

# Registered pharmacy inspection report

**Pharmacy Name:** Wylde Green Chemist, 441a Birmingham Road,  
Wylde Green, BIRMINGHAM, West Midlands, B72 1AX

**Pharmacy reference:** 1037919

**Type of pharmacy:** Community

**Date of inspection:** 19/03/2024

## Pharmacy context

This busy community pharmacy is located alongside shops and services in the Wylde Green area of Birmingham. People who use the pharmacy are from the local community and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it provides NHS funded services such as the Pharmacy First service, blood pressure testing and seasonal vaccinations. The pharmacy team dispenses some medicines into multi-compartment compliance packs for people to help make sure they remember to take them. Private services are also available, and these include travel vaccinations and weight loss medicines.

## Overall inspection outcome

✓ **Standards met**

**Required Action:** None

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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy manages the risks associated with its services to make sure people receive appropriate care. Members of the pharmacy team follow written procedures to make sure they work safely, and they complete tasks in the right way. They discuss their mistakes so they can learn from them. And team members understand their role in protecting vulnerable people and they keep people's personal information safe.

### Inspector's evidence

A range of standard operating procedures (SOPs) were in place which covered the activities of the pharmacy and the services provided. The SOPs were reviewed and updated at regular intervals and had been dated to show when they had last been reviewed. Signature sheets were used to record staff training, and roles and responsibilities were highlighted within the SOPs. Some of the regular team members had not signed SOPs related to the tasks that they were undertaking.

The pharmacy had recently started using an electronic system for some of its records. This was still a new system, and team members were still learning how to use it and what they could use it for. Near misses were recorded on the system, but the system had not been enabled to produce the monthly near miss report. The team were unsure whether any team members had carried out a review of the near misses using any other tool as they could not recall any examples of patterns and trends being shared with them. The pharmacy team gave some examples of different types of mistakes that they had made, such as compliance packs not being sealed securely, and explained how processes had been adapted to try and avoid the same mistake happening again. Dispensing errors were recorded, reviewed and reported to the SI.

One of the regular pharmacists was an independent prescriber and offered a private prescribing service. This was a face-to-face service and mainly for travel vaccinations and malaria prophylaxis, but also for some weight loss medicines. The consultation notes were retained, and a form was used to gather information about the patient, their medical history, their travel details, and to record details of the vaccinations administered. The completed forms were kept in the consultation room and a record was made onto the patient medication record (PMR) and the private prescription register. The services had been risk assessed and the risk assessment had been reviewed at regular intervals. The pharmacist had carried out an audit of the service which had focused on record keeping. A travel health resource was used to check that the vaccination requirements for the area that the person was travelling to.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. A dispensing assistant correctly answered hypothetical questions related to high-risk medicine sales and discussed how she managed requests for codeine containing medicines.

The pharmacy's complaints process was explained in the SOPs. People could give feedback to the pharmacy team in several different ways including verbal, written or Google reviews. The pharmacy team members tried to resolve issues within their control and involved the SI if they could not reach a

solution.

The pharmacy had up-to-date professional indemnity insurance. The Responsible Pharmacist (RP) notice was clearly displayed, and the RP log met requirements. Controlled drug (CD) registers were in order and two random balance checks matched the balances recorded in the register. Patient returned CDs were recorded in a register. Private prescription records were seen to comply with requirements. Specials records were maintained with an audit trail from source to supply.

Confidential waste was stored separately from general waste and destroyed securely at head office. The pharmacy team members had their own NHS Smartcards and they confirmed that passcodes were not shared. The pharmacy team understood what safeguarding meant and a list of safeguarding contacts was available. A dispensing assistant gave examples of types of concerns that they may come across and correctly described what action they would take.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough team members to effectively manage the workload and the services that it provides. Team members plan absences in advance, so the pharmacy has enough cover to provide the services. They work well together in a supportive environment, and they can raise concerns and make suggestions.

### Inspector's evidence

The pharmacy team comprised of the SI, two regular pharmacists, four dispensing assistants, six trainee dispensing assistants, a level two apprentice, and a home delivery driver. Several part-time team members were employed, and they were flexible to work evenings, weekends and college/university holidays. The SI found that this provided holiday cover for the other members of the team, and it gave students useful experience, so they had a reference for further education or for their chosen career after their studies. All of the team members were enrolled or had completed a combined medicines counter assistant and dispensing assistant course. This was the course preferred by the SI the team members were able to work on the counter and in the dispensary.

Holidays were discussed with other team members to ensure no-one else had already booked the same week, and requests were authorised by the SI. Cover was provided by other members of the team as required and having several part-time team members helped with this. Pharmacy team members completed ongoing training and training needs were identified according to new services, seasonal events, and the NHS Pharmacy Quality Scheme (PQS).

The pharmacy team worked well together and were observed helping each other with more urgent tasks when required. Tasks were delegated to different members of the team so that the workload was managed effectively and there was a rota to show which team member was in the dispensary, the retail counter, and answering the telephone.

The team discussed any pharmacy issues as they arose and held regular huddles within the dispensary during quieter times. Members of the team explained they could raise any concerns or suggestions with the SI and felt that he was responsive to feedback. Team members said that they would speak to other members of the team or contact the GPhC if they ever felt unable to raise an issue internally. The RP was observed making herself available throughout the inspection to discuss queries with people and giving advice when she handed out prescriptions, or with people on the telephone. No targets were set for professional services.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean and tidy, and it provides a suitable environment for the delivery of healthcare services. It has a consultation room, so that people can speak to the pharmacy team in private when needed.

### Inspector's evidence

The premises were smart in appearance and appeared to be well maintained. Any maintenance issues were reported to the SI. The dispensary was clean and tidy and was cleaned by team members. Hot and cold running water, hand towels and hand soap were available. The pharmacy temperature felt comfortable during the inspection and lighting was adequate for the services provided.

Prepared medicines were held securely within the pharmacy premises and pharmacy medicines were stored behind the medicines counter. There was a secure shipping container to the rear of the premises for additional storage.

The dispensary was an adequate size for the services provided and an efficient workflow was seen to be in place. Dispensing and checking activities took place on separate areas of the worktops and there was ample space to store completed prescriptions. There was a clean and adequately equipped consultation room which was signposted.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. It manages its services and supplies medicines safely. The pharmacy obtains its medicines from licensed suppliers, and stores them securely and at the correct temperature, so they are safe to use. People receive appropriate advice about their medicines when collecting their prescriptions.

### Inspector's evidence

The pharmacy had step-free access from the pavement and an automatic front door. A home delivery service was available for people who could not access the pharmacy. Health promotion leaflets were available, and posters were displayed in the waiting area. Pharmacy staff referred people to other local services using local knowledge and the internet to support signposting.

Medicines were dispensed into baskets to help make sure prescriptions were not mixed up together. Different coloured baskets were used to prioritise prescriptions. Team members signed the 'dispensed-by' and 'checked-by' boxes on medicine labels, so there was a dispensing audit trail for prescriptions. The team were aware of the risks associated with the use of valproate during pregnancy, and the need for additional counselling. Patient cards and counselling materials were available and valproate containing medicines were supplied in their original packaging.

Multi-compartment compliance packs were supplied to some people living in their own home. Prescriptions were requested from the surgeries to allow for any missing items to be queried ahead of the intended date of collection or delivery. A sample of dispensed compliance packs were labelled with descriptions of medicines to help people identify them. Patient information leaflets were sent with each supply so people could access additional information about their medicine. There was a process in place for managing changes to medicines after packs had been supplied to people and suitability assessments were completed for any new requests. Monthly and acute NHS prescriptions were provided to local care homes. Audit trails were in place for each of the homes and the processes for ordering, dispensing and delivering were explained.

A random sample of dispensary stock was checked, and all the medicines were found to be in date. Date checking records were maintained for both the dispensary and the shop, and medication was proactively removed prior to its expiry date. Medicines were stored in an organised manner on the dispensary shelves. All medicines were stored in their original packaging. Split liquid medicines with limited stability once they were opened were marked with a date of opening. Patient returned medicines were stored separately from stock medicines in a designated area. Medicines were obtained from a range of licenced wholesalers. Drug recalls were received electronically and marked when they were actioned.

The controlled drug cabinets were secure and a suitable size for the amount of stock that was held. Medicines were stored in an organised manner inside. Fridge temperature records were maintained, and records showed that the pharmacy fridge was working within the required temperature range of

2°C and 8°Celsius.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide services safely. The pharmacy team stores and uses the equipment in a way that keeps people's information safe.

### Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including the British National Formulary (BNF) and the children's BNF. Internet access was available. Patient records were stored electronically and there were enough computer terminals for the workload currently undertaken. A range of clean, crown stamped measures and counting triangles were available. Equipment for clinical consultations had been procured and was stored appropriately. Some of the equipment was single use, and ample consumables were available.

Computer screens were not visible to members of the public. Cordless telephones were in use and staff were observed taking phone calls in the back part of the dispensary to prevent people using the pharmacy from overhearing.

### 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.