

Registered pharmacy inspection report

Pharmacy Name: Queens Road Pharmacy, 23A Queen Road, Skewen, SWANSEA, West Glamorgan, SA10 6UH

Pharmacy reference: 1075833

Type of pharmacy: Community

Date of inspection: 25/04/2019

Pharmacy context

This is a pharmacy located opposite a busy health centre. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy provides 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	N/A	N/A	N/A
2. Staff	Standards met	2.5	Good practice	Staff are able to openly raise concerns and provide feedback to improve services
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 for preparing medicines to help make sure the team works safely. Its team members generally deal with mistakes responsibly. They take action to help stop the same sorts of mistakes from happening again. But they don't always keep records of mistakes. So it is possible that some chances to learn from these might be missed. The pharmacy's team members keep the records they need to by law. The pharmacy 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 some records of dispensing errors and near misses. However, the most recent dispensing error records available during the inspection had been made in 2016 and it was unclear if any errors had been made or recorded since these entries. The locum pharmacist demonstrated that if necessary he could record dispensing errors on the pharmacy's software system.

Near misses had not been recorded since 2017; however, staff said that the pharmacist always discussed near misses with them at the time of the occurrence and they were able to describe recent action that had been taken to reduce risk as a result: for example, atenolol 100mg and allopurinol 100mg tablets had been separated after a spate of picking errors. Many proactive examples of risk management were observed during the inspection: a dispenser putting away a stock delivery made all staff aware that the packaging for atorvastatin 40mg tablets had changed; Physeptone mixture had been put in a bag, marked and physically separated from Physeptone SF oral solution in the controlled drug (CD) cabinet and many similarly-named products and different strengths of the same product had been separated on dispensary shelves to reduce the risk of incorrect selection.

A range of written Standard Operating Procedures (SOPs) underpinned the services provided. These were regularly reviewed and had been signed by most staff, although signature sheets were not marked to show which SOP each one corresponded to. A medicines counter assistant (MCA) had not signed relevant SOPs but said that he had been trained and was observed to understand and competently follow procedures for receipt and handout of prescriptions, sale of OTC medicines and provision of advice to patients during the inspection.

The accuracy checking technician (ACT) said that she was able to perform accuracy checks on most items that had been clinically checked by a pharmacist, although she would always ask the pharmacist to double check any controlled drugs or high-risk medicines such as warfarin, lithium or methotrexate. The SOP for accuracy checking stated that the pharmacist should initial a quad stamp to show that a prescription had been clinically checked, but staff said that this did not happen in practice, which meant there was no record to show who had taken responsibility for the clinical check. This also created a risk that medicines might be supplied to a patient without having been subject to a clinical check.

However, during the inspection, the ACT was observed to ask the locum pharmacist if he had clinically checked some walk-in prescriptions before going on to carry out an accuracy check on these. She also explained that before she checked repeat prescriptions she would always look at the form that had been used to place the repeat prescription order and compare this with the prescription itself to see if there were any discrepancies or changes; if so, she would ask the pharmacist to clinically check the

prescription again before carrying out an accuracy check. Evidence showed that each patient's completed repeat prescription order form was included with their dispensed medicines for reference. The Responsible Pharmacist notice displayed was incorrect; the locum pharmacist 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 in the staff area showed that this was mostly positive, although some patients had commented that waiting times could be shorter. Some letters from patients thanked the pharmacy team for their friendly and caring service. A formal complaints procedure was in place although this was not advertised in the retail area.

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, 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, and it was not always clear whether the supply had been made at the request of the patient or the prescriber.

Staff had received training on the General Data Protection Regulations and signed confidentiality agreements. Staff 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 was displayed that advertised the way in which data was used by the pharmacy and gave details of the pharmacy's Data Protection Officer. A leaflet displayed in the retail area explained how NHS Wales used prescription information to help them make better informed decisions about medicines and patient services.

The pharmacist and ACT had undertaken formal safeguarding training and had access to guidance and local contact details that were available in the SOP file. Some staff had received in-house training; others had not but they were able to identify different types of safeguarding concerns and said that they would refer these to the pharmacist, who confirmed that he would report concerns via the appropriate channels where necessary. The pharmacy had a chaperone policy that was available in the SOP file.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to manage the workload safely. The pharmacy's team members understand their roles and responsibilities. They are encouraged to speak up about the way the pharmacy works to improve services.

Inspector's evidence

The regular pharmacist manager oversaw all professional activities; he was absent at the time of the inspection and his role was being covered by a locum pharmacist. The superintendent pharmacist usually visited weekly and was present during the latter part of the inspection.

There were enough suitably qualified and skilled staff present to manage the workload during the inspection and the staffing level appeared adequate for the services provided, although the pharmacy was very busy and one patient complained about the length of time they had to wait for their prescription to be dispensed. Staff members had the necessary training and qualifications for their roles; a trainee MCA worked under the pharmacist's supervision. A technician was observed to resolve several patient queries appropriately and efficiently by contacting the local surgery for help and advice.

Targets were set for MURs. Staff said that these were managed appropriately and did not affect the pharmacist's professional judgement or patient care. Staff said that the superintendent pharmacist usually visited the pharmacy on one day each week to cover the dispensary and allow the regular pharmacist to carry out MURs.

Staff worked well together and had an obvious rapport with customers since they served a close-knit community. They said that they were happy to make suggestions within the team. They demonstrated that they had suggested colour-coding prescription baskets for repeat prescriptions to show which day of the week the patient would be expecting to collect or receive a delivery. This had helped them to manage the workload more efficiently. They said that they felt comfortable raising concerns with the pharmacist or superintendent pharmacist. A whistleblowing policy that included a confidential helpline for reporting concerns outside the organisation was available in the SOP file.

The member of staff working on the medicines counter gave a coherent explanation of the WWHAM questioning technique 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 said that much of their learning was via informal discussions with the pharmacist: as a team they had recently discussed the risks of supplying valproate to people who may become pregnant and the CD schedule change for pregabalin and gabapentin. They had also recently completed training provided by NHS Wales on improving the quality of services provided. However, there was a risk that the lack of a structured training programme might restrict the ability of individuals to keep up to date with current pharmacy practice.

There was no formal appraisal system in place but all staff could discuss performance and development

issues informally with the pharmacist 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 had been completely refitted to a high standard about two years previously. It was clean, tidy and well-organised, with sufficient space to allow safe working, although some stock and prescriptions were temporarily stored on the floor. A separate room on the first floor of the pharmacy was used for the assembly of MDS trays and storage of excess stock. The sinks had hot and cold running water and soap and cleaning materials were available.

A digitally-locked consultation room was available for private consultations and counselling and its availability was clearly advertised. A semi-private hatch opened into the dispensary from the retail area; no confidential information was visible.

The pharmacy was lockable and protected by external shutters and a security alarm. The lighting and temperature in the pharmacy were generally appropriate, although an area in which the CD cabinets were situated was not very well-lit.

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 the pharmacy can't provide a service it directs people to somewhere that can help. The pharmacy's working practices are safe. But it does not always keep prescription forms for the dispensed medicines waiting to be collected. So there is a risk the pharmacy's team members will not have all the information they might need when medicines are handed out. The pharmacy generally manages medicines appropriately. The pharmacy's team members check expiry dates of the medicines the pharmacy stocks but they do not record this very well. So it is not clear how often checks are made. This may increase the chance of giving out-of-date medicines to people by mistake.

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 patients requesting services they could not provide to nearby pharmacies or other providers such as the local surgery. The pharmacy had some health promotional material on display near the consultation room. The pharmacist had recently visited local surgeries to discuss and promote the Choose Pharmacy common ailments service as part of a health board-funded collaborative working initiative.

Staff said that most of the dispensing workload consisted of walk-in prescriptions from the local surgery opposite the pharmacy. There was a logical workflow in the dispensary: walk-in prescriptions were assembled and checked on the front dispensary bench, while another bench at the rear was used for the assembly and checking of repeat prescriptions.

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; if a third person had labelled the prescription items they also initialled the dispensing label to provide an audit trail. Controlled drugs and insulin 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.

Prescriptions were not always retained for dispensed items awaiting collection, except for controlled drugs that required safe custody; this meant that prescriptions for some Schedule 3 CDs might not be marked with the date of supply at the time the supply was made, as required by legislation. The majority of prescriptions were scanned and the image remained available for reference; however, the pharmacist admitted that this was not the case for all prescriptions.

Stickers were used on prescriptions awaiting collection to alert staff to the fact that a CD or fridge item was outstanding. 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 and so there was a risk that the dispensed medicines might be supplied to patients against a prescription that was invalid. Patients on high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified for counselling. Staff said that they would ask these patients for relevant information about blood tests and dose changes and record this on their patient medication record (PMR); however, no evidence of this was available. The information pack for valproate patients was available in the

dispensary. Staff said that the pharmacy had no current patients prescribed valproate who met the eligibility criteria for risk.

Signatures were usually obtained for prescription deliveries; separate signatures were always obtained for controlled drugs and fridge lines. If a patient or their representative was not at home to receive a delivery, the delivery driver usually put a note through the door and returned the medication to the pharmacy. However, records showed that prescriptions were occasionally posted through letterboxes at the patient's request. There was no evidence that any risks associated with this practice had been identified and assessed to make sure it was safe.

Disposable MDS trays were used to supply medicines to a number of patients who had compliance difficulties. These were assembled in a dispensary on the first floor with its own telephone line. Trays were labelled with descriptions, although these needed more detail to enable identification of individual medicines. Patient information leaflets were not routinely supplied, and there was a risk that the patient would not have all the information required for them to make informed decisions about their own treatment. A labelled basket for each patient included their stock medicines, current prescriptions and other relevant documents such as discharge summaries.

Medicines were obtained from licensed wholesalers and generally stored appropriately, although some tablets for MDS patients 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 errors and did not comply with legislative requirements. Medicines requiring cold storage were stored in two tidy, well-organised drug fridges. Maximum and minimum temperatures were recorded daily; however, records consistently showed the minimum temperature to be 2 degrees Celsius and the maximum temperature to be 4 degrees Celsius with no variation: staff said that the thermometer was reset each day but it was unclear whether the record was an accurate reflection of the real maximum and minimum daily temperatures as the maximum temperature for both was found to be over 4 degrees Celsius at the time of the inspection. CDs were stored appropriately in two tidy, well-organised CD cabinets.

There was some evidence to show that regular expiry date checks were carried out, although the frequency and scope of these checks were not documented. 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 which was checked at the beginning and end of each day. The pharmacist and 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 or manufacturer. The pharmacy had the necessary hardware and software to work in accordance with the Falsified Medicines Directive but medicines were not being decommissioned on the day of the inspection. Records showed that some medicines had been decommissioned on the 29 March and 1 April 2019.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide 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. Triangles and a capsule counter were used to count tablets and capsules; a separate triangle was available for use with loose cytotoxics. The triangles were dusty, but staff gave assurances that they would be washed before their next use. The pharmacy had a range of up-to-date reference sources.

Equipment was in good working order, clean and appropriately managed; evidence showed that it had recently been tested. However, some medicine bottles were stored uncapped, which increased the risk of contamination.

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. 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.