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: 04/03/2020

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 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	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 mistakes from happening again. But their records are not very detailed. So they may miss some opportunities to learn. 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

A range of written SOPs underpinned the services provided. The dispensing assistant was able to explain in detail which activities could and could not take place in the absence of the responsible pharmacist. The pharmacy had some systems in place to identify and manage risk, including the recording of dispensing errors, although these 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. They were aware of the risks associated with 'Look-Alike, Sound-Alike' or 'LASA' drugs, such as atenolol, amlodipine, allopurinol and amitriptyline and demonstrated that these were stored on different shelves. Different forms of Tegretol had been separated in the dispensary after a near miss and a caution sticker had been used to highlight the risk of selection errors with sildenafil and other 'LASA' drugs. The procedure to follow in the event of needlestick injury was available in the standard operating procedure (SOP) file. A poster describing action to be taken in the event of anaphylaxis was displayed in the consultation room.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey were displayed at the medicines counter and showed that this was mostly positive. The pharmacy used the NHS complaints procedure 'Putting Things Right' to deal with complaints and a poster advertising this was displayed near the medicines counter. Information about how to make complaints was included in the practice leaflet which was also displayed at the medicines counter.

Evidence of professional indemnity insurance was not available at the time of the inspection, but the pharmacist owner provided this the next day. All necessary records were kept and generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, and controlled drug (CD) records. However, some electronic emergency supply records had not been made in line with the legal requirements necessary to provide a clear audit trail in the event of queries or errors. This was because they did not always include the nature of the emergency. CD running balances were typically checked monthly. Records of patient-returned CDs that had recently been destroyed did not include a witness's signature, although the dispensing assistant confirmed that she had witnessed the destruction of these items by the pharmacist.

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 and managed 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 level two safeguarding training and had access to guidance and local contact details that were available in the SOP file. The dispensary assistant had received level one safeguarding 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 pharmacist owner worked on most days, 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. She said that she was happy to approach the superintendent pharmacist with suggestions or concerns. The pharmacy had a whistleblowing policy which included a confidential helpline for reporting concerns outside the organisation. The dispensing assistant understood that she could also contact the local health board or GPhC to report concerns.

The dispensing assistant gave a coherent explanation of the WWHAM questioning technique for 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 was registered with a training provider and also 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. 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 owner 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 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. Some stock and prescriptions were temporarily stored on the floor but did not pose a trip hazard. 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 appropriate. It was a cold day and a heater was being used to keep the dispensary warm.

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.

Inspector's evidence

The pharmacy offered a range of services that were clearly and 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 he was able 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 nearby pharmacies or other providers, such as the local medical practice. The pharmacist said that he had recently visited the local surgeries and dentist to discuss and promote services as part of a health board-funded collaborative working initiative. Visits had involved discussions around the influenza vaccination service, the smoking cessation service and the common ailments service. Information about Covid-19 was displayed clearly in the waiting area.

The pharmacist said that the dispensing workload was easy to manage as it mostly consisted of repeat prescriptions with occasional walk-ins. Disposable compliance aid trays were used to supply medicines to a number of patients. The superintendent pharmacist said that he was not currently taking on any new patients as the service was at capacity. Trays were labelled with descriptions to enable identification of individual medicines and the dispensing assistant said that 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 usually initialled by the dispenser and checker to provide an audit trail, except for labels on substance misuse clients' daily doses. The lack of a clear audit trail might prevent a full analysis of dispensing incidents. Stickers were used on prescriptions awaiting collection to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding, or that the pharmacist wished to speak to the patient or their representative at the point of handout. These prescriptions were kept in a designated area to further alert the team that an intervention needed to be made before supply. Stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

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 dispensing assistant said that she would recognise these medicines as high-risk and would refer to the pharmacist before supply. The pharmacist said that he asked all walk-in patients prescribed warfarin for relevant information about blood tests and dosage changes and counselled them appropriately. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that

patients prescribed valproate who met the risk criteria had been provided with appropriate information and counselling, either directly or via their carers. Patient information about valproate was available in the dispensary and displayed at the medicines counter. 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. However, delivery sheets were marked if a controlled drug was included in the package to allow the driver to notify the patient they were receiving a CD. If a patient or their representative was not at home to receive a delivery, the delivery driver put a notification card though the door and brought the prescription back to the pharmacy.

The pharmacist said that uptake of the common ailments and smoking cessation services was quite high as the pharmacy had many referrals from local surgeries. He said that the private health check services involving blood pressure, blood glucose and cholesterol measurement were also popular, and he had recently referred at least three people using these services to their GP for further investigations.

Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were stored in a small drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. Most CDs were stored in a well-organised CD cabinet. Stock methadone and some other CDs were stored in a large safe that the pharmacist said had been approved by the police. Pharmacy medicines were stored in a padlocked glass cabinet in the retail area that was marked ‘Please ask for assistance’.

Stock was subject to regular expiry date checks. These were documented, and short-dated items were highlighted with stickers. However, two bottles of furosemide oral solution were found to be out of date. On investigation, there was no recent date-check record for the internal liquids section. Laxity of date-checking procedures creates the risk that out-of-date medicines might be supplied. However, the pharmacist said that he included an expiry date check as part of his accuracy checking procedure. 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 pharmacist owner’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. Drug alerts and recalls were printed, filed and signed when actioned. 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 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 and the dispensing assistant said that these were washed after use. A Dispensette pump was used to measure methadone. Records showed that the pump was cleaned after each use and calibrated regularly. 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 electrical equipment 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.