

# Registered pharmacy inspection report

**Pharmacy Name:** A & J M Sheppard Ltd, 59 Oxford Street, MOUNTAIN ASH, Mid Glamorgan, CF45 3HD

**Pharmacy reference:** 1043574

**Type of pharmacy:** Community

**Date of inspection:** 21/08/2019

## Pharmacy context

This is a busy high street pharmacy situated next door to a medical centre in a small town. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. 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. The pharmacy changed ownership in July 2018.

## 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
<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	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
<b>5. Equipment and facilities</b>	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. But its team members do not always record or review their mistakes. So it may miss some opportunities to learn from these. 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

The pharmacy had systems in place to identify and manage risk, including the recording of dispensing errors and near misses. However, very few near misses had been recorded during the current month and it was unlikely that the pharmacy's records were an accurate reflection of the occurrence rate. There was no evidence available to show that near misses were regularly reviewed. One of the pharmacists explained that the Superintendent's Office collated and analysed all patient safety data and sent out an annual summary bulletin to all branches. Some action had been taken to reduce risks that had been identified: staff demonstrated that Lustral and losartan had been separated on dispensary shelves to help reduce the incidence of picking errors after several near misses. They were aware of the risks of picking errors with 'Look-Alike, Sound-Alike' drugs, such as atenolol, amlodipine, allopurinol and amitriptyline and demonstrated that these were not stored closely together on dispensary shelves. Staff said that creating a dedicated section for fast-moving lines had helped to reduce the frequency of some selection errors, as commonly-confused products such as different forms of ramipril and aspirin were now separated. A poster describing the process to follow in the event of needlestick injury was displayed in the consultation room.

A range of written standard operating procedures (SOPs) underpinned the services provided and these had recently been reviewed. Staff were in the process of reading and signing these new versions. An appendix of the Staff Roles and Responsibilities SOP showing the tasks that each staff member was expected to perform had not yet been completed, although staff were able to clearly describe their roles and responsibilities when questioned. The accuracy checking technician (ACT) said she was able to check prescriptions for compliance aid trays where these had been clinically checked by the pharmacist. Two responsible pharmacist notices were displayed; the pharmacist in charge remedied this as soon as it was pointed out to him.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed on the consultation room door showed that this was overwhelmingly positive. A formal complaints procedure was in place and information about how to make complaints was included in the practice leaflet displayed at the medicines counter. A poster advertising the NHS complaints procedure 'Putting Things Right' was displayed on the consultation room door and inside the room itself.



A current certificate of professional indemnity insurance was on display. All necessary records were kept and generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, specials procurement and controlled drug (CD) records. However, electronic emergency supply records were not always made in line with the legal requirements necessary to provide a clear audit trail in the event of queries or errors as some did not include the nature of the emergency. CD running balances were typically checked monthly.

Staff 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. A privacy notice displayed at the pharmacy entrance advertised the way in which data was used by the pharmacy and gave details of the pharmacy's Data Protection Officer. A leaflet displayed at the medicines counter gave a comprehensive summary of the ways in which patient information was managed and safeguarded.

The pharmacist and staff had undertaken formal and in-house safeguarding training. They had access to guidance and local contact details that were available in the consultation room. Staff were able to identify different types of safeguarding concerns and said that they would refer these to the pharmacists, who confirmed that they would report concerns via the appropriate channels where necessary. A summary of the company's chaperone policy was advertised in a poster displayed on the consultation room door and inside the room itself. A local support group for people with memory difficulties and their carers was advertised in the retail area.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough staff to manage its workload. They are properly trained for the jobs they do. And they feel comfortable speaking up about any concerns they have.

### Inspector's evidence

The regular pharmacist manager usually oversaw all professional activities, assisted by another pharmacist on three days each week. The regular pharmacists were absent on the day of the inspection and their roles were being covered by two employee pharmacists. The pharmacy was busy and the dispensary was unexpectedly short-staffed as two regular dispensing assistants were absent, but staff present worked well together to manage the workload effectively. The team consisted of an accuracy checking technician (ACT), three dispensing assistants, three medicines counter assistants and two pharmacy students. Staff members had the necessary training and qualifications for their roles. One dispensing assistant had been declared competent under the grandparent clause and the pharmacy students worked under the pharmacists' supervision.

Targets were set for MURs but these were managed appropriately and the pharmacists said they did not affect their professional judgement or patient care. The pharmacy served a small and close-knit community and staff had an obvious rapport with customers. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists, superintendent pharmacist or other head office staff. A whistleblowing SOP that listed ways of reporting concerns outside the organisation had been read and signed by all staff.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients and referred to the pharmacist on several occasions for further advice on how to deal with a transaction. Staff had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They also had access to modules on obstetric and paediatric topics provided by an external training provider. All staff had recently completed training provided by NHS Wales on improving the quality of services provided and some had recently attended a bowel cancer awareness course. However, the lack of a structured training programme might restrict the ability of individuals to keep up to date with current pharmacy practice. All staff were subject to annual performance and development reviews and could informally discuss issues with the pharmacist manager 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 generally clean, tidy and well-organised. The dispensary was small but there was enough space to allow safe working, although some stock and prescriptions were temporarily stored on the floor. An area on the first floor of the pharmacy was used for the assembly of compliance aid trays. 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 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 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 range of services that were appropriately advertised. Services such as MURs, DMRs, the smoking cessation service and the prescription collection and delivery service were advertised on the front of the company's disposable compliance aid trays. There was wheelchair access into the pharmacy and consultation room. Lists of local family planning clinics and pharmacies providing a needle exchange service were displayed in the consultation room. Details of local blood-borne virus testing sites were available behind the medicines counter. Staff said that they would signpost patients requesting services they could not provide to other nearby pharmacies. A range of health promotional material and information about local community services was on display in the retail area. The pharmacist manager had recently visited local surgeries to promote services as part of a health board-funded collaborative working initiative. Recent visits had involved discussions around the DMR service and the common ailments service.

Dispensing staff used a colour-coded basket system to ensure that medicines did not get mixed up during dispensing and to differentiate between different prescriptions. Some baskets were stacked on top of each other in unstable piles and this created a risk that medicines could be transposed between patients, potentially leading to errors. Dispensing labels were usually initialled by the dispenser and checker to provide an audit trail. However, some labels for medicines supplied in or with compliance aids did not bear the dispenser's initial and this might prevent a full analysis of dispensing incidents.

Stickers were used on prescriptions awaiting collection to identify patients eligible for an MUR and 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 and were marked with the date after which the prescription was invalid and could no longer be supplied.

Stickers were used to routinely identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate so that they could be counselled. The pharmacy team were aware of the risks of valproate use during pregnancy. They said that prescriptions for valproate for patients meeting the risk criteria were stored in a dedicated area and not dispensed until the point of collection. This alerted the pharmacists to counsel the patient or their representative appropriately and provide them with patient safety information, which was available in the dispensary. A valproate information poster near the medicines counter listed the questions pharmacists should ask patients at the point of handout. 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.

Signatures were obtained for prescription deliveries. Separate signatures were obtained for controlled drugs. In the event of a missed delivery, the delivery driver put a notification card through the door and brought the prescription back to the pharmacy.

Disposable compliance aid trays were used to supply medicines to a number of patients. Trays were labelled with descriptions and patient information leaflets were routinely supplied. Each patient had a section in a dedicated file that included their personal and medication details, collection or delivery arrangements, details of any messages or queries and any relevant documentation, such as discharge summaries. The file was flagged if a patient had been admitted to hospital.

Medicines were obtained from licensed wholesalers and were generally stored appropriately, including those requiring cold storage. However, storage space was limited and some different products and different strengths of the same product were stored very closely together, which increased the risk of error. 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 legislative requirements. Controlled drugs were generally stored appropriately in three well-organised CD cabinets. There were large quantities of obsolete CDs which were segregated from usable stock.

There was some evidence to show that regular expiry date checks were carried out, but the frequency and scope of these checks were not documented. This created a risk that out-of-date medicines might be supplied, although none were found. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. A scheme run in association with GSK allowed the pharmacy to recycle returned inhalers. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist was able to describe how he 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 and hardware to work in accordance with the Falsified Medicines Directive but the team had not yet begun to decommission medicines, contrary to legal requirements. The pharmacists said that the process was currently being piloted in two branches and was shortly to be rolled out throughout the company.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide services. It makes sure these are always safe and suitable for use. The pharmacy's 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 tablets and a separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was in good working order, clean and appropriately managed. Evidence showed 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 computer was password-protected and the consultation room was used for private consultations and counselling.

### What do the summary findings for each principle mean?

#### ✓ 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.