General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M W Phillips Chemists, 7 South Park Road, Splott, CARDIFF, CF24 2LU

Pharmacy reference: 1119825

Type of pharmacy: Community

Date of inspection: 21/02/2020

Pharmacy context

This is a pharmacy in a suburb of Cardiff. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers some services including treatment for minor ailments and a seasonal 'flu vaccination service for NHS and private patients.

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 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 its staff know how to keep people's private information safe. The pharmacy's team members understand how to recognise and report 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 and root cause analysis (RCA) of dispensing errors. However, RCAs did not contain very much information and in one case the root cause had not been identified. Near misses were recorded regularly and were reviewed monthly by staff members. Reviews were not very detailed and there was a risk that patterns and trends might not be identified and managed appropriately. However, staff demonstrated that some action had been taken to reduce risk: for example, different strengths of gabapentin and different forms of aspirin had been separated on dispensary shelves following selection errors. Staff said that they discussed patient safety issues during regular team meetings. These included issues such as similar packaging, selection errors that had recently occurred, and any company-wide learning points received via head office bulletins.

A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Lists of procedures to follow and activities that could and could not take place in the absence of the responsible pharmacist were displayed on the dispensary noticeboard.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. Staff said that this was mostly positive. A card from a patient displayed in the dispensary thanked the pharmacy team for their care. The pharmacy used the NHS procedure 'Putting Things Right' to deal with complaints, although this was not advertised in the retail area.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. However, the pharmacist had occasionally not signed out of the web-based RP register to show the time at which they had relinquished the safe and effective running of the pharmacy. The register also included one incorrect entry which the pharmacist said was an oversight. She explained that when the system was shut down for any reason, the programme automatically signed the RP out of the register. On this occasion, the pharmacist had gone back into the system and signed into the register but had selected the first person on the list in error rather than themselves. The mistake had been rectified after a few minutes. Some electronic emergency supply records did not include the nature of the emergency, and it was not always clear whether the person requesting the supply was the patient or the prescriber. There was a risk that there would not be enough information available to provide a complete audit trail in the event of an error or incident. CD running balances were typically checked monthly.

The NVQ3 qualified dispensing assistant said that she had signed a confidentiality agreement while

working at another branch of the company. The trainee dispensing assistant said that she could not remember signing a confidentiality agreement. However, 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 gave a summary of the way in which personal data was used and managed by the pharmacy. It included details of the company's data protection officer.

The pharmacist had undertaken level two safeguarding training and had access to guidance and local contact details that were displayed in the dispensary. The NVQ3 qualified dispensing assistant had received in-house training. The trainee dispensing assistant said she had not yet undertaken any safeguarding training, but she was able to identify different types of safeguarding concerns. Cards that included details of a charity that provided support for people affected by dementia were displayed at the medicines counter.

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

The regular pharmacist manager worked at the pharmacy on most days. She was assisted by a full-time trainee dispensing assistant, who worked under her close supervision and a full-time dispensing assistant who had an NVQ3 qualification. The pharmacy team worked well together. They could comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided.

Targets were set for MURs, but these were managed appropriately, and the pharmacist said that they did not affect her professional judgement or compromise patient care. The pharmacy served a small and close-knit community and staff had an obvious rapport with customers. The trainee dispensing assistant said that she was happy to make suggestions and felt comfortable raising concerns with the pharmacist, the area office manager or the superintendent pharmacist. A whistleblowing policy that included a helpline for reporting concerns outside the organisation was displayed in the dispensary.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients. She referred to the pharmacist on several occasions for further advice on how to deal with a transaction. The WWHAM questioning procedure for over-the-counter sales was displayed at the till for reference. Staff 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. They had not received formal appraisals but said that they could informally discuss performance and development issues with the pharmacist whenever the need arose. The pharmacist said that a formal appraisal process was due to be implemented very soon. The lack of a structured training and development programme increased the risk that individuals might not keep up to date with current pharmacy practice and that opportunities to identify training needs could be missed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy. 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 stock and dispensed prescriptions 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. A lockable 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. 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 some checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. Leaflets in the retail area also advertised several private services that were not currently offered, as the patient group directions underpinning them had expired. Access to the pharmacy entrance was uneven, but the pharmacist said that the team would go out to people in wheelchairs and help them into the pharmacy if necessary. There was wheelchair access into the consultation room. A list of local pharmacies participating in the health board's palliative care scheme was displayed in the consultation room. Staff said that they would signpost people requesting services they could not provide to other nearby pharmacies. Some health promotional material was displayed near the pharmacy entrance.

Dispensing staff used a colour-coded basket system to help ensure that medicines did not get mixed up during dispensing and to differentiate between different prescriptions. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Stickers were attached to prescriptions awaiting collection to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. Pre-printed labels were used to show that a patient was eligible for an MUR. Pre-printed labels were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was no longer valid. However, one prescription for gabapentin was found present that was not marked in this way.

The pharmacist said that stickers were attached to prescription bags to routinely identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate. Staff recorded information about blood tests and dose changes on the patient medication record (PMR). The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that one patient prescribed valproate who met the risk criteria had been counselled and provided with information. A valproate information pack was available 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. However, the delivery sheet was marked with a CD sticker, which alerted the driver to notify the patient they were receiving a controlled drug. In the event of a missed delivery, the delivery driver put a notification card though the door and either returned the medication to the pharmacy or took it to another nearby branch. It was unclear if patients had given consent for their medicines to be left at another branch under these circumstances, and there was a risk that this practice could compromise confidentiality.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a number of

patients. Trays were labelled with descriptions to enable identification of individual medicines. Patient information leaflets were routinely supplied. Each patient had a section in a dedicated file that included their personal and medication details, details of any messages or changes, and a record of staff involved in dispensing and checking each tray on any given date. A list of patients that included their collection or delivery arrangements was displayed on the front of the file for reference.

Medicines were obtained from licensed wholesalers and stored appropriately. Some NFA-VPS category veterinary medicines were stored in a locked glass cabinet in the retail area to prevent self-selection. Medicines requiring cold storage were stored in a well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in two well-organised CD cabinets.

Stock was subject to regular expiry date checks. These were documented, and short-dated items were highlighted with stickers. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. A scheme run in association with GSK allowed the pharmacy to recycle returned inhalers. The pharmacy received drug alerts and recalls via NHS email. The pharmacist was able to describe how she would deal with medicines or medical devices that had been recalled as unfit for purpose by contacting patients where necessary and returning quarantined stock to the relevant supplier. The pharmacy had the necessary hardware to work in accordance with the Falsified Medicines Directive but the software had not been installed and so the pharmacy was not yet in a position to comply with legal requirements.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. 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. Triangles and capsule counters were used to count tablets and capsules. A separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was clean and in good working order. The pharmacist said that a head office staff member had visited the pharmacy to test portable electrical equipment about six months previously. 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 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.