

Registered pharmacy inspection report

Pharmacy Name: Well, 62 Tylacelyn Road, Penygraig, TONYPANDY,
Mid Glamorgan, CF40 1JU

Pharmacy reference: 1043642

Type of pharmacy: Community

Date of inspection: 10/12/2019

Pharmacy context

This is a village pharmacy. 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.

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	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
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 some of their mistakes. But they do not always take action to stop them from happening again and they do not always review everything that goes wrong. So they may miss some opportunities to learn. The pharmacy generally keeps the records it needs to by law. But some details are missing, so it may not always be able to show exactly what has happened if any problems arise. 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, recording of near misses was sporadic, with two incidents recorded in November and none recorded during the current month. There was no evidence to show that near misses were subject to review. However, staff were able to demonstrate that some action had been taken to reduce risks that had been identified: for example, different strengths of citalopram had been separated in the dispensary after several near misses. They said that different forms of aspirin tablets had also been separated for the same reason. However, on investigation, the different forms were still being stored together. The pharmacy manager separated these as soon as this became evident. A poster describing the basic adult life support process was displayed in the consultation room.

A range of electronic standard operating procedures (SOPs) underpinned the services provided. These were regularly reviewed. Some staff were in the process of reading and completing online declarations and assessments for new versions of some SOPs. A list of daily tasks was displayed in the dispensary for reference.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. Results from the previous year's 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 near the consultation room. A poster advertising the NHS complaints procedure 'Putting Things Right' was displayed on the consultation room door.

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. However, 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 they did not always include the nature of the emergency. Records of unlicensed specials were not always marked with patient details as required by legislation. CD running balance checks were erratic and were carried out at intervals that varied from a few weeks to two months. Running balance checks for methadone sometimes recorded high volumes of overage, increasing the risk that concerns such as dispensing errors or diversion might be missed. The register for patient-returned CDs was generally properly-maintained. However, several entries had been signed by the pharmacist carrying out the destruction but not counter-signed by another member of staff, which created the risk that accidental loss or diversion could go unnoticed.

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 near the consultation room signposted people to the company's website for more information on the way in which personal data was used and managed by the company. A poster displayed on the consultation room door explained how NHS Wales used prescription information to help it make better informed decisions about medicines and patient services

The pharmacist had undertaken level two safeguarding training and had access to guidance and local contact details that were displayed on a noticeboard in the staff area and available in the dispensary. Staff had undertaken level one safeguarding 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 near the consultation room.

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 pharmacist worked on most days and was assisted in the day-to-day operation of the pharmacy by the branch manager, who was a trainee dispensing assistant. The pharmacist was absent on the day of the inspection and their role was being covered by a relief pharmacist. The support team consisted of four dispensing assistants 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. Staff members had the necessary training and qualifications for their roles. The trainee dispensing assistant worked under the pharmacist's supervision.

Targets were set for MURs, but these were managed appropriately, and the pharmacy manager said that they did not affect the pharmacist's professional judgement or compromise patient care. Staff were happy to make suggestions within the team and said that they felt comfortable raising concerns with the pharmacist or Regional Development Manager. 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 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 undertook online training on new products, clinical topics, operational procedures and services. They had recently completed training on the company's new patient medication record (PMR) system. All staff had recently completed training provided by NHS Wales on improving the quality of services provided. All staff were subject to six-monthly performance and development reviews and could discuss issues informally with the pharmacist or pharmacy manager whenever the need arose.

Principle 3 - Premises ✓ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean. It was generally tidy and well-organised. The dispensary was small, but there was enough space to allow safe working. Some stock and dispensed prescriptions awaiting collection were temporarily stored on the floor and posed a potential 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 this 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. Its 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. A hearing aid loop was available in the 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. The pharmacy manager said that the pharmacist had recently visited local surgeries 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, the influenza vaccination 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 patient receiving the wrong medicine.

The pharmacy team said that a new pharmacy software system had recently been installed which allowed some prescription items 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. Prescription items scanned to the hub before 3pm were generally returned to the branch within 48 hours, although there were occasional delays.

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 usually placed on bags to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. However, one prescription that included buprenorphine patches was found not to be marked in this way. Staff said that CD 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. However, one prescription for clobazam was found not to be marked in this way. Stickers were used on prescriptions awaiting collection to identify patients eligible for an MUR.

Staff said that pre-printed forms were attached to prescriptions to routinely identify patients prescribed warfarin. The forms included prompt questions to ensure that the member of staff handing out the prescription obtained all necessary information from the recipient, which staff said was then added to the patient medication record (PMR). However, one record checked did not include any information about blood tests or dosage changes. Another included information that had not been updated since

May 2019. The pharmacy team were aware of the risks of valproate use during pregnancy. Staff said that one person prescribed valproate who met the risk criteria had been counselled appropriately and provided with patient information. A poster displayed in the dispensary listed actions to be taken by the pharmacy team when dispensing valproate prescriptions for people who met the risk criteria. A valproate patient information pack was available in the dispensary. 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 controlled drug. 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. Staff said that new patients requesting the service were assessed for suitability. They said that patient information leaflets were routinely supplied with compliance aid trays although there were no examples of this available. Trays were not labelled with descriptions to enable identification of individual medicines. This meant that patients might not always have all the information they need 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, details of any messages or queries and documents such as their current repeat prescription order form. A workload tracker was available at the front of each file and showed the status of each patient's tray at any given time. It included collection or delivery details.

The pharmacy had carried out approximately 70 influenza vaccinations during the 2019/20 season. Staff said that the majority of these had been as part of the NHS enhanced service.

Medicines were obtained from licensed wholesalers and generally stored appropriately. However, some loose blister strips that had been removed from their original packaging were not adequately labelled either as stock or as named-patient medication. This increased the risk of error and did not comply with legislative requirements. Dispensary shelves were fairly tidy, but there was limited storage space for medicines and some different products and different strengths of the same product were stored closely together, increasing the risk of errors.

Medicines requiring cold storage were stored in a well-organised drug fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in two well-organised CD cabinets and obsolete CDs were segregated from usable stock. The CD key for one of the cabinets was in the cabinet door at the beginning of the inspection, compromising the security of these medicines. The pharmacist removed the key and secured it on her person as soon as this was pointed out. Patients supplied substance misuse treatments against instalment prescriptions were allocated a section in a dedicated file which included their prescription, personal details, details of supervision or collection and any messages or queries.

Stock was subject to regular date-checks, although the pharmacy manager said that the team were slightly behind schedule with these. Two date-expired packs of tramadol were found on dispensary shelves. However, these had been marked with stickers to highlight the fact that they were short-dated. 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

demonstrated that they had dealt appropriately with a recall for Zantac tablets by quarantining affected stock that was waiting to be returned to the supplier. They explained that the PMR software flashed up a real-time alert on the screen for all drug recalls. 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. Triangles and capsule counters were used to count tablets and capsules. 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.

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.