General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Marshfield Pharmacy And, Convience Store, 127 Marshfield Road, Marshfield, CARDIFF, CF3 2TU

Pharmacy reference: 1120348

Type of pharmacy: Community

Date of inspection: 25/09/2019

Pharmacy context

This is an Essential Small Pharmacy situated inside a village store and post office on the outskirts 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.

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. The pharmacist records 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 it keeps people's private information safe. The pharmacist is trained to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

The locum pharmacist displayed an appropriate notice to show that she was in charge of the safe and effective running of the business. She worked in accordance with a set of written Standard Operating Procedures (SOPs) that were in the process of being reviewed by the superintendent pharmacist. There were systems in place to record dispensing errors and near misses, although numbers of these were low. An error report had been completed following a recent quantity error where 28 tablets had been supplied against a prescription for 56 tablets. The pharmacist said that the prescription information had been entered manually instead of being scanned onto the system. The error had not been picked up when the item had been self-checked. She said that the pharmacists now scanned all prescriptions where possible to reduce the possibility of human error when labelling. She was able to describe recent action that had been taken to reduce risk: a caution sticker had been used to highlight the risks of picking errors with prochlorperazine and prednisolone tablets.

The pharmacist said that regular customer feedback was encouraged via a comments and suggestions box at the medicines counter. She said she believed that most feedback was positive. A formal complaints procedure was in place. A leaflet advertising the NHS complaints procedure 'Putting Things Right' was displayed at the medicines counter.

A certificate of current professional indemnity insurance was displayed. All necessary records were kept, including Responsible Pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. Most records were properly maintained, although the pharmacists had occasionally failed to sign out of the RP register to show when they had relinquished responsibility for the safe and effective running of the pharmacy. Some private prescription records were missing relevant dates. These omissions did not meet legal requirements and there was a risk that a clear audit trail might not be available in the event of queries or errors.

The pharmacist was aware of the need to protect confidential information and dispose of it appropriately. Confidential records were stored out of public view. Both the pharmacist and the superintendent pharmacist had undertaken level two safeguarding training and had access to local guidance and contact details available via the internet.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's workload is primarily managed by the pharmacist. They are generally able to provide safe and effective services as the volume of work is low. However, as no regular staff members are employed at the pharmacy the pharmacist's ability to carry out services such as medicines reviews and minor ailment consultations is limited.

Inspector's evidence

The uptake of services was low and the pharmacist was able to comfortably manage the minimal workload during the inspection. Her absences were covered by the superintendent pharmacist or other locum pharmacists. The pharmacy served a small village and the pharmacist had an obvious rapport with customers, most of whom she knew by name. She said that the superintendent pharmacist did not set any specific targets or incentives for the services provided.

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, tidy and well-organised. It was small but had sufficient space to allow safe working. Some dispensed prescriptions were being 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 lockable consultation room was available for private consultations and counselling, although it could not be seen from the waiting area. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that are easy for people to access. If it can't provide a service it directs people to somewhere that can help. Its working practices are generally safe and effective. It stores most medicines appropriately and carries out some checks to help make sure that they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a limited range of services that were advertised appropriately. There was wheelchair access into the pharmacy and the consultation room. The pharmacist said that she would signpost patients requesting services she did not offer to other local pharmacies. Some health promotional material was on display at the medicines counter.

The pharmacist used a basket system to help ensure that medicines did not get mixed up during dispensing. She initialled dispensing labels to provide an audit trail. She said that as all prescription items were self-checked she was careful to take a mental break in between assembling the items and performing her final check. She said that the first step in her process was to label and clinically check the prescription. She then picked the stock medicines against the prescription and put them into a basket. She labelled each item and then took a break before performing the final check. She said that she circled the quantity and ticked the strength and form on each dispensing label as a physical aid to her mental checking process.

Stickers were attached to prescriptions to alert the pharmacist to the fact that a fridge item was outstanding. The pharmacist said that controlled drugs (CDs) requiring safe custody were generally not dispensed until the patient or their representative came to collect them. Controlled drugs requiring safe custody and fridge lines were dispensed in clear bags. This allowed the pharmacist to check these items at all points of the dispensing process and reduced the risk of a patient receiving the wrong medicine. The pharmacist said that as she handed out all prescriptions she was able to check the validity of Schedule 3 and 4 CDs that did not require safe custody before supply to the patient.

The pharmacist said that she would routinely counsel patients prescribed high-risk medicines such as warfarin, lithium or methotrexate at the point of handout. She was aware of the risks of valproate use during pregnancy and said that any patients meeting the risk criteria would be counselled and provided with appropriate information. The information pack for valproate patients 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.

The pharmacist and superintendent pharmacist delivered prescriptions themselves outside working hours where necessary. The pharmacist said that the numbers of deliveries involved were very low and signatures were not routinely obtained as an audit trail. She said that she had never known a delivery to include a CD.

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

of patients. The pharmacist said that new patients were only supplied with compliance aids at the request of their GP. Compliance aids were labelled with descriptions to enable identification of individual medicines. Patient information leaflets were not always supplied, which does not comply with legislation, and so there was a risk that patients might not always have all the information they need for them to make informed decisions about their own treatment. One compliance aid included paracetamol at a dose of two tablets four times daily, although the prescription stated that it should be taken when required. The pharmacist said that the paracetamol dose was included in the compliance aid at the request of the GP. She said that she would ask the surgery to alter the prescription to reflect this. Each patient had a section in a file that included their personal and medication details, collection or delivery arrangements, and details of any messages or queries.

Medicines were obtained from licensed wholesalers and most were stored appropriately. Some bottles containing loose tablets that had been removed from their original packaging were not adequately labelled either as stock or named-patient medication. This increased the risk of error and did not comply with legal requirements. 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. There was a very small stockholding of CDs which was stored appropriately in a well-organised CD cabinet. Obsolete CDs were segregated from usable stock.

Stock was regularly checked and date-expired medicines were disposed of appropriately, as were patient returns. The pharmacy received drug alerts and recalls via its NHS email account. 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 software required to work in accordance with the Falsified Medicines Directive. However, the pharmacist said that the superintendent was intending to replace the scanners as they were not compatible with the software. This meant that 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 services. It uses these in a way that protects people's privacy.

Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Triangles and a capsule counter were used to count tablets and capsules. The pharmacist said that these would be washed after use with loose cytotoxics. There was a range of up-to-date reference sources available. All equipment was clean and in good working order, although there was no evidence to show 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 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.