

Registered pharmacy inspection report

Pharmacy Name: M W Phillips Chemists, 9 Vere Street, Cadoxton, BARRY, South Glamorgan, CF63 2YE

Pharmacy reference: 1043659

Type of pharmacy: Community

Date of inspection: 26/09/2019

Pharmacy context

This is a neighbourhood pharmacy in a coastal town. 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 provides medicines in multi-compartment compliance aids to a large number of patients who live in the surrounding area. 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: Improvement Action Plan

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 some of their mistakes. And they take action to stop them from happening again. But they do not record and review everything that goes wrong. So they may miss some opportunities to learn. 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 analysis of dispensing errors and near misses. However, very few near misses had been recorded in recent months and it was likely that some incidents had not been captured. The pharmacy technician said that the pharmacist reviewed patient safety incidents on a regular basis, although no documentary evidence of this was available. Some action had been taken to reduce risks that had been identified: for example, 'Look-Alike, Sound-Alike' or 'LASA' drugs such as amlodipine and amitriptyline, clarithromycin and ciprofloxacin and olanzapine and omeprazole had been separated on dispensary shelves to help reduce the incidence of errors. Caution stickers had been used to highlight the risks of picking errors with escitalopram and esomeprazole following a recent near miss.

A range of written standard operating procedures (SOPs) underpinned the services provided. These were regularly reviewed. The trainee dispensing assistant had not yet signed the SOPs. However, he was able to clearly describe his role and responsibilities when questioned. He understood which activities could not take place in the absence of the Responsible Pharmacist. The Responsible Pharmacist notice displayed was incorrect. The locum pharmacist remedied this as soon as it was pointed out to her.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the current year's survey showed that feedback was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in the practice leaflet.

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, unlicensed specials and controlled drug (CD) records. However, the web-based RP register had some duplicate entries, which was confusing. Staff said that if the server crashed or the system was shut down for any reason, the programme automatically signed the RP out of the register. When the system came back on line, it required the RP to sign in again, creating another entry for that day. A written record had been made on a few occasions when the pharmacist had been unable to access the electronic register at all.

Most staff had signed confidentiality agreements, apart from the medicines counter assistant who was absent. However, there was evidence that all staff had completed training on the General Data Protection Regulations.

Staff present were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. Leaflets displayed at the medicines counter

gave a comprehensive summary of the ways in which patient information was managed and safeguarded. A poster in the retail area explained how NHS Wales used prescription information to help them make better informed decisions about medicines and patient services.

The pharmacists and pharmacy technician had undertaken level two safeguarding training and had access to guidance and local contact details via the internet. Staff had undertaken level one safeguarding training and were able to identify different types of safeguarding concerns. They said that they would refer these to the pharmacist, who confirmed that she would report concerns via the appropriate channels where necessary.

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. She was absent during the inspection and her role was covered by a locum pharmacist. The support team consisted of a pharmacy technician, a trainee dispensing assistant and a medicines counter assistant, who was 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 worked well together and had the necessary training and qualifications for their roles. The trainee dispensing assistant worked under the supervision of the pharmacist and the pharmacy technician. Targets were set for MURs. Staff said that these were managed appropriately and did not affect the pharmacists' professional judgement or compromise patient care.

Staff said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist or superintendent pharmacist. A whistleblowing policy included a confidential helpline for reporting concerns outside the organisation. The pharmacy technician said that she understood she could also report concerns to the local health board or the GPhC.

A member of staff gave a coherent explanation of the WWHAM questioning technique and gave appropriate examples of situations she would refer to the pharmacist. The WWHAM questions were displayed at the medicines counter for reference. Staff had access to regular training modules on counter skills provided by a supplier. They also had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. All staff had recently completed training provided by NHS Wales on improving the quality of services provided. The pharmacy technician said that she kept up-to-date with her revalidation portfolio. She said that she based her continuing professional development entries on training and on situations she came across in her day-to-day working environment. Staff had not received appraisals, although the pharmacy technician said that she believed a formal appraisal process was due to be implemented soon. All staff could informally discuss performance and development issues with the pharmacist whenever the need arose. The lack of a structured training and development programme increased the risk that individuals might not keep up to date with current pharmacy practice and that opportunities to identify training needs could be missed.

Principle 3 - Premises ✓ Standards met

Summary findings

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

Inspector's evidence

The pharmacy occupied an old building but had been refitted at the end of May 2015 and most of the interior was clean and modern. Staff said that a recent roof leak had led to a damaged ceiling tile in the corner of the dispensary, which had been reported to the company's head office. The dispensary was well-organised, with enough space for safe working. Some stock was being temporarily stored on the floor but did not pose a trip hazard. The sink 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'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. But members of the pharmacy team do not always know when higher-risk medicines are being handed out. So they might not always check that medicines are still suitable, or give people advice about taking them. The pharmacy 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

There was a small step up to the pharmacy entrance, but the pharmacy technician said that the team would go out to people in wheelchairs and help them into the pharmacy if necessary. There was wheelchair access into the consultation room. The pharmacy offered a range of services that were appropriately advertised. A poster in the retail area advertised a range of private services. However, the pharmacy technician said that they were temporarily unable to provide these as the patient group directions that underpinned them had expired and were in the process of being renewed. Staff said that they would signpost people requesting services they could not provide to other nearby pharmacies. Lists of local pharmacies providing the All-Wales EHC service, the needle exchange service and the local health board's palliative care scheme were displayed in the dispensary. Some health promotional material and information about local support groups was on display in the retail area.

Dispensing staff used baskets to help ensure that medicines did not get mixed up during dispensing. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Stickers were used on prescriptions awaiting collection to identify patients eligible for an MUR. Prescriptions were annotated to highlight the fact that a CD or fridge line needed to be added at the hand-out stage. There was no strategy in place to ensure that Schedule 3 or 4 CDs were not supplied to the patient or their representative more than 28 days after the date on the prescription. A prescription for oxazepam and one for zopiclone found in the retrieval area were over 28 days old, so no longer valid. The pharmacy technician said this was an oversight and removed them from the prescription retrieval system. She said that she would send the prescriptions back to the surgery for their information.

The pharmacy technician said that prescriptions for warfarin were annotated with the word 'INR' to identify patients for counselling. Information about blood tests and dose changes was recorded on the patient medication record (PMR). Prescriptions for other high-risk medicines such as lithium and methotrexate were not marked and there was a risk that counselling opportunities might be missed. The pharmacy technician said that the pharmacy had identified one patient prescribed valproate who had met the criteria for risk. She said the patient had been counselled and provided with information explaining the risks of use during pregnancy. The valproate information pack could not be located during the inspection, but the pharmacy technician demonstrated that information cards were attached to original packs of valproate products. 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. If a controlled drug was included in the delivery

the recipient was asked to sign a separate sheet to reflect this rather than the main delivery form. If a patient or their representative was not at home to receive a delivery, the delivery driver usually put a notification card through the door and brought the prescription back to the pharmacy. However, records showed that prescriptions were occasionally posted through letterboxes or left in a safe place at the patient's request. This increased the risk of errors and might compromise confidentiality. The pharmacy technician said that this was a last resort rather than a routine occurrence and the final decision was always made by the pharmacist after risks had been assessed.

The pharmacy provided medicines in disposable multi-compartment compliance aids to a number of patients. Trays were labelled with descriptions to enable identification of individual medicines. 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 and details of any messages or queries. It also contained initials of staff members involved in dispensing each compliance aid with dates as an audit trail.

Medicines were obtained from licensed wholesalers and generally stored appropriately. 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 legal requirements. Medicines requiring cold storage were stored in a well-organised drug fridge. Maximum and minimum temperatures observed during the inspection were consistently within the required range. However, staff said that although they checked temperatures daily they did not record them. The lack of a clear audit trail meant that it was difficult for the pharmacy to provide assurance that fridge items were stored appropriately and were safe and fit for purpose. Some food was stored in the drug fridge. This increased the risk of temperature fluctuations and contamination.

Most CDs were stored appropriately in a well-organised CD cabinet and obsolete CDs were segregated from usable stock. Some CDs were stored in a safe. It was unclear whether or not this was secured to the fabric of the building. The safe had been issued with an exemption certificate by the local police but this had expired at the end of March 2015. The keys to the CD cabinet and safe were stored on a hook in the dispensary during the inspection. The pharmacist secured them on her person as soon as this was pointed out. The pharmacy technician said that there was a particular problem with over-the-counter codeine misuse in the area and as a consequence the team had taken the decision not to keep items containing codeine on display in the retail area.

Stock was subject to regular expiry-date checks. However, one stock pot of levothyroxine 50mcg tablets stored in the compliance aid dispensing area was out of date. The pharmacy technician disposed of this immediately and added the compliance aid section to the date-checking matrix. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received drug alerts and recalls via its NHS email account. Staff were able to describe how they 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 hardware to work in accordance with the Falsified Medicines Directive, but the software had not been installed and so the pharmacy was not yet able 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 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. Triangles and a capsule counter 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.