General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: St Mellons Pharmacy, Seaview Stores, Newport Road, St. Mellons, CARDIFF, South Glamorgan, CF3 5UA

Pharmacy reference: 1092564

Type of pharmacy: Community

Date of inspection: 17/07/2019

Pharmacy context

This is an Essential Small Pharmacy in a village shop. 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, smoking cessation, treatment for minor ailments and a seasonal 'flu vaccination service for NHS and private patients. Substance misuse services are also available. The pharmacy does not open at weekends.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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	1.8	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 not all met	3.4	Standard not met	Security arrangements are not adequate.
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 record their mistakes. And they take action to help stop some mistakes from happening again. But their records are not very detailed. So it may miss some opportunities to learn from mistakes. 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 some systems in place to identify and manage risk, including the recording of dispensing errors and near misses, although electronic records of dispensing errors did not include much detail. Very few near misses had been recorded in recent months but the pharmacist said that these were rare and that records reflected the occurrence rate. The pharmacist and dispensing assistant said that incidents were always discussed at the time of each occurrence. Some action had been taken to reduce risk: different forms of Tegretol had been separated on dispensary shelves after a near miss to reduce the incidence of picking errors. The pharmacist and dispensing assistant were aware of the risks of picking errors with 'Look-Alike, Sound-Alike' drugs, such as atenolol, amlodipine, allopurinol and amitriptyline and demonstrated that these were stored on different shelves. The procedure to follow in the event of needlestick injury was available in the standard operating procedure (SOP) file.

A range of written SOPs underpinned the services provided, although these were overdue for review and there was a risk that they might not reflect current practice. The dispensing assistant understood which activities could and could not take place in the absence of the responsible pharmacist (RP). An RP notice was conspicuously displayed.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. A formal complaints procedure was in place and information about how to make complaints was included in the practice leaflet displayed at the medicines counter. A poster advertising the NHS complaints service 'Putting Things Right' was also displayed near the medicines counter.

A current certificate of professional indemnity insurance was available. All necessary records were kept and generally properly maintained, including RP, private prescription, emergency supply, specials procurement and controlled drug (CD) records. However, electronic emergency supply records were not always made in line with the legal requirements necessary to provide a clear audit trail in the event of queries or errors, as some did not include the nature of the emergency.

The dispensing assistant had signed the information security SOP and a confidentiality agreement. She was 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 at the medicines counter advertised the way in which data was used by the pharmacy and gave details of the pharmacy's Data Protection Officer. Leaflets available to provide to patients gave a comprehensive summary of the ways in which patient information was managed and safeguarded.

The pharmacist had undertaken formal safeguarding training and had access to guidance and local

contact details that were available in the SOP file. The dispensary assistant had received informal training and was able to identify different types of safeguarding concerns. The team were able to give examples of how they had identified and supported potentially vulnerable people, which had resulted in positive outcomes. A chaperone policy was available in the SOP file and a summary of the policy was displayed outside the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generally has enough staff to manage its workload. Staff are properly trained for the jobs they do. And they feel comfortable speaking up about any concerns they have. But the company does not provide cover when staff members are away. This means the pharmacy may not be able to provide its services as effectively as usual.

Inspector's evidence

The superintendent pharmacist oversaw all professional activities, assisted by a qualified dispensing assistant. The pharmacy did not employ any other support staff so there was limited flexibility to cover absences. The pharmacy was very quiet during the inspection and the team were able to comfortably manage the workload. The dispensing assistant had the necessary training and qualifications for her role. There were no specific targets or incentives set for the services provided. The dispensing assistant had an obvious rapport with customers since the pharmacy served a small and close-knit community. She said that she was happy to approach the superintendent pharmacist with suggestions or concerns. The pharmacy's whistleblowing policy included a confidential helpline for reporting concerns outside the organisation and the dispensing assistant said she understood she could also contact the local health board or GPhC.

The dispensing assistant 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. She had access to informal training materials such as articles in trade magazines, information about new products from manufacturers and updates from the local health board. She said that she was always involved in the provision of any new services and had recently received training from the local health board on the blood borne virus testing service. However, the lack of a structured training programme increased the risk that she might not be able to keep up to date with all aspects of current pharmacy practice. There was no formal appraisal system in place which increased the risk that opportunities to identify training needs could be missed. However, the dispensing assistant said that she could discuss performance and development issues informally with the pharmacist whenever the need arose.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is clean and tidy. It has enough space to allow safe working and its layout protects people’s privacy. But security arrangements are not always adequate.

Inspector's evidence

The pharmacy was situated inside a convenience store. It was clean, tidy and well-organised. The dispensary was small but there was enough space to allow safe working, although some stock and prescriptions were temporarily stored on the floor. The sinks 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 generally appropriate, although the lighting in the room housing the controlled drugs cabinet was a little dim.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is good at promoting the services it provides so that people know about them. But some people, such as wheelchair users, may have difficulty accessing the premises. The pharmacy's working practices are generally safe and effective. And it generally manages medicines well. But it doesn't always keep prescription forms with dispensed medicines. This means that the pharmacy's team members may not always have all the information they need when handing out the medicines.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was flat access into the convenience store but the flight of stairs leading up to the pharmacy could not be accessed by a wheelchair. The pharmacist and dispensing assistant said that they would go down to patients in wheelchairs and help them with transactions if necessary. There was no wheelchair access into the consultation room. However, the pharmacist said that in the past he had arranged to close the store to provide services or private consultations to people who could not access the room. He said that he could also conduct private consultations over the telephone if necessary. The dispensing assistant said that she would signpost patients requesting services they could not provide to other nearby pharmacies. The pharmacist said that he 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 influenza vaccination service and the common ailments service.

The pharmacist said that the dispensing workload was easy to manage as it mostly consisted of repeat prescriptions with occasional walk-ins. The pharmacy dispensed an average of 1,800 prescription items each month. Disposable MDS trays were used to supply medicines to 13 patients. Trays were labelled with descriptions and patient information leaflets were routinely supplied. A list of patients was available in the dispensary for reference.

Baskets were not used to assemble prescriptions, but these were dispensed and bagged one at a time to avoid the risk of transposition of medicines. Dispensing labels were not always initialled by the dispenser and checker to provide an audit trail and there was a risk that this might prevent a full analysis of dispensing incidents. Prescriptions were not always retained for dispensed items. Most prescriptions were scanned and the image remained available for reference. However, this was not the case for all prescriptions and there was a risk that prescriptions for some Schedule 3 CDs might not be marked with the date of supply at the time the supply was made, as required by legislation. The pharmacist said that stickers were used on prescriptions awaiting collection to alert the dispensing assistant to the fact that a CD requiring safe custody or fridge item was outstanding, although there were no examples of this available as evidence. There was no strategy in place to ensure that Schedule 3 or 4 CDs were not supplied to the patient or their representative more than 28 days after the date on the prescription.

The pharmacist said that patients prescribed high-risk medicines such as warfarin, lithium and methotrexate were identified using 'pharmacist consultation required' stickers and that he asked all walk-in patients prescribed warfarin for relevant information about blood tests and dosage changes. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that two patients prescribed valproate who met the risk criteria had been provided with appropriate information and counselling via their carers. The dispensing assistant demonstrated that valproate

patient information leaflets and cards were stored in the dispensary. 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 not obtained for controlled drugs. The pharmacist said that the delivery sheet was marked if a controlled drug was included in the package to allow the driver to notify the patient they were receiving a CD. However, there were no examples of this available. If a patient or their representative was not at home to receive a delivery, the delivery driver usually put a notification card though the door and brought the prescription back to the pharmacy. However, records showed that prescriptions were occasionally posted through letterboxes at the patient's request, which increased the risk of errors. The pharmacist said that this was always at his discretion after risks had been assessed and was a last resort rather than a routine occurrence.

Medicines were obtained from licensed wholesalers and generally stored appropriately, although some different products and different strengths of the same product were stored very closely together which increased the risk of picking errors. Medicines requiring cold storage were stored in a small drug fridge which contained some ice; the dispensing assistant said that it was due to be defrosted. Maximum and minimum temperatures were recorded daily and were consistently within the required range. The fridge thermometer was not working during the inspection and the pharmacist said that the batteries had failed that morning. After the batteries had been changed the temperature displayed was within the required range. Most CDs were stored appropriately in a tidy and generally well-organised CD cabinet. P medicines were stored in a padlocked glass cabinet in the retail area that was marked 'Please ask for assistance'.

There was some evidence to show that regular expiry date checks were carried out, but the frequency and scope of these checks were not documented. This created a risk that out-of-date medicines might be supplied. 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 and the superintendent pharmacist's private e-mail account. The pharmacist was able to describe how he had dealt with medicines or medical devices that had been recalled as unfit for purpose by quarantining stock and returning it to the relevant supplier. The pharmacy was fully compliant with the Falsified Medicines Directive.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide 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 and the dispensing assistant said that these were washed after use. A Dispensette pump was used to measure methadone. The pharmacist said that the pump was cleaned after each use and calibrated regularly, although no records were available. 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, 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 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.