

Registered pharmacy inspection report

Pharmacy Name: Well, 6 Marine Street, Cwm, EBBW VALE, Gwent,
NP23 7ST

Pharmacy reference: 1043379

Type of pharmacy: Community

Date of inspection: 04/07/2022

Pharmacy context

This is a village pharmacy. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. About half of the NHS prescriptions it supplies are assembled off-site at another pharmacy owned by the company. It offers a wide range of services including emergency hormonal contraception, smoking cessation, treatment for minor ailments and a seasonal 'flu vaccination service for NHS and private patients. Substance misuse services are also available.

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	2.2	Good practice	Staff have the appropriate skills, qualifications and competence for their roles and are supported to address their learning and development needs
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
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 discuss 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 it keeps 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

A range of electronic standard operating procedures (SOPs) underpinned the services provided. These were regularly reviewed. The pharmacy had systems in place to identify and manage risk, including the recording of dispensing errors and near misses. The pharmacist discussed patient safety incidents with relevant staff at the time of the occurrence to reduce the risk of similar errors occurring in future. Records documented that a root cause analysis (RCA) had been conducted following a recent dispensing error, although the RCA itself could not be located during the inspection. Action had been taken to reduce risks that had been identified: for example, different strengths of venlafaxine had been separated on dispensary shelves following a selection error and methadone 1mg/ml oral solution and SF methadone 1mg/ml oral solution were stored in separate CD cabinets to reduce the risk of errors.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, although these had been suspended during the pandemic. The pharmacist said that verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place and information about how to provide feedback or make complaints was included in a poster displayed on the consultation room door.

Evidence of current professional indemnity insurance was available. All necessary records were kept and properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and electronic controlled drug (CD) records. Only one historic example of an emergency supply record was seen. However, the pharmacist explained that he could not remember the last time a supply had been made, as the local surgery was open during pharmacy hours and was almost always able to issue a prescription in an emergency. CD running balances were typically checked fortnightly. One electronic record of a destroyed patient-returned CD was available, although it did not show which individuals had been involved in the destruction process as an audit trail.

Staff received training on the information governance policy and had signed confidentiality agreements. They were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. Privacy notices displayed in the consultation room and at the medicines counter signposted people to the company's website for information about the way in which their personal data was used and managed.

The pharmacist had undertaken formal safeguarding training and had access to guidance and local contact details via the internet. Staff had undertaken in-house safeguarding training. A summary of the chaperone policy was advertised in a poster on the consultation room door. Information about support groups and services for carers was available in a leaflet displayed at the medicines counter.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. Pharmacy team members complete regular training and have a good understanding about their roles and responsibilities. They feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacist manager worked at the pharmacy on most days. The support team consisted of three dispensing assistants, one of whom was absent, and a trainee dispensing assistant, who was also absent. There were enough suitably qualified and skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. Staff members had the necessary training and qualifications for their roles. The pharmacist said that the trainee dispenser worked under his supervision or under the supervision of other trained staff.

Targets were set for some services, but these were managed appropriately, and the pharmacist said that they did not affect his professional judgement or compromise patient care. Staff worked well together and had an obvious rapport with customers. They were happy to make suggestions within the team and said that they felt comfortable raising concerns with the pharmacist or area manager. A whistleblowing policy was available on the intranet and a poster advertising a confidential helpline for reporting concerns outside the organisation was displayed in the staff area.

Members of staff working on the medicines counter were observed to use appropriate questions when selling over-the-counter medicines to patients. They referred to the pharmacist on several occasions for further advice on how to deal with transactions. Staff undertook online training on new products, clinical topics, operational procedures and services. They had recently completed refresher training on the responsible pharmacist SOPs. The pharmacist understood the revalidation process. He said that he based his continuing professional development entries on situations he came across in their day-to-day working environment as well as internal and external training. All staff were subject to probationary and annual performance and development reviews and could discuss issues informally with the pharmacist whenever the need arose.

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, with enough space to allow safe working. Some stock and dispensed prescriptions awaiting collection were temporarily stored on the floor but they did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. A poster describing hand washing techniques was displayed above the sink. Hand sanitiser was available for staff and customer use. A consultation room was available for private consultations and counselling and its availability was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy promotes the services it provides so that people know about them and can access them easily. 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 checks to help make sure that they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was a small step up to the pharmacy entrance. The pharmacist said that the team would go out to people in wheelchairs and serve them at the door or help them into the pharmacy if necessary. Clearly labelled electronic push pads located inside and outside the pharmacy could be used to open the entrance door. There was wheelchair access into the consultation room. Staff said that they would signpost people requesting services they could not provide to nearby pharmacies or other healthcare providers, such as the local surgery. A booklet provided by the local health board displayed at the medicines counter provided information about other local NHS healthcare services. The pharmacist said that he had recently visited the local surgery to discuss and promote services as part of a health board funded collaborative working initiative. Recent visits had involved discussions around the repeat dispensing service and the Choose Pharmacy common ailments service.

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. Controlled drugs requiring safe custody, fridge lines and compliance aids were dispensed in clear bags to allow staff members to check these items at all points of the dispensing process and reduce the risk of a person receiving the wrong medicine. Each bag label attached to a prescription awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail. The pharmacy dispensed medicines against some faxed prescriptions from local surgeries. There were mechanisms in place to ensure that Schedule 2 or 3 CDs were only ever supplied against the original prescription.

The pharmacist said that about half of the prescriptions they received were sent offsite to be assembled at the company's hub pharmacy. The hub pharmacy could not assemble split packs, fridge lines, compliance aids or most controlled drugs, and these continued to be dispensed at the branch. A text messaging service was available to let patients know when their medicines were ready for collection. Prescriptions awaiting collection remained on the shelf for four weeks before they were moved to a designated 'uncollected' area in the dispensary. People whose prescriptions had been moved to this area were contacted each week for two weeks as a reminder. If the prescription remained uncollected, the medicines were returned to stock.

Each prescription awaiting collection was assigned to a specific storage location in the dispensary. When staff needed to locate a prescription, the patient's name was typed into a handheld device and this brought up a list of locations in which their items were being stored, including the drug fridge or CD cabinet where applicable. In addition, stickers were placed on bags to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. Stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection. This practice helped ensure that prescriptions were checked

for validity before handout to the patient.

Stickers marked 'Therapy Check' were used to routinely identify prescriptions for patients prescribed high-risk medicines such as warfarin, lithium and methotrexate. The pharmacist said that the team asked people receiving these medicines questions about blood tests and dosage changes, although they did not record any information on the patient medication record (PMR). The pharmacy team were aware of the risks of valproate use during pregnancy. A poster detailing action to be taken by pharmacists when supplying valproate was displayed in the dispensary. The pharmacist explained that any patients prescribed valproate who met the risk criteria would be counselled and provided with patient information. 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.

Disposable compliance aid trays were used to supply medicines to a number of patients. Trays were usually, but not always, labelled with descriptions of individual medicines. The descriptions did not always include enough detail to enable identification of the medicines, with many described simply as: 'round white tablet'. There was a risk that people would not have all the information they might require for them to make informed decisions about their own treatment. Patient information leaflets were routinely supplied. Each patient had a section in one of five dedicated files that included their personal and medication details as well as their collection or delivery arrangements. A list of patients was available at the front of each file for reference.

The pharmacy provided a wide range of services. The pharmacist explained that he promoted the common ailments service heavily within the village community and consequently uptake was high. The pharmacy provided a discharge medicines review service, but local hospitals did not automatically send through electronic copies of discharge letters via the Choose Pharmacy software platform, so the pharmacist was reliant on people bringing paper copies of their discharge letter to the pharmacy. This meant that uptake of the service was relatively low. The pharmacy provided a prescription collection service from three local surgeries. It also offered a prescription delivery service. Signatures were obtained for deliveries of controlled drugs. In the event of a missed delivery, the driver put a notification card through the door and brought the prescription back to the pharmacy.

Medicines were obtained from licensed wholesalers and were generally stored appropriately, although some loose blisters that had been removed from their original packaging were not adequately labelled as either named-patient medication or stock. Medicines requiring cold storage were stored in a drug fridge. It was clear that fridge stock levels were at capacity and the lack of space meant that some items such as different insulins were stored closely together, increasing the risk of picking errors. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored in two well-organised CD cabinets and obsolete stock was generally segregated from usable stock. However, one expired pack of Butec 5mg patches had not been segregated, increasing the risk of errors, although the pack was marked to show that it was short-dated. A box of MST Continus 10mg tablets and a box of Tranquilyn 10mg tablets contained mixed cut-offs from blister strips that did not include the product's batch number or expiry date. There was a risk that if any of these medicines were subject to a drug alert or recall it might not be possible to identify them. There was also a risk that the medicines could pass their expiry date without this being identifiable.

Stock was subject to regular expiry date checks. These were documented and stickers were used to highlight short-dated stock. Despite this, one expired stock pot of levothyroxine 100mcg tablets was found in the compliance aid stock area. The pharmacist admitted that this was an oversight. Date-

expired medicines were disposed of appropriately, as were patient returns and waste sharps. There was no separate bin for disposing of cytotoxic waste, but the pharmacist manager said that he was in the process of ordering one from their waste contractor and would segregate any cytotoxic waste he received in the meantime. The pharmacy received drug alerts and recalls via its NHS email account. The PMR software also flashed up a real-time alert on the computer screen. Alerts and recalls were printed and filed for reference. The pharmacist was able to describe how he had recently dealt with some baby milk that was unfit for purpose by contacting patients and returning quarantined stock to the relevant supplier.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide services. Its 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. Separate measures were used for methadone. Triangles were used to count loose tablets and were washed after use with cytotoxics. The pharmacy had a range of up-to-date reference sources. Most equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. However, a sticker on a hearing aid loop in the consultation room showed that it had failed its most recent test and one of the endorsing printers was broken. The pharmacist said that he had reported the broken printer but it had not yet been replaced. 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.