General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: A & J M Sheppard Ltd, 65-66 High Street, FERNDALE, Mid Glamorgan, CF43 4RR

Pharmacy reference: 1091688

Type of pharmacy: Community

Date of inspection: 18/05/2023

Pharmacy context

This is a high street pharmacy. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a wide range of services including emergency hormonal contraception, smoking cessation, 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	1.8	Good practice	Safeguarding is an integral part of the culture within the pharmacy.
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 works closely with local healthcare providers to ensure its services are accessible to patients and the public.
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 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 are good at recognising and reporting 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 and monthly analysis of dispensing errors and near misses. Root cause analyses had been conducted following recent dispensing errors, although these were not always very detailed. Some action had been taken to reduce risks that had been identified: for example, highlight stickers had been used on dispensary shelves to alert staff to the risks of selection errors with escitalopram and enalapril following a patient safety incident. Regular bulletins issued by the superintendent's office included clinical updates and information about company-wide patient safety issues and these were read by all staff members. A poster describing the process to follow in the event of anaphylaxis was displayed in the dispensary. A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. The delivery driver had not signed the delivery SOPs, but the pharmacist explained that all delivery drivers were trained on relevant SOPs as part of their induction and these training records were kept centrally.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, but these had been suspended during the pandemic and had not yet resumed. A device situated at the medicines counter was used to obtain feedback on a regular basis: customers used buttons to rate their experience in-store as green (good), yellow (neutral) or red (bad). The feedback was received and analysed centrally and the company's head office informed the branch of their scores on a regular basis. The pharmacist said that feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place. Information about how to provide feedback or make complaints was included in a poster which was displayed in the main consultation room rather than the retail area, so it was not visible to every customer. However, a poster advertising the NHS complaints procedure 'Putting Things Right' was displayed at the medicines counter.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. CD running balances were typically checked every one to two weeks, although some items that were not frequently dispensed were checked monthly.

Staff had signed confidentiality agreements and 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 in the retail area 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 formal safeguarding training and had access to guidance and local contact details that were available in the dispensary. Members of the pharmacy team had received internal training. The team were able to give examples of how they had identified and supported potentially vulnerable people, which had resulted in positive outcomes. A summary of the pharmacy's chaperone policy was advertised in a poster displayed inside the main 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

A regular pharmacist worked at the pharmacy on most days. He was assisted in the day-to-day operation of the pharmacy by the branch manager, who was a qualified pharmacy technician. The support team consisted of two part-time dispensing assistants, one of whom had recently been enrolled on a pharmacy technician training course, and a part-time medicines counter assistant (MCA). 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. The branch manager spent some time each week managing a neighbouring branch and a relief dispenser covered her role every Tuesday during these absences. A new member of staff had recently been recruited and was soon to begin working at the branch to permanently cover the manager's absences on Tuesdays, and to work on Fridays and Wednesday afternoons.

The pharmacist said that the company offered incentives for the provision of certain services, but he was careful to ensure that these did not affect his professional judgement or compromise patient care. There were no specific targets set for the services provided. The pharmacy team worked very well together. The pharmacy served a small and close-knit community and staff had an obvious rapport with customers. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist or regional manager. A whistleblowing policy that included details for reporting concerns outside the organisation was available in the SOP file. The policy included internal details that were no longer correct, following a recent change of ownership, but a review was due in June 2023 and staff expected details to be updated. They were aware of the name and contact details for an internal whistleblowing contact employed by the new owners and understood how to raise a concern via this channel.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients and 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 articles in trade magazines and information about new products from manufacturers. They also had access to an online training programme that had recently been introduced by the company, although they had not yet completed any training modules. The pharmacist said that the whole team were soon to complete mental health training provided by HEIW. The pharmacy technician understood the revalidation process and based her continuing professional development entries on issues she came across in her day-to-day working environment. Staff members said that they had not received a performance and development review for over a year, which increased the risk that opportunities to identify training needs could be missed. However, they explained that they could discuss issues with the pharmacist or branch manager informally whenever the need arose.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is 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 clean, tidy and well-organised, with enough space to allow safe working. Some prescriptions were being temporarily stored on the floor but these did not pose a trip hazard. The sinks had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use. A plastic screen at the medicines counter had been installed to reduce the risk of viral transmission between staff and customers. Two lockable consultation rooms were available for private consultations and counselling and these were 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. If it can't provide a service, it directs people to somewhere that can help. The pharmacy's working practices are safe and effective. It stores medicines appropriately and carries out checks to make sure these are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation rooms. Staff signposted people requesting services they could not provide to other nearby pharmacies. A list of local sexual health clinics was available in a folder in the dispensary. The pharmacist and technician had recently visited local surgeries to discuss and promote services as part of a health board funded collaborative working initiative. Visits had involved discussions around the common ailments service and the repeat dispensing process.

Dispensing staff used a basket system for repeat prescriptions to help ensure that medicines did not get mixed up during dispensing. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Stickers were used on prescription bags awaiting collection to alert staff to the fact that a CD requiring safe custody was outstanding. Fridge items were not dispensed until the patient or their representative arrived to collect them as there was limited storage space in the drug fridge. Prescriptions that included a fridge item were stored in a dedicated section of the prescription retrieval area. Stickers were used to identify dispensed Schedule 3 and 4 CDs awaiting collection to help ensure that prescriptions were checked for validity before handout to the patient.

Prescriptions for high-risk medicines such as warfarin and methotrexate were marked to routinely identify patients so that they could be counselled. Staff asked for relevant information about blood tests and dose changes and there was evidence that they recorded this on the patient medication record (PMR). The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacy did not currently have any patients prescribed valproate who met the risk criteria, but the pharmacist said that any such patients would be counselled and provided with information at each time of dispensing. A poster displayed in the dispensary listed important actions that needed to be taken by the pharmacist and dispensing team when processing prescriptions for valproate. 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 pharmacy provided medicines in disposable multi-compartment compliance aids to a number of patients. Compliance aids were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied. Each patient had a section in a dedicated file that included their personal and medication details and any delivery arrangements. However, some individual sheets listing medication details were untidy. For example, some dosage changes had been altered by obliteration and were difficult to read, which may increase the risk of errors.

The pharmacy provided a wide range of services. The pharmacist had recently completed an

independent prescribing qualification and was awaiting accreditation to provide health board-commissioned prescribing services. The pharmacy currently provided a sore throat test and treat service, although uptake was moderately low, with only one or two people requesting the service each month. There was a high demand for the pharmacy's common ailments service, with many referrals from local surgeries. Uptake of the influenza vaccination service was reasonably high and the pharmacy had vaccinated about 250 people during the 2022/23 season, most of whom were eligible for the free NHS service. There was a steady uptake of the pharmacy's discharge medicines review service, with about three consultations taking place each month. The pharmacy provided a supervised consumption service. Each substance misuse client had a designated section in a file that included their personal and medication details as well as their current prescription. The pharmacy provided supply and monitoring smoking cessation services and currently had two registered clients. It also provided an EHC service. It provided blood pressure measurement on request for a charge. Uptake of the emergency supply of prescribed medicines service was steady: the pharmacist explained that demand would probably decrease soon, as the pharmacy was due to close on Saturdays.

The pharmacy provided a prescription collection service from local surgeries. It also offered a free prescription delivery service on four days each week. Signatures were usually obtained for prescription deliveries and 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.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were stored in a well-organised drug fridge. Maximum and minimum temperatures recorded for the fridge were consistently within the required range. However, there were some gaps in the records. The pharmacist said that this was an oversight and gave assurances that temperatures were checked daily. CDs were stored appropriately in two well-organised CD cabinets. Obsolete CDs were segregated from usable stock. The pharmacy had frequent issues with out-of-stock medicines and had recently been unable to obtain Eumovate formulations, Ozempic injections and atorvastatin tablets, amongst other items. The pharmacist said that the pharmacy used several different wholesalers and the team were able to transfer stock from other branches of the company, so they could sometimes obtain out-of-stock medicines from another source.

Stock was subject to regular documented expiry date checks. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist was able to describe how he would deal appropriately with a drug recall by contacting patients where necessary, quarantining affected stock and returning it to the relevant supplier.

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 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 were used to count tablets and a separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was in good working order 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 pharmacy software system was protected with a password and the consultation rooms were 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.