General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Health Plus Pharmacy, Grange medical centre, Bishop Street, Grangetown, CARDIFF, CF11 6PG

Pharmacy reference: 1115768

Type of pharmacy: Community

Date of inspection: 29/04/2024

Pharmacy context

This pharmacy is inside a medical practice in a southern 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 emergency hormonal contraception, smoking cessation and treatment for minor ailments. 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	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. Its team members record their mistakes so they can learn from them. And they take action to help reduce the risk of similar mistakes from happening again. The pharmacy keeps the records it needs to by law. But some details are missing, so it may not always be able to show exactly what has happened if any problems arise. Pharmacy team members keep people's private information safe. And they understand how to recognise and report 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 of dispensing errors and near misses. There were no records of dispensing errors, but the pharmacist explained that no errors had been made since the pharmacy had changed ownership the previous year. She reviewed near miss errors weekly and discussed any emerging patterns or trends with the pharmacy team. Some action had been taken to reduce risks that had been identified. For example, different strengths of amlodipine tablets and citalopram tablets had been distinctly separated on dispensary shelving. This was a proactive measure to help reduce the risk of selection errors with these products. The pharmacist explained that incorrect drug and strength errors had reduced dramatically since the recent implementation of the pharmacy's new software system. The software allowed most prescription items to be scanned so that the medicine field in the patient medication record (PMR) could be populated directly from the barcode. If the wrong item was scanned, the system would not generate a label, which helped to reduce picking errors. However, analysis of near misses showed that some quantity errors still occurred. To help reduce the incidence of these, the pharmacy team had been asked to circle quantities on original packs to show that they had been double-checked. The pharmacist explained that whenever she checked a split pack, she would count the quantity supplied and write this on the carton before performing her final accuracy check.

A range of paper standard operating procedures (SOPs) underpinned the services provided. Members of the pharmacy team had signed training records to confirm that they had read and understood the SOPs. SOPs were not marked to show who had produced them, the date on which they had been produced or the date of next review, so there was a risk that they might not be up to date. However, the pharmacist explained that they had been produced by the superintendent pharmacist the previous year when the pharmacy had changed ownership. Some SOPs referred to processes that were only applicable to England, so there was a risk that these might not always accurately reflect the activities currently carried out by the pharmacy. The pharmacist explained that a set of electronic SOPs also existed, but these could not currently be accessed by the pharmacy team. Team members understood their roles and responsibilities. A trainee dispensing assistant was able to describe the activities that could not take place in the absence of the responsible pharmacist.

The pharmacy team explained that they had received some negative customer feedback following the recent change of ownership. The changes to the way the pharmacy operated had led to problems with longer waiting times and other customer service issues. However, the team gave assurances that the situation had improved considerably, and verbal feedback from people using the pharmacy was now mostly positive. There was no formal complaints procedure available or advertised in the pharmacy. However, the pharmacist gave assurances that an electronic SOP existed. She explained that

she provided people who wished to make a formal complaint with the email addresses of the superintendent pharmacist or pharmacist owner.

Evidence of current professional indemnity insurance was available. Most records were up to date and properly maintained, including responsible pharmacist (RP), private prescription, emergency supply and unlicensed medicines records. However, emergency supply records did not always include the nature of the emergency and some unlicensed medicine records were not marked with patient details. This might make it difficult to resolve queries or investigate errors. CD running balances were typically checked monthly, except for methadone balances, which were checked weekly.

Some members of the pharmacy team had received training on confidentiality that had been provided by the pharmacy's previous owner. Newer members of the team explained that they had received verbal training on confidentiality and understood the importance of protecting patients' privacy and dignity. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. A trainee dispensing assistant offered the use of the consultation room to a person who wished to speak to the pharmacist during the inspection.

The pharmacist had undertaken advanced formal safeguarding training. Some team members had undertaken in-house safeguarding training that had been provided by the previous pharmacy owner. Newer members of the team had not yet undertaken any training but were able to describe basic safeguarding issues and understood that they should refer these to the pharmacist. All team members had access to guidance and local safeguarding contact details via the internet.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members are properly trained for the jobs they do. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacist manager worked at the pharmacy on most days. Her absences were covered by locum pharmacists or the superintendent pharmacist. She was supported by two dispensing assistants (DAs) and five trainee DAs. Pharmacy team members were able to comfortably manage the workload and the staffing level appeared adequate for the services provided. The delivery driver had worked at the pharmacy for two months and was shortly to be enrolled on an accredited training course relevant to his role. Trainees worked under the supervision of the pharmacist or another trained member of the pharmacy team.

Members of the pharmacy team working on the medicines counter were observed using 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. A computer terminal at the medicines counter allowed team members to access patient medication records to help them make decisions about sales of medicines or provision of advice.

Team members 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. The pharmacist explained that she regularly asked team members to complete short quizzes or assessments on different clinical or operational topics. She also held weekly ‘huddles’ for team discussions where time permitted. Short one-to-one reviews were held with each member of the team once a month. Newer members of the team also received a review following their three-month probation period.

There were no specific targets or incentives set for the services provided. Pharmacy team members worked well together and 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, superintendent pharmacist and owner. There was no whistleblowing policy available in the pharmacy. However, team members understood that they could contact the GPhC if they wished to raise a concern outside the organisation.

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 and well-organised. Some medicine stock and dispensed prescriptions were temporarily stored on the floor and posed a trip hazard. The pharmacy team moved these as soon as it was pointed out. The sink had hot and cold running water. Soap and cleaning materials were also available. Hand sanitiser was available for staff use. A consultation room was available for private consultations and counselling, and this 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 largely 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. The pharmacy entrance had automatic doors and there was wheelchair access into the pharmacy and consultation room. Pharmacy team members said that they would signpost people requesting services they could not provide to nearby pharmacies or other providers such as the local council, which offered a needle and sharps collection service. A signposting file provided by the local health board was available. The pharmacy team spoke five languages between them and explained that this benefited many people from the local community whose first language was not English.

The dispensary was well-organised with a logical workflow, and the atmosphere in the pharmacy was calm and professional. The pharmacy team had a good relationship with the GP surgery team, which meant that queries and problems were usually dealt with quickly and effectively. Dispensing staff used colour-coded baskets to help ensure that medicines did not get mixed up during dispensing and to differentiate between different people's prescriptions.

The pharmacy team processed people's prescriptions on a patient medication record (PMR) system that used barcode scanning technology. A list of tasks that needed to be performed each day was displayed on the dispensary wall for reference to help make sure that the dispensing process ran smoothly. Dispensing labels generated using the system were not initialled by team members. This was because the PMR software provided an audit trail to show who had been involved in the dispensing process. Each member of the team, including the pharmacists, had an individual password to log into the system and their initials were printed in the 'dispensed by' or 'checked by' boxes of the dispensing label. Only the pharmacists were able to access the clinical check function. The pharmacist explained that a physical accuracy check was not performed for all prescription items as the software system would only generate dispensing labels if the correct product was selected and scanned. In this case the 'checked by' box on the dispensing label was simply marked with a tick. The pharmacist always performed a physical accuracy check for controlled drugs and split packs.

Prescriptions were not always retained for dispensed items awaiting collection, except for prescriptions for controlled drugs and any prescriptions that could not be scanned. However, most prescriptions were scanned, and the image remained available for reference. Each prescription awaiting collection was assigned to a specific storage location in the dispensary. When pharmacy team members needed to locate a prescription, the patient's name was entered into the PMR system and this brought up a list of locations in which their items were being stored, including medical fridges or the CD cabinet where applicable. In addition, stickers were placed on prescription bags to alert team members to the fact that a CD requiring safe custody or fridge item was outstanding. 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. Each bag label attached to a prescription

awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail. A text messaging service was available to let people know that their medicines were ready for collection.

Prescriptions for people prescribed high-risk medicines such as warfarin, lithium and methotrexate were marked with stickers to identify the patient for counselling. The pharmacist explained that she would ask these 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. Monitoring booklets for lithium, methotrexate and warfarin were available in the consultation room for provision to patients. 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 wherever possible. 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 dispensary and the consultation room.

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. Each patient was allocated a labelled box file which was used to store their dispensed compliance packs. The file was marked with a CD sticker if their medicines included a controlled drug. A plastic wallet inside the box file contained the patient's personal and medication details, collection or delivery arrangements, details of any messages or queries for communication purposes and any relevant documentation, such as their current prescriptions and any hospital discharge letters.

The pharmacy provided a discharge medicines review service, although uptake of this was low. The common ailments service was well-established, and there was a high uptake of this, as the pharmacy received frequent referrals from the adjacent GP surgery. The superintendent pharmacist was an independent prescriber and was able to provide the extended common ailments service on some days. Demand for the emergency supply of prescribed medicines service was occasional, 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 offered a smoking cessation service (supply only) and an EHC/bridging contraception service. Some substance misuse services were also provided, including a supervised consumption service. The pharmacy team planned to provide an influenza vaccination service to NHS and private patients later in the year.

The pharmacy provided a prescription collection service from six local surgeries. It also offered a free medicines delivery service. The pharmacy team telephoned people requesting a delivery a week before their medicines were due. A date was then arranged for delivery, and this was recorded in the pharmacy's delivery record book. Patients or their representatives did not usually sign to acknowledge receipt of their medicines, except for controlled drugs. This meant that pharmacy team members might not be able to resolve queries or manage complaints effectively. In the event of a missed delivery, the delivery driver usually 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. Two boxes containing medicines that had been removed from their original packaging were not marked with their batch number or expiry date, which could make it difficult for the pharmacy to respond effectively to a query or safety recall. Two bottles of time-sensitive liquid medicines had not been marked with the date of opening. So it was unclear whether or not they were still suitable for supply. The pharmacist dealt with these items appropriately as soon as they were pointed out to her. Medicines requiring cold

storage were kept in a large, well-organised medical fridge. Maximum and minimum temperatures for the fridges were usually checked and recorded daily, although there were occasional gaps in the records. The recommended maximum temperature had been exceeded on a few occasions. Pharmacy team members explained that they had managed this appropriately by resetting the thermometer and rechecking temperatures until they were within the required range, although they had not made records of this. CDs were stored in two well-organised CD cabinets. Some dispensed CDs awaiting collection in one of the cabinets could no longer be legally supplied, as more than 28 days had elapsed since the date marked on the prescription. The pharmacist admitted that this was an oversight and dealt with the prescriptions appropriately. The pharmacy stored some Pharmacy only medicines in glass cabinets in the retail area, which were marked 'Please ask for assistance with these medicines'. The cabinets were not locked, but there was always a pharmacy team member at or near the medicines counter who could intervene if a member of the public attempted to self-select a medicine.

Stock was subject to regular documented expiry date checks. Short-dated items were highlighted with stickers. Date-expired medicines were disposed of appropriately, as were patient returns. There was no separate bin for disposing of cytotoxic waste, but the pharmacist explained that she was in the process of ordering one from the pharmacy's waste contractor. She gave assurances that the team would separate any cytotoxic waste they received in the meantime. The pharmacy received safety alerts and recalls via MHRA (Medicines and Healthcare products Regulatory Agency) and manufacturer emails. The pharmacist described how the team 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 team has the equipment and facilities it needs to provide the services. Its 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 to prevent cross-contamination. Triangles were used to count loose tablets and a separate triangle was available for use with cytotoxics. The pharmacy had a range of up-to-date reference sources.

Most equipment was new and had been installed when the pharmacy had changed ownership the previous year. 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 pharmacy software system was protected with a password and computer screens were not visible to people using the pharmacy. The consultation room was used for private conversations 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.