General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Canna Pharmacy, 27 Wyndham Crescent, CARDIFF, CF11 9EE

Pharmacy reference: 1114605

Type of pharmacy: Community

Date of inspection: 20/05/2024

Pharmacy context

This pharmacy is inside a medical centre in an inner-city district of Cardiff. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a range of services including provision of emergency hormonal contraception, treatment for minor ailments and a seasonal influenza vaccination service for NHS patients. Substance misuse services are also available.

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	N/A	N/A	N/A
2. Staff	Standards not all met	2.1	Standard not met	Members of the pharmacy team are not all suitably trained for the tasks that they carry out which means they may not always complete tasks in an effective manner.
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 some of their mistakes so they can learn from them. And they take action to help reduce the risk of similar mistakes happening again. But they do not record or review all of their mistakes, so they may miss some opportunities to learn and improve. The pharmacy keeps the records it needs to by law. But details are missing from some of the records, so it may not always be able to show exactly what has happened if any problems arise.

Inspector's evidence

The pharmacy had some systems in place to identify and manage risk, including the recording of dispensing errors and near misses. Only one record of a dispensing error was available to view, but the pharmacist said that no other errors had been made. There were no records of near miss incidents available, but the pharmacist said that he sometimes used individual logs with new starters, or if he noticed a pattern of frequent errors. He explained that he and the accuracy checking technician (ACT) discussed near misses with relevant team members at the time they came to light. And that any patterns or trends that emerged were discussed with the pharmacy team. Action had been taken to reduce some risks that had been identified. For example, following some near misses, different forms of ramipril and different strengths of citalopram, losartan and venlafaxine had been distinctly separated on dispensary shelving. Shelf edge stickers had also been used to highlight these products to the pharmacy team to help reduce the risk of selection errors. The ACT explained that the most common error she identified involved an incorrect quantity. Action had been taken to help reduce this type of error: for example, quantities had been circled on different pack sizes of ibandronic acid tablets as an alert.

A range of paper standard operating procedures (SOPs) underpinned the services provided. Most members of the pharmacy team had signed training records to confirm that they had read and understood these. The ACT said that she had been verbally trained on the pharmacy's procedures but had not yet read or signed the SOPs. And a dispensing assistant said that she had read the SOPs but had not yet signed them. However, both were able to describe their roles and responsibilities when questioned. The ACT was able to describe the activities that could not take place in the absence of the responsible pharmacist.

Evidence of current professional indemnity insurance was available. Pharmacy records appeared to be up to date, and most were properly maintained, including responsible pharmacist (RP), private prescription, emergency supply and unlicensed medicines records. However, there were occasions on which the pharmacist had not signed out of the RP register to show the time at which he had relinquished responsibility for the safe and effective running of the pharmacy. So there was a risk that it would not be possible to identify the pharmacist in charge if something went wrong. Emergency supply records did not always include the nature of the emergency, and some unlicensed medicine records did not include patient details. This might make it difficult to resolve queries or investigate errors. CD running balances were typically checked at the time of dispensing, or monthly. Methadone balances were checked weekly. However, some medicines which were not frequently supplied had not been subject to a balance check for several months, which increased the risk that concerns such as dispensing errors or diversion might be missed.

The pharmacist and ACTs had undertaken advanced formal safeguarding training, although the ACT present said that she was due to undertake a refresher course on this topic. Some team members had undertaken basic formal safeguarding training. All team members had access to guidance and local safeguarding contact details via the internet. A notice in the consultation room advised people to ask if they would like to have a chaperone present.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough staff to manage its workload. Most pharmacy team members understand their roles and responsibilities. But two team members are not suitably trained for the tasks that they carry out, so they may not always work safely and effectively.

Inspector's evidence

The superintendent pharmacist worked at the pharmacy on most days. His absences were covered by regular locum pharmacists. The pharmacy team consisted of a full-time pharmacy technician, who worked as an accuracy checker (ACT) and had undertaken a qualification in advanced practice, a part-time dispensing assistant (DA) and a full-time member of staff who had qualified as a pharmacist in India and had worked in the pharmacy as a dispensing assistant for about two years. He worked under the supervision of the superintendent pharmacist but had not undertaken any formal training. A delivery driver worked at the pharmacy every Tuesday. The pharmacist explained that the delivery driver was his sister and that she also manned the medicines counter for a few hours a week under his supervision. She had worked at the pharmacy for about four months but had not received any formal training. Another full-time ACT was absent, and the pharmacist explained that she would only be working at the pharmacy for just over another week. He had recruited a qualified dispensing assistant to replace her role. The staffing level appeared adequate for the services provided. There were no specific targets or incentives set for the services provided.

Members of the pharmacy team were observed to use appropriate questions when selling over-the-counter medicines and referred to the pharmacist on several occasions for further advice on how to deal with transactions.

The ACT understood the revalidation process and explained that she based her continuing professional development entries on situations she came across in her day-to-day working environment. Other team members had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They explained that much of their learning was via informal discussions with the pharmacist. Members of the team had completed mandatory training provided by NHS Wales on mental health awareness and improving the quality of services provided. However, the pharmacy team did not have a structured training programme, which meant that individuals might not keep up to date with current pharmacy practice. There was no formal appraisal system in place, which meant that development needs might not always be identified or addressed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, tidy and well-organised. 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. It was small but had enough space to allow safe working. Some dispensed medicines awaiting collection 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. Hand sanitiser was available for staff use. A consultation room was used 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's services are easy for people to access. Its working practices are generally safe and effective. It generally stores its medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy team offered a range of services which were appropriately advertised. There was wheelchair access into the pharmacy but access into the consultation room was impeded by a table that partially blocked the entrance door. The pharmacist explained that he could provide services to people who could not access the consultation room in the main retail area outside pharmacy hours, or during the lunch hour when the pharmacy was closed. He was also able to use one of the surgery's treatment rooms to provide services if necessary. The pharmacy had an internet-based telephone system with multiple handsets that allowed two people to make calls to its number at the same time. This meant that people had good access to the pharmacy team by phone. Pharmacy team members said that they would signpost people requesting services they could not provide to other nearby pharmacies. Some health promotional material was on display in the retail area. The pharmacy team spoke four languages between them and explained that this benefited many people from the local community whose first language was not English.

The pharmacy team used baskets to help 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. However, some daily doses for substance misuse clients were not marked in this way, which might prevent a full analysis of any dispensing incidents. Prescription forms were not always retained for dispensed items awaiting collection, except for prescriptions for controlled drugs requiring safe custody. This meant 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. Most prescriptions were scanned, and the image remained available for reference. However, this was not the case for all prescriptions. There was a risk that an accurate and complete record of prescription details might not be available for reference at the time of supply.

Stickers were placed on prescription bags to alert team members to the fact that a CD requiring safe custody or fridge item was outstanding. A member of the dispensing team explained that stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was invalid and could no longer be supplied. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

Supplies had recently been made against two private prescriptions that had not been signed by the prescriber. The pharmacist said that this was an oversight. There is a risk that a supply made against an unsigned prescription might not be in accordance with the directions of a prescriber.

Prescriptions for high-risk medicines such as warfarin, lithium and methotrexate were not routinely highlighted so there was a risk that counselling opportunities could be missed. However, the pharmacist explained that local surgery teams annotated prescriptions for methotrexate and lithium with the date on which the person's next blood test was due. And he would always ask new or walk-in patients for

relevant information about blood tests and dosage changes. However, this information was not recorded, which might lead to a lack of continuity of care. Pharmacy team members were aware of the risks of valproate use during pregnancy. They were also aware of the requirement to supply valproate products in original packs. The pharmacy did not have any people prescribed valproate who met the risk criteria. However, the pharmacist confirmed that any such patients would routinely be counselled and provided with information that was available in the retail area.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. Compliance packs were labelled with descriptions of the medicines they contained so that individual medicines could be easily identified. Patient information leaflets were routinely supplied. A list of people who received their medicines in compliance packs was displayed in the dispensary for reference. Each patient had a clear plastic wallet that contained their personal and medication details and any current 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 might increase the risk of errors. The pharmacy also provided an original pack and MAR chart service to a small number of care home residents.

The pharmacy provided a discharge medicines review service and uptake of this was steady. There was a high uptake of the common ailments service. The pharmacist was an independent prescriber and was able to provide the extended common ailments service to treat UTIs, and minor skin and ear infections. The pharmacy offered a sore throat test and treat service and uptake of this was also high. Demand for the emergency supply of prescribed medicines service was low, as the pharmacy was situated inside the local surgery, which had similar opening hours, so people were usually able to obtain a valid prescription from a GP in an emergency.

The pharmacy provided a prescription collection service from three local surgeries. It also offered a medicines delivery service on one day each week for a charge. The delivery driver used a delivery sheet to record each delivery that was made. Patients or their representatives signed to show if they had received a controlled drug as an audit trail. 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 generally stored appropriately. Medicines requiring cold storage were kept in a large medical fridge. Maximum and minimum temperatures for the fridge were checked and recorded daily and the records showed that temperatures were consistently within the required range. However, the maximum temperature was slightly high during the inspection. The pharmacist managed this appropriately by resetting the thermostat and rechecking the temperature until it was within the required range. CDs were stored in a well-organised CD cabinet. However, the CD key had been left in the door of the cabinet, which could compromise security. The pharmacist removed the key and secured it on his person as soon as this was pointed out. Obsolete CDs were kept separately from usable stock.

There was some evidence to show that 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 overlooked, although none were found. Date-expired medicines were disposed of appropriately. The pharmacy received safety alerts and recalls via email. The pharmacy team described how they would deal with a medicine recall by contacting patients where necessary, quarantining affected stock, and returning it to the supplier.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide the services that it offers. And its team members use these 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 to prevent cross-contamination. Triangles and a capsule counter were used to count loose tablets and capsules. A separate triangle was available for use with cytotoxics. Members of the pharmacy team had access to personal protective equipment such as disposable gloves. The pharmacy had a range of up-to-date reference sources. All equipment was clean and in good working order.

Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the consultation room was used for private conversations and counselling. Computer screens were not visible to people using the pharmacy.

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.