General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M W Phillips Chemist, Whitchurch Road Surgery, Sachville Avenue, Cardiff, Caerdydd, CF14 3NY

Pharmacy reference: 9012097

Type of pharmacy: Community

Date of inspection: 27/11/2024

Pharmacy context

This pharmacy is in a medical centre in Cardiff. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy offers a range of services including provision of emergency hormonal contraception, treatment for minor ailments and a seasonal 'flu vaccination service for both 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 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. Pharmacy team members know how to 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 a recording process for dispensing errors and near misses. There were no records of dispensing errors available to view, but the superintendent pharmacist explained that there had been no recent errors at the branch. He gave an appropriate description of the way in which he would record a dispensing error if this was necessary. Near miss records were available. The dispensing assistants explained that pharmacists 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 whole team. Some action had been taken to reduce risks that had been identified. For example, a shelf edge sticker had been used to highlight different forms of ramipril, following some near misses. The team had used an elastic band to group ramipril tablets together to help ensure that they were double checked before selection.

A range of standard operating procedures (SOPs) underpinned the services provided, although some of these were overdue for review. Pharmacy team members had signed the SOPs to show that they had read and understood them. The superintendent pharmacist gave assurances that a set of reviewed electronic SOPs were in the process of being rolled out throughout the company and that those currently in place were still fit for purpose. Members of the team were able to describe their roles and responsibilities. The RP notice displayed was incorrect, but the pharmacist remedied this as soon as it was pointed out to him.

The pharmacy team explained that verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place. But this was not advertised in the retail area, so people using the pharmacy may not know how to raise a complaint.

Evidence of current professional indemnity insurance was available. Pharmacy records were up to date, including private prescription, emergency supply, unlicensed medicines and controlled drug (CD) records. Running balances of controlled drugs (CDs) were usually checked at the time of dispensing, although medicines that were not frequently supplied were typically checked every two months. Infrequent CD balance checks could lead to concerns such as dispensing errors or diversion being missed. On discussion, the pharmacy team understood the risks and agreed to conduct more frequent CD balance checks going forward.

Members of the pharmacy team explained that they had signed confidentiality agreements as part of their contract of employment. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. The pharmacists had undertaken advanced formal safeguarding training. Other team members had completed basic formal safeguarding training. The team 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. 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 three days each week. Her absences were usually covered by regular locum pharmacists, although the superintendent pharmacist was working as the responsible pharmacist on the day of the inspection. The pharmacy team consisted of three dispensing assistants (DA), one of whom was absent during the inspection, and a trainee DA. The staffing level appeared adequate for the services provided and pharmacy team members were able to safely manage the workload. The trainee DA worked under the supervision of the pharmacist or other trained members of staff.

Members of the pharmacy team working on the medicines counter were observed using appropriate questions when selling over-the-counter medicines to people. And they referred to the pharmacist on several occasions for further advice on how to deal with transactions. Pharmacy 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. They had also recently completed mandatory training provided by NHS Wales on mental health awareness. However, the lack of a structured training programme 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. But all pharmacy team members could informally discuss performance and development issues with the pharmacists whenever the need arose.

There were no specific targets or incentives set for the services provided. Pharmacy team members worked well together. They were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists and members of the company’s senior management team. A whistleblowing policy was available in the SOP file. It included details of confidential helplines that could be used to report concerns outside the organisation.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean, tidy and well-organised. It is secure and has enough space to allow for safe working. There is a room where people can have conversations with team members in private.

Inspector's evidence

The pharmacy was generally clean and tidy, with enough space to allow for safe working. Some stock medicines were being temporarily stored on the floor, but these did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available.

A consultation room was available for private consultations and counselling, but its availability was not 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. But members of the pharmacy team do not always know when higher-risk medicines are being handed out. So, they might not always be able to check that medicines are still suitable or give people advice about taking them. The pharmacy stores medicines appropriately and carries out 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 advertised on the company's website. The website address was conspicuously displayed on a large board in the retail area. There was wheelchair access into the pharmacy and consultation room. Pharmacy team members signposted people requesting services that could not be provided to other nearby pharmacies or other providers such as the local council, which offered a waste sharps collection service.

Dispensing staff used baskets to help ensure that medicines did not get mixed up during the dispensing process. The dispenser and accuracy checker initialled dispensing labels to provide an audit trail. Stickers were placed on prescription bags to alert team members to the fact that a CD requiring safe custody or fridge item was outstanding. There was no process in place to routinely identify Schedule 3 or 4 CDs that were awaiting collection, so there was a risk that these items might be supplied past their 28-day validity period. A text messaging service was available to let people know that their medicines were ready for collection.

Prescriptions for higher-risk medicines such as warfarin, lithium and methotrexate were not routinely highlighted, so there was a risk that counselling opportunities could be missed. However, pharmacy team members explained that they asked people collecting prescriptions for warfarin about their most recent blood test result and relayed this information to the pharmacist. The pharmacy team were aware of the risks of valproate and topiramate use during pregnancy. They were also aware of the requirement to supply valproate products in original packs. They confirmed that anyone prescribed valproate or topiramate who met the risk criteria would be counselled and provided with information at each time of dispensing. Patient information about valproate and topiramate was available in the dispensary.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. Most compliance packs were assembled off-site in another pharmacy owned by the company. However, the team explained that if a person required a compliance pack at short notice, they assembled it at the pharmacy. Compliance packs were accompanied by descriptions of the medicines they contained so that individual medicines could be easily identified. Patient information leaflets were routinely supplied with compliance packs assembled at the pharmacy. However, they were not included with compliance packs assembled off-site. Instead, the backing sheets for these packs included a statement which signposted people to the Electronic Medicines Compendium website to view the leaflets. This statement was printed in a very small font and was not very conspicuous, so there was a risk that people might not see it and would not understand how to access this information. A list of patients receiving their medicines in compliance packs was displayed in the dispensary for reference.

The pharmacy team explained that the regular pharmacist and other locum pharmacists were able to provide a range of services on most days. The superintendent pharmacist was able to provide the common ailments service during the inspection. He explained that uptake of this service was steady, as the pharmacy received regular referrals from the adjacent GP practice. Uptake of the emergency supply of prescribed medicines service was also steady and the team explained that it tended to be used by the large student population living in the surrounding area. The pharmacy also provided blood pressure measurement, an emergency hormonal contraception (EHC) service and a seasonal influenza vaccination service for NHS and private patients.

The pharmacy provided a prescription collection service from seven local surgeries. It also offered a free medicines delivery service. Patients or their representatives signed to acknowledge receipt of the delivery as an audit trail. The delivery sheet was marked with a sticker if a CD was included in the package, which allowed the driver to notify the patient that they were receiving a controlled drug. In the event of a failed delivery, the driver brought the prescription back to the pharmacy.

Medicines were obtained from licensed wholesalers. Medicines requiring cold storage were kept in a large well-organised medical fridge. Maximum and minimum temperatures were recorded daily and were usually within the required range. A few discrepancies had been recorded but evidence showed these had been monitored appropriately. CDs were stored in a well-organised CD cabinet and obsolete CDs were kept separately from usable stock.

Medicines stock was subject to regular documented expiry date checks. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received medicines alerts and recalls via email. A dispensing assistant described how the team would deal with a safety recall by contacting patients where appropriate, 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 they offer. And they use equipment 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 loose tablets and capsules. A separate triangle was available for use with loose cytotoxics to prevent cross-contamination. The pharmacy had a range of up-to-date reference sources. All equipment was in good working order, clean and appropriately managed.

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. Some dispensed medicines could be seen from the retail area, but no confidential information was visible. The pharmacy software system was protected with a password, and 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.