

Registered pharmacy inspection report

Pharmacy Name: Millstream, The Avenue, Featherstone,
WOLVERHAMPTON, West Midlands, WV10 7AX

Pharmacy reference: 1038574

Type of pharmacy: Community

Date of inspection: 17/06/2024

Pharmacy context

This is a traditional community pharmacy located on a parade of shops in a residential area of Featherstone in South Staffordshire. 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 and blood pressure testing. The pharmacy team dispenses some medicines into multi-compartment compliance packs for people to help make sure they remember to take them.

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
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 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 that they can learn from them. 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 by the superintendent pharmacist (SI) and dated to show when this had last been completed. Signature sheets were used to record staff training on SOPs, and roles and responsibilities were highlighted within the SOPs. The SI worked at the pharmacy as the regular responsible pharmacist (RP). The pharmacy employed an accuracy checking pharmacy technician (ACPT) to support the team by checking certain prescriptions. The SI and the ACPT had verbally agreed which prescriptions could be checked by the ACPT and the process to follow. But this was not documented in the SOPs meaning that other RPs or pharmacy team members may not be aware of this agreement and deviate from it.

A near miss log was available and near misses were recorded. Near misses were discussed with the dispenser involved to ensure they learnt from the mistake, and any immediate learnings were shared verbally with the team. The team gave some examples of medicines that had been separated on the shelves to reduce the risk of them being selected in error during the dispensing process. The near miss log was reviewed at the end of the month and patterns and trends were identified. The outcome was shared with the pharmacy team and an action plan was created. The monthly reviews were used to create an annual patient safety report. The SI had a clear understanding of the process for reporting and investigating an incident. He completed a root cause analysis (RCA) to aid the review process and identify actions to prevent a similar mistake occurring in the future.

Members of the pharmacy team were knowledgeable about their roles and discussed these during the inspection. The ACPT correctly answered hypothetical questions related to high-risk medicine sales and discussed how requests for codeine containing medicines were handled to make sure people were given the right advice.

The pharmacy's complaints process was explained in the SOPs, in the practice leaflet and on a poster displayed to people using the pharmacy. People could give feedback to the pharmacy team verbally or in writing. The pharmacy team members tried to resolve issues that were within their control and the SI had a template form that was used for investigating complaints. The SI had worked at the pharmacy for several years and he had developed a good rapport with people who regularly used the pharmacy. People were asking to speak to the pharmacist throughout the inspection for advice, to discuss their medicines, to update him on their health condition or about a recent GP or hospital appointment.

The pharmacy had up-to-date professional indemnity insurance. The 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. Private prescription records were generally seen to comply with requirements. There was some confusion about whether the pharmacy was using a paper record book, or an electronic record. The SI agreed to review the electronic records and to consider whether to switch to electronic records instead of the paper record book moving forward. Specials records were maintained with an audit trail from source to supply. Home deliveries were tracked and recorded using a delivery smartphone application (app).

Confidential waste was stored separately from general waste and destroyed securely offsite. The pharmacy team members had their own NHS Smartcards. The SI had completed the Centre for Pharmacy Postgraduate Education Training (CPPE) on safeguarding, and the pharmacy team had a clear understanding of what safeguarding meant and what to do if they had a concern.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough team members to manage the workload and the services that it provides. Its team members plan absences in advance, so the pharmacy has enough staff cover to provide the services. Team members 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 (RP during the inspection), an accuracy checking pharmacy technician (ACPT), two trained dispensing assistants, a medicine counter assistant (MCA), and a home delivery driver. A vacancy for a replacement MCA for someone who had recently left was being advertised. The SI felt that he would have enough staff when he had filled the vacancy. He had advertised for an MCA as he felt that if someone covered the medicines counter it would allow the dispensing assistant to focus on dispensary tasks. Annual leave was booked in advance and locum dispensing assistants were used to provide cover when the full-time members of the team were on holiday.

The pharmacy team were observed working well together and they helped each other by moving from their main duties to help with more urgent tasks when required. The team members discussed any pharmacy issues as they arose. They held regular meetings within the dispensary during quieter times or before the pharmacy opened. The team members had annual appraisals and they completed ongoing training aligned to the NHS Pharmacy Quality Scheme (PQS) training requirements and new pharmacy services.

The pharmacy team members said that 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, the operations manager, or the GPhC if they ever felt unable to raise an issue internally. The SI was observed making himself available throughout the inspection to discuss queries with people and giving advice when he handed out prescriptions.

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 members in private when needed.

Inspector's evidence

The premises were smart in appearance and well maintained. Any maintenance issues were reported to the SI or the operations manager and various maintenance contracts were in place. 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.

The dispensary was clean and tidy. The pharmacy was cleaned by pharmacy staff. Hot and cold running water, hand towels and hand soap were available. The temperature in the dispensary felt comfortable and lighting was adequate for the services provided.

There was a private consultation room which was used by the pharmacy team during the inspection. The consultation room was professional in appearance and signposted to people using the pharmacy.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are accessible. 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. A home delivery service was available for people who could not easily access the pharmacy. A range of health promotion leaflets were available and posters signposted people to other healthcare services that were available locally. The pharmacy offered the NHS Pharmacy First service. Quick reference guides were available, and the NHS PGDs (patient group directions) and supporting documentation were available for reference.

Medicines were dispensed into baskets to help make sure they 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. A 'four way' check was recorded on prescription forms if the prescription was suitable for the ACPT to accuracy check. This provided an additional audit trail for dispensing, the clinical check, the accuracy check and who handed out the prescription.

Stickers or notes were attached to completed prescriptions to highlight people suitable for certain services or that needed fridge or CD items adding. The team had a clear understanding of the risks associated with the use of valproate containing medicines during pregnancy, and the need for additional counselling. They knew to supply valproate containing medicines in original containers. The team were also aware of the additional counselling required for high-risk medicines, such as warfarin and methotrexate.

Multi-compartment compliance packs were used to supply medicines for some people. Prescriptions were ordered in advance to allow for any missing items or changes to be queried with the surgery ahead of the intended date of supply. Each person had a record to show what medication they were taking and how it should be packed. Notes about prescription changes and queries were kept on the patient medication record. Descriptions of medicines were routinely recorded on the dispensing labels and patient information leaflets were supplied every month. There was a process in place for managing mid-cycle change requests.

A random sample of dispensary stock was checked. One of the medicines checked was out of date. The SI explained this as a human error as it had been missed when the team had undertaken routine date checking. Medicines were stored in an organised manner on the dispensary shelves. All medicines were observed being 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 designated bins. Medicines were obtained from a range of licenced wholesalers. Drug recalls were received electronically and printed and annotated to show that the stock had been checked.

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 fridges were working within the required temperature range of 2° 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 suitably 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.