

Registered pharmacy inspection report

Pharmacy Name: A. & J.M. Sheppard Ltd., 15 Llwynypia Road,
TONYPANDY, Mid Glamorgan, CF40 2EL

Pharmacy reference: 1043640

Type of pharmacy: Community

Date of inspection: 05/12/2019

Pharmacy context

This is a busy high street pharmacy 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.

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 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 its members understand how to keep people's private information safe. They also understand how to recognise and report concerns about vulnerable people to help keep them safe.

Inspector's evidence

The pharmacy had some systems in place to identify and manage risk, including the recording of dispensing errors and near misses. No examples of dispensing error records were available, but the pharmacist said that these were stored at the company's head office. He said that near misses were reviewed by the regular pharmacist manager, but reviews were not documented. Some action had been taken to reduce risks that had been identified: for example, different forms of Epilim and ramipril had been separated on dispensary shelves to help reduce the incidence of picking errors. A poster describing the process to follow in the event of anaphylaxis was displayed in the consultation room.

A range of written standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Two different responsible pharmacist notices were displayed, contrary to legal requirements. The pharmacist removed the pharmacist manager's notice as soon as this was pointed out to him.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed behind the medicines counter showed that this was overwhelmingly positive. A formal complaints procedure was in place. Information about how to make comments, compliments or complaints was included in the practice leaflet displayed in the retail area and in a notice at the medicines counter.

A current certificate of professional indemnity insurance was on display. All necessary records were kept and were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. However, emergency supply records were not always made in line with legal requirements as some did not include the nature of the emergency. There was a risk that there might not be enough information available to allow the pharmacy team to fully resolve queries or deal with errors effectively. CD running balances were typically checked every two months. There was a risk that infrequent balance checks might lead to concerns such as dispensing errors or diversion being missed. A check of the methadone stock balance against the register revealed a discrepancy that could not be resolved during the inspection. The next day, the pharmacist was able to explain that the deficit was the result of a missing entry and the discrepancy was resolved.



Staff said they had signed confidentiality agreements, although these could not be located. 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 summary of the company's confidentiality policy was displayed at the medicines counter. A privacy notice displayed behind the medicines counter explained the way in which data was used by the pharmacy and gave details of the pharmacy's Data Protection Officer. However, it was not easily visible from the retail area. Leaflets displayed in the retail area gave a comprehensive summary of the ways in which patient information was managed and safeguarded.

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 received in-house training and were able to identify different types of safeguarding concerns. They said that they would refer these to the pharmacist, who confirmed that he would report concerns via the appropriate channels where necessary. A summary of the chaperone policy was advertised in a poster displayed on the consultation room door and inside the room itself.

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 and a second pharmacist worked at the pharmacy on most days, except Mondays and Thursday afternoons, when only one pharmacist was on duty. The support team consisted of two accuracy checking technicians, two pharmacy technicians, a dispensing assistant, a trainee dispensing assistant and a medicines counter assistant. 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 worked well together and had the necessary training and qualifications for their roles. The trainee dispensing assistant worked under the pharmacists' supervision.

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. He said that the target was generally achievable and there was no pressure to complete MURs if other issues took priority. Staff 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 policy that included details for reporting concerns outside the organisation was available in the SOP file. It had been read and signed by all staff.

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 had access to informal training materials such as counter skills modules, articles in trade magazines and information about new products from manufacturers. However, the lack of a structured training programme might restrict the ability of individuals to keep up to date with current pharmacy practice. Two pharmacy technicians said they understood the revalidation process, basing their continuing professional development entries on external training and on issues they came across in their day-to-day working environment. They said that they had recently attended training events on inhaler technique and hearing problems. All staff were subject to annual performance and development reviews. They could informally discuss issues with the pharmacists whenever the need arose.



Principle 3 - Premises ✓ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and well-organised, with enough space to allow safe working. However, tote boxes containing stock were being temporarily stored in the middle of the dispensary floor and posed a possible trip hazard. Staff moved these as soon as this was pointed out. 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. A semi-private hatch that opened into the dispensary from a screened part of the retail area was used by substance misuse clients. The entrance to the hatch was partially obstructed by an old weighing machine and some boxes of point-of-sale materials. Stored prescriptions were visible from the hatch and some patient information could be seen. Staff said that this was an oversight and moved the prescriptions as soon as this was pointed out. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are easy for people to access. 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 make sure 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 wheelchair access into the pharmacy and consultation room. Staff said that they would signpost people requesting services they could not provide to other nearby pharmacies. Some health promotional material was on display in the retail area.

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. Stickers, a green highlighter pen or the annotation 'CD' were used on prescriptions awaiting collection to alert staff to the fact that a CD requiring safe custody was outstanding, or that a Schedule 3 or 4 CD was present in the bag. However, two prescriptions for Schedule 3 CDs were found not to be marked in this way. One of these was no longer valid as the prescription was over 28 days old. The pharmacist removed the prescription from the retrieval area and dealt with it appropriately. A yellow highlighter was used to identify prescriptions with a fridge item outstanding. Staff said that stickers were used to identify patients eligible for an MUR.

Prescription bags were marked 'INR' to routinely identify patients prescribed warfarin so that they could be counselled. An accuracy checking technician said that staff asked for relevant information about blood tests and dose changes and recorded this on the patient medication record (PMR). Patients prescribed other high-risk medicines such as lithium and methotrexate were not routinely identified and there was a risk that opportunities for counselling might be missed. The pharmacy team were aware of the risks of valproate use during pregnancy. They said that any patients prescribed valproate who met the risk criteria would be counselled and provided with appropriate information. Information for patients prescribed valproate 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 and 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.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a number of patients. The compliance aids were labelled with descriptions. However, these did not always include



enough detail to enable identification of individual medicines, with many described simply as: 'round white tablet'. Patient information leaflets were routinely supplied. A list of patients and their delivery or collection arrangements was available in the dispensary for reference. 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 changes and any relevant documentation, such as current prescriptions.

The pharmacy had carried out approximately 50 influenza vaccinations during the 2019/20 season. The majority of these had been as part of the NHS enhanced service. The pharmacist said that there was a high uptake of the recently-implemented sore throat test and treat service, although the pharmacy manager was the only person currently able to provide this.

Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were stored in two fairly well-organised drug fridges. Maximum and minimum temperatures were recorded daily and were consistently within the required range. However, some different insulin products and strengths were jumbled together in one fridge, which increased the risk of errors. Some food was stored in the other fridge, which increased the risk of temperature fluctuation and contamination. The pharmacist removed the food as soon as this was pointed out. CDs were stored appropriately in three CD cabinets. Large quantities of obsolete CDs were segregated from usable stock. One CD cabinet was very full, with different products and different strengths of the same product stored closely together, increasing the risk of errors.

Stock was subject to regular expiry date checks. These were documented, and short-dated items were highlighted with stickers. Date-expired medicines were disposed of appropriately, as were patient returns, waste sharps and clinical waste. An unsealed sharps bin containing used sharps was situated in the unlocked consultation room, which could be accessed from the retail area. Staff moved this as soon as it was pointed out. 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 which was checked at the beginning and end of each day. The pharmacy team were able to describe how they had dealt 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 hardware to work in accordance with the Falsified Medicines Directive, but the software had not been installed and so the pharmacy was not yet in a position to comply with legal requirements.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It generally makes sure these are 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 marked. Triangles were used to count tablets and staff said that these would be washed after use with loose cytotoxics. Some dispensing bottles were stored uncapped, which increased the risk of contamination. The pharmacy had a range of up-to-date reference sources. All equipment was in good working order 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.

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.