General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Castle Pharmacy, 44 Queens Road, Mumbles, SWANSEA, West Glamorgan, SA3 4AN

Pharmacy reference: 1088347

Type of pharmacy: Community

Date of inspection: 28/06/2019

Pharmacy context

This is a pharmacy located near two medical centres in a seaside town. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers an emergency hormonal contraception service and treatment for minor ailments. The pharmacy does not open at weekends.

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. But its team members do not always record or review their mistakes. So it is likely that some chances to learn from them might be missed. 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

The pharmacy had some systems in place to identify and manage risk. Dispensing errors were recorded but did not include details of the pharmacist or staff members involved in the incidents. The most recent near miss records had been made in October 2018. Staff said that the pharmacists discussed near misses with them at the time of each occurrence.

Some action had been taken to reduce risk: a caution sticker had been used to alert staff to the risk of picking errors with atorvastatin 10mg and amlodipine 10mg tablets following a recent dispensing error. Stickers had also been used to highlight the risks of picking errors with different pack sizes of codeine tablets, as the packaging was almost identical.

A range of written standard operating procedures (SOPs) underpinned the services provided; these were regularly reviewed. The newest member of staff had not signed to show that she had read relevant SOPs. However, she was able to describe her role and responsibilities. She explained that she had not yet been trained to label dispensed medicines but could select stock against a prescription and attach pre-printed labels to items for the pharmacist to check. She correctly listed tasks that staff were unable to carry out in the absence of the responsible pharmacist.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The locum pharmacist and staff were unable to locate the results of these surveys. A card received from a patient's family thanked the pharmacy team for their care and understanding toward a relative. A formal complaints procedure was in place and information about how to make complaints was included in the practice leaflet displayed in the retail area.

Evidence of current professional indemnity insurance was provided by the superintendent pharmacist. All necessary records were kept and generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, specials procurement and controlled drug (CD) records. However, electronic emergency supply records did not include the nature of the emergency nor the identity of the person requesting the supply. 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 monthly or every two months.

Staff had signed confidentiality agreements. 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 privacy notice displayed behind the medicines counter advertised the way in which data was used by the pharmacy and gave details of the pharmacy's Data Protection Officer. However, the information

was not easy to read from the retail area.

The pharmacists and staff members had undertaken formal safeguarding training and had access to guidance and local contact details that were available via the internet, as well as at the back of the SOP file and in a branch information file in the dispensary.

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 generally feel able to speak up about any concerns they have.

Inspector's evidence

Three regular long-term locum pharmacists oversaw all professional activities as part of a job-share. There were enough suitably qualified and skilled staff present to manage the workload during the inspection and the staffing level appeared adequate for the services provided. Staff members had the necessary training and qualifications for their roles. A new member of staff enrolled on both the dispensing assistant and medicines counter assistant training courses worked under the pharmacist's supervision. There were no specific targets or incentives set for the services provided.

Staff worked well together and had an obvious rapport with customers since they served a small and close-knit community. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist and superintendent pharmacist or the pharmacy owner. A whistleblowing policy that included a confidential helpline for reporting concerns was available in an information file in the staff area. The newest staff member who had worked at the pharmacy for about six months was not aware of this but on discussion she understood where to find the information.

The trainee medicines counter assistant gave examples of appropriate questions she would ask when dealing with requests for over-the-counter medicines. However, she said that she ultimately referred all requests for medicines or advice to the pharmacists as she was not yet confident to deal with these on her own.

Staff had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They said that much of their learning was via informal discussions with the pharmacist. There was no formal appraisal system in place but all staff could discuss performance and development issues informally with the pharmacists whenever the need arose. There was a risk that the lack of a structured training and development programme might restrict the ability of individuals to keep up to date with current pharmacy practice and that opportunities to identify training needs might be missed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean, tidy and secure. It has enough space to allow safe working and its layout protects people’s privacy.

Inspector's evidence

The pharmacy was housed in an old building and some of the décor was in need of refreshment. A ramp in the retail area was highlighted with hazard tape. The dispensary was generally clean and there was enough space to allow safe working. However, it was clear that more storage and workbench space would be beneficial, as dispensary work surfaces were a little cluttered and some stock and prescriptions were temporarily stored on the floor. The sink had hot and cold running water and soap and cleaning materials were available.

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 provides services that people can access easily. 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. And it generally manages medicines appropriately. But it doesn't always keep prescription forms for the dispensed medicines waiting to be collected. This means that the pharmacy's team members will not always have all the information they may need when the medicines are handed out.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was a step up to the pharmacy's entrance but the pharmacist said that the team would go out to patients in wheelchairs and help them into the pharmacy if necessary. There was wheelchair access into the consultation room. The newest member of staff said that she had would refer to the pharmacist if a patient requested a service the pharmacy could not provide. She said that she had done so recently and the pharmacist had signposted the patient to a nearby GP surgery. There was an array of health promotional material on display in the retail area, including details of local support groups.

Staff said that the dispensing workload was split fairly equally between walk-in and repeat prescriptions.
The pharmacy dispensed an average of 5,500 prescription items each month. It supplied medicines in multi-compartment compliance aids for 37 patients. Three patients received original packs of medicines accompanied by MAR charts. The pharmacy had no substance misuse clients.

Dispensing staff used a basket system to ensure that medicines did not get mixed up during the dispensing process. Dispensing labels were usually initialled by the dispenser and checker to provide an audit trail. However, some items waiting to be checked had not been initialled by the dispenser involved in assembling the prescription. There was a risk that the lack of a complete audit trail might prevent a full analysis of dispensing incidents. Multi-compartment compliance aids were dispensed in clear bags to allow staff members to check these items at all points of the dispensing process and reduce the risk of a patient receiving the wrong medicine.

Prescriptions were not always retained for dispensed items awaiting collection. Most prescriptions were scanned and the image remained available for reference. However, this was not the case for all prescriptions.

Controlled drugs (CDs) requiring safe custody and fridge lines were generally not dispensed until the patient or their representative arrived at the pharmacy to collect them. The locum pharmacist said that prescriptions for schedule 3 or 4 CDs were attached to the bag, although there was no evidence of this available at the time of the inspection. Staff said they would always show pharmacists the prescriptions before they were handed out to ensure these items were not supplied to the patient or their representative more than 28 days after the date on the prescription.

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 locum pharmacist said that he always asked walk-in patients for relevant information about blood tests and

dose changes. He did so for one such patient during the inspection and recorded the information on the patient medication record (PMR).

The pharmacist was aware of the risks of valproate use during pregnancy. He understood the need to counsel and provide information to any patients prescribed valproate who met the risk criteria, although he said the pharmacy currently had no such patients. A valproate information pack was available in the dispensary.

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 though the door and brought the prescription back to the pharmacy.

Disposable compliance aids were used to supply medicines to a number of patients. Compliance aids were labelled with descriptions to enable identification of individual medicines. Patient information leaflets were not supplied frequently enough to comply with legislation and there was a risk that the patient might not have all the information needed for them to make informed decisions about their own treatment. Each patient had a section in a dedicated file that included their personal and medication details, details of any messages or queries and any relevant documentation, such as discharge summaries and current repeat prescriptions. 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 increased the risk of errors.

Medicines were obtained from licensed wholesalers and generally stored appropriately including those requiring cold storage. However, some food was stored in the drug refrigerator. This took up space and there was a risk of contamination.

CDs were stored in two tidy, well-organised CD cabinets. Obsolete CDs were segregated from usable stock.

Short-dated medicines were highlighted with stickers as evidence that expiry-date checks were carried out. However, staff could not locate any documentary evidence to confirm the frequency and scope of these checks. One pot of levothyroxine tablets used for dispensing compliance aids had recently passed its expiry date. 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 and returning quarantined stock to the relevant supplier. During the inspection the superintendent pharmacist telephoned the pharmacy to alert the pharmacist to a drug recall she had just received. The pharmacist actioned the recall appropriately.

The pharmacy had the necessary hardware and software to work in accordance with the Falsified Medicines Directive, but staff had not been trained in its use 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 generally has the equipment and facilities it needs to provide 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 staff said that they would wash these after use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources.

All equipment was clean and most was in good working order. However, there was no evidence to show that it had recently been tested. Staff said that they were unable to use the fax machine as they believed it was faulty. The pharmacist said that the fax and telephone line were connected to the same number, so if an attempt was made to fax a document to the pharmacy, staff could pick up the telephone and explain to the sender that the fax machine was broken.

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.

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.