient or their representative arrived at the pharmacy. Prescriptions awaiting collection that included Schedule 3 and 4 CDs were not routinely identified, but staff said that they were all trained to recognise these items as CDs and check that the prescription was still valid at the point of supply.

Patients on high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified but staff said that they would recognise these medicines as high-risk and refer to the pharmacist before handout. The pharmacist said that he asked patients or their representatives for information about blood tests and dosage changes at the time of supply but did not record this information. The pharmacy team were aware of the risks of valproate use during pregnancy. Staff said that any patients prescribed valproate who met the risk criteria would be counselled and provided with appropriate information, which was available on original packs and could also be printed from the internet. 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 controlled drugs. In the event of a missed delivery, the delivery driver put a notification card through the door and brought the prescription back to the pharmacy.

Disposable compliance aid trays were used to supply medicines to a number of patients. The pharmacist said that new patients were only taken on as a result of referrals from hospital, occupational health or social services, or at the request of a patient's GP. Trays were labelled with descriptions. However, these did not always include enough detail to enable identification of individual medicines. There was a risk that patients might not have access to all the information they required to make informed decisions about their own treatment. The pharmacist said that patient information leaflets were routinely supplied. A list of patients was displayed on a whiteboard in the dispensary for reference. Each patient had a section in one of three dedicated files that included their personal and medication details and any relevant documents, such as repeat prescription order forms and hospital discharge summaries. Some individual sheets listing medication details were quite untidy. For example, some dosage changes had been altered by obliteration and were difficult to read, which may increase the risk of errors. A labelled basket for each patient was used to store their stock medicines. Two compliance aids that had been assembled that morning were not adequately labelled either as pre-packed or dispensed medicines. A dispensing assistant labelled these as soon as this was pointed out.

Patients supplied substance misuse treatments against instalment prescriptions had a section in a dedicated file which included their personal details and current prescription, along with copies of their signed supervision contract and claim form. The pharmacist offered water to supervised clients.

The pharmacy had carried out about ten influenza vaccinations during the 2019/20 season as part of the NHS enhanced service. The pharmacist said that there was little demand for influenza vaccination or for the Choose Pharmacy minor ailments scheme, as two other pharmacies nearer to the local surgery also offered these services. He said that uptake of the Just in Case palliative care service was currently high.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, some different types of insulin were jumbled together in the dispensary fridge which increased the risk of errors. Maximum and minimum fridge temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in a large, well-organised CD cabinet and obsolete CDs were segregated from usable stock. However, the CD key had been left in the door of the cabinet, compromising the security of these medicines. The pharmacist removed the key and secured it on his person as soon as this was pointed out.

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. The pharmacy received drug alerts and recalls via its NHS email account. 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, quarantining affected stock and returning it to the relevant supplier. The pharmacy was not currently working in accordance with the Falsified Medicines Directive legislation.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It makes sure these are always 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. Separate measures were used for methadone. Triangles and a capsule counter were used to count tablets and capsules. A separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. Most equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. The pharmacist said that the fax machine was not working but explained that the local surgeries and hospital communicated with the pharmacy by e-mail and telephone rather than fax. He said that the out-of-hours GP service team did not use the pharmacy to fax through requests for urgent prescriptions as they were aware it was not open late in the evening or at weekends. Equipment and facilities were used to protect the privacy and dignity of patients and the public: for example, the computer was password-protected 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.