

Registered pharmacy inspection report

Pharmacy Name: Well, 167 Bute Street, Treherbert, TREORCHY, Mid Glamorgan, CF42 5PE

Pharmacy reference: 1043629

Type of pharmacy: Community

Date of inspection: 30/10/2019

Pharmacy context

This is a village pharmacy in the Rhondda valley. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. Some NHS prescriptions 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	1.2	Good practice	Information about risk is reviewed and analysed to optimise the safety and quality of pharmacy services
2. Staff	Good practice	2.2	Good practice	Staff have the appropriate skills, qualifications and competence for their role and are supported to address their learning and development needs
		2.4	Good practice	A culture of continuous improvement through learning exists within the team
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 and review 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

The pharmacy had systems in place to identify and manage risk, including the recording and monthly analysis of dispensing errors and near misses. Root cause analyses had been conducted following recent dispensing errors. Staff said that they had team discussions about patient safety case studies provided by the superintendent's office. Some action had been taken to reduce risks that had been identified: for example, caution stickers had been used to alert staff to the risks of picking errors with different forms of co-codamol and different strengths of metformin, atorvastatin and bendroflumethiazide. The team understood the risks of errors with 'Look-alike, Sound-alike' or 'LASA' drugs and caution stickers had been used to highlight the similarities between amitriptyline and amlodipine and pregabalin and gabapentin.

A range of electronic standard operating procedures (SOPs) underpinned the services provided. These were regularly reviewed. The trainee dispensing assistant was in the process of reading and completing online declarations and assessments for all SOPs.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. Results from a recent survey showed that this was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in a poster displayed on the consultation room door. A poster advertising the NHS Complaints service, 'Putting Things Right', was displayed in the retail area.

Evidence of current professional indemnity insurance was available. All necessary records were kept and generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. CD running balances were typically checked weekly.

Staff received annual 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. Individual staff members had unique passwords to access the pharmacy computer system. A privacy notice displayed in the retail area signposted people to the company's website for information about how their personal data was used and managed. A poster in the retail area described how NHS Wales used prescription information to help them make better informed decisions about medicines and patient services.

The pharmacists had undertaken level two safeguarding training and had access to guidance and local contact details that were available via the internet. Staff had undertaken in-house training and were

able to identify different types of safeguarding concerns. All staff were trained Dementia Friends. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door.

Principle 2 - Staffing ✓ Good practice

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. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

A regular relief pharmacist worked on Tuesdays, Fridays and alternate Saturdays. A regular locum pharmacist worked on Mondays, Wednesdays and Fridays. Their absences were covered by other locum pharmacists. They were assisted in the day-to-day operation of the pharmacy by a part-time branch manager, who was a pharmacy technician. The support team consisted of a trainee pharmacy technician and a trainee dispensing assistant who worked well together. 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. The trainee staff members worked under the supervision of the pharmacist.

Targets were set for MURs, but these were managed appropriately and the pharmacist said that they did not affect his professional judgement or compromise 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 would feel comfortable raising concerns with the pharmacists, the Regional Development Manager or their union representative. A poster advertising a confidential helpline for reporting concerns outside the organisation was displayed in the staff area.

A member of staff working on the medicines counter gave a coherent explanation of the WWHAM questioning technique and gave appropriate examples of situations she would refer to the pharmacist. Staff undertook online training on new products, clinical topics, operational procedures and services. They were able to access training modules from home and had recently completed training on the company's new patient medication record (PMR) system. All staff were subject to six-monthly performance and development reviews and could discuss issues informally with the pharmacists or pharmacy manager whenever the need arose.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is generally clean and tidy. It is secure. It has enough space to allow safe working and its layout protects people's privacy.

Inspector's evidence

The pharmacy was housed in an old building and some of the décor needed refreshment. The carpet in the retail area was stained. The basement area had suffered some water damage and the flooring was dirty. However, no stock was stored in this area and staff said that it was not really used. The dispensary was clean, tidy and well-organised. It was small but there was enough clear bench space for safe working. The floor was uneven, and staff said that this had been reported to the superintendent's office, as it posed a possible trip hazard. The sinks had hot and cold running water and soap and cleaning materials were available. 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 provides services that are generally easy for people to access. If it can't provide a service it directs people to somewhere that can help. The pharmacy is well-organised and its working practices are generally effective. It supports people taking higher-risk medicines by making extra checks and providing counselling where necessary. It stores 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. However, the team said that enhanced services could only be provided by the regular relief pharmacist on Tuesdays, Fridays and alternate Saturdays. There was a small step up to the pharmacy entrance, but staff said that they would go out to patients in wheelchairs and help them into the pharmacy if necessary. There was wheelchair access into the consultation room. Hearing aid loops were available in the consultation room and at the medicines counter. Staff said that they would signpost patients requesting services they could not provide to other nearby pharmacies.

The pharmacy team said that a new pharmacy software system had recently been installed which allowed about 43% of their prescription items to be assembled at the Well hub pharmacy in Stoke-on-Trent. The hub pharmacy could not assemble split packs, controlled drugs requiring safe custody, fridge lines or monitored dosage system (MDS) trays and these continued to be dispensed at the branch. Prescription items scanned to the hub before 3pm were generally returned to the branch within 48 hours, although there were occasional delays. A text messaging service was available to let patients know their medicines were ready for collection. Prescriptions remained on the retrieval shelves for three weeks before the patient was contacted again, and the medicines were returned to stock after a further week if not required.

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. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Controlled drugs requiring safe custody, fridge lines and MDS trays 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 patient 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.

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 the patient's 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 and were marked with the date after which the prescription was invalid and could no longer be supplied. Staff said that stickers were placed on prescriptions awaiting collection to identify patients eligible for an MUR. Notes were attached to prescriptions if the pharmacist wished to speak to the patient or their representative at the point of handout.

Pre-printed notes were used to routinely identify patients prescribed high-risk medicines such as warfarin, lithium and methotrexate. The pharmacist demonstrated that relevant information about blood tests and dose changes was recorded on the PMR. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that any patients prescribed valproate who met the risk criteria would be counselled appropriately and provided with appropriate information. A valproate patient information pack was available in the consultation room. 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 not obtained for controlled drugs. However, these were supplied in separate clear bags and the delivery sheet was marked with a CD sticker, which alerted the driver to notify the patient they were receiving a CD. 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 MDS trays were used to supply medicines to a number of patients. Patient information leaflets were routinely supplied. However, trays were not labelled with descriptions to enable identification of individual medicines. This created a risk that the patient might not have all the information needed for them to make informed decisions about their own treatment. Each patient had a section in one of four dedicated files that included their personal and medication details. The files contained progress logs which showed the status of each patient's tray at any given time. They included the patients' collection or delivery details. Details of any messages or medication changes were added to the computerised patient medication record (PMR). A separate file was kept for patients who were currently in hospital. Staff said that any new patients requesting the service were assessed for suitability using a questionnaire.

Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were stored in a tidy, well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored in two tidy, well-organised CD cabinets and obsolete CDs were segregated from usable stock.

Stock was regularly checked and 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. Staff described how they had dealt appropriately with a recent drug recall involving ranitidine products. They demonstrated that the PMR software flashed up a real-time alert on the screen when a recall was received. Drug recalls were printed, filed and signed to show that they had been actioned. The pharmacy had the necessary hardware and software to work in accordance with the Falsified Medicines Directive but the team said that they were not currently compliant due to some problems with the software that needed to be resolved.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its 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 and these were clearly segregated. 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 pharmacy software system was protected with a password and the consultation room was used for private consultations and counselling. Dispensed prescriptions could be seen from the retail area but no confidential information was visible.

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.