Registered pharmacy inspection report

Pharmacy Name: Vale Road Pharmacy, 83 Vale Road, RHYL, Clwyd, LL18 2PG

Pharmacy reference: 1080333

Type of pharmacy: Community

Date of inspection: 23/05/2019

Pharmacy context

The pharmacy is located opposite a GP practice, amongst a small number of other retail shops in a residential area, in the coastal town of Rhyl, North Wales. The pharmacy premises are accessible for people, with adequate space in the retail area and consultation room for wheelchairs or prams. The pharmacy sells a range of over-the-counter medicines and dispenses both private and NHS prescriptions.

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	1.2	Good practice	The pharmacy records and analyses adverse dispensing incidents to identify learning points which are then incorporated into day to day practice to help manage future risk.
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 manages the risks associated with its services and protects peoples' information. It asks people for their views and uses this feedback to improve its services. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. They record their mistakes so that they can learn from them and they act to help stop the same sort of mistakes from happening again. The team members complete training so they know how to protect vulnerable people.

Inspector's evidence

Dispensing incidents were reported on an incident report form and learning points were included. The dispensing incidents were reviewed by the superintendent (SI). The pharmacist said near misses were discussed with the pharmacy team member at the time and were reported on a log. He said because of near miss errors with risperidone and ropinirole in several branches, the stock had been separated in the dispensary.

The pharmacist explained that the accuracy checking pharmacy technician (ACPT) collated near miss errors for all branches and reviewed for trends and patterns. The latest review indicated that an increased number of near miss errors had been reported for prednisolone 1mg and prednisolone 5mg tablets, and each branch had been asked to separate the stock.

The correct responsible pharmacist (RP) notice was prominently displayed in the pharmacy. There were up-to-date Standard Operating Procedures (SOPs) for the services provided kept on Dropbox, with a separate signature sheet showing that trained members of staff had read and accepted them. The two trainee members of staff were in the process of reading and signing the relevant SOPs for their roles. Roles and responsibilities of staff were defined in the SOPs. A dispenser was seen to be following the relevant SOPs for her role and was able to clearly describe her duties.

A customer satisfaction survey was carried out annually and the results were displayed in the retail area. The pharmacist explained that this was because of feedback from some patients about waiting times for their prescriptions to be dispensed, all patients were provided with an estimated time for dispensing, or asked if they would like to call back, to help manage their expectation.

The pharmacist said he aimed to resolve complaints and concerns in the pharmacy and if he was unable to, he would refer the patient to superintendent. A written complaints procedure was in place. A poster informing patients how to raise concerns, complaints or provide suggestions and feedback was displayed next to the medicines counter.

A copy of the current professional indemnity and public liability insurance certificate was displayed in the pharmacy. The electronic CD register (CDRE-Plus), private prescription record, emergency supply record and specials procurement record were in order. Patient returned CDs were recorded and disposed of appropriately.

The responsible pharmacist (RP) record had the time the RP ceased their duty missing from some

entries in the record and in some cases, there appeared to be a duplication of some entries. The pharmacist said he was going to report the issue to the software provider, RxWeb and the superintendent had advised him they were going to revert to a paper-based RP record in future. Therefore, the RP record does not comply with legal requirement.

Confidential waste was placed in designated bags, to be collected by an authorised carrier. A dispenser described what it meant to maintain patient confidentiality, including ensuring that no patient information was visible at the counter. She said all staff had signed a confidentiality clause and had read the SOP relating to information governance. Assembled prescriptions awaiting collection were stored away from the retail area in a manner which protected patient information. Computers were password protected for pharmacy staff.

The medicines counter assistant said she voiced any concerns regarding children and vulnerable adults to the pharmacist. The pharmacist explained he assessed any situation presented to him and contacted the GP if needed. Up to date contact numbers for safeguarding were displayed. There was a safe guarding children and vulnerable adult procedure in place. The pharmacist said he had completed the level 2 WCPPE training module on safe guarding and other staff had completed the level 1 safe guarding training with WCPPE. The details of this staff training were provided. The staff provided examples of different safe guarding concerns they had dealt with.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. The team members are trained and work effectively together. They are comfortable about providing feedback to the manager. The pharmacy enables its team members to act on their own initiative and use their professional judgement, to the benefit of people who use the pharmacy's services.

Inspector's evidence

There was a pharmacist manager, an accuracy checking pharmacy technician (ACPT), two dispensers, a medicines counter assistant, a trainee dispenser, a trainee medicines counter assistant and a delivery driver on duty at the time of inspection. The staff were kept busy providing pharmacy services but appeared to manage the workload effectively. The staff said the pharmacist manager was very approachable, supportive and answered any questions they had.

Each staff member had a written training record in place. The dispensers said they were asked to complete training when necessary and they had completed training on GDPR in 2018. The pharmacist said all staff had all signed up to the Numark training modules online and were asked to complete training occasionally. Most staff had completed a "improving quality together bronze" training module in October 2018. The lack of a regular training programme might restrict the ability of some staff to keep up to date with current pharmacy practice.

A dispenser explained that all the staff had received an appraisal at the end of 2017 with the pharmacist manager and were due another appraisal now. A dispenser said she felt there was an open and honest culture in the pharmacy, she wasn't blamed for dispensing incidents that she was involved with and they were seen as opportunities to learn.

The medicines counter assistant was clear about her role. She knew what questions to ask when making a sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if she suspected a customer might be abusing medicines such as nurofen plus. i.e. she referred to the pharmacist for support.

The pharmacist said there was an MUR target in the pharmacy and he felt there was no organisational pressure placed upon him to achieve this. He said there was no compromise to patient safety or the quality of services provided because of the MUR target and he was not aware of any consequences to not hitting the target.

Principle 3 - Premises ✔ **Standards met**

Summary findings

The pharmacy is clean and tidy. It is a suitable place to provide healthcare.

Inspector's evidence

The pharmacy's retail area and dispensary were clean. The retail area was free from obstructions and had a waiting area. All pharmacy staff were responsible for the cleaning in the pharmacy with dispensary benches, the sink and floors being cleaned regularly. The temperature in the pharmacy was controlled by air conditioning / heating units. Lighting was adequate.

Staff facilities available were all clean, including a kettle, toaster, microwave, WC with hand wash basin and antibacterial hand wash was available.

There was a locked consultation room which was uncluttered and clean in appearance. Staff explained they used this when customers needed a private area to talk or the pharmacist was providing one of the services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people and they are generally well managed. The pharmacy sources and stores medicines safely and carries out checks to help make sure that medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy and pharmacy counter were accessible for all patients, including patients with mobility difficulties or wheelchairs. A range of healthcare leaflets were available in the retail area. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Baskets were used to seperate prescriptions during dispensing to avoid them being mixed up.

Stickers were used on prescriptions awaiting collection to highlight important information. e.g. when CDs or fridge lines need to be added. CDs requiring safe custody were highlighted with a CD sticker attached to the bag. All CD prescriptions had a red dot on the top of the prescription to indicate that a CD was prescribed and to act as a prompt when handing out. Assembled prescriptions awaiting collection for diazepam and gabapentin were highlighted with a red dot.

High risk medicines such as warfarin, methotrexate and lithium were not highlighted, so the pharmacy team may not be aware when they were being handed out, in order to check that the supply was suitable for the patient.

The pharmacist demonstrated that the pharmacy had the valproate patient information resources, including, cards, leaflets and warning stickers. He said he had identified four female patients in the at risk group that were prescribed valproate during clinical audits carried out. All patients had been spoken to, provided with necessary information and one of the patients was referred back to their GP for a medication review. The work flow in the pharmacy was organised into areas – dispensing bench space, designated room for assembly of MDS and a checking area for the pharmacist.

A dispenser explained how the MDS service was provided to patients. Disposable equipment was used. Changes to medication were updated on the computer patient medication record (PMR) and the MDS preparation sheet, with any discrepancies between the prescription received and the MDS preparation sheet / PMR clarified with the GP to ensure the patient received the correct medicines each month. She said patient information leaflets were supplied to each patient and that tablet descriptions were included on the MDS tray. Tablet descriptions were observed to be included with MDS awaiting collection and patient information leaflets were included. An MDS diary was used to help plan the workload and pass on information between staff members.

A dispenser explained the process for delivering medicines to patients. She said that a patient signature was obtained electronically on the Pro Delivery Manager (PDM) mobile application to confirm receipt. She said if a patient was not at home when the delivery driver attempted delivery, a note was left, and the medicines were returned to the pharmacy. Patient returned CDs were destroyed using denaturing kits and records made online. A quantity of out of date CDs were kept segregated from stock pending destruction.

The pharmacy was using 2D barcode scanners and appropriate software to comply with the Falsified Medicines Directive (FMD). Staff had received training, including an online presentation. The pharmacist said that the superintendent was in the process of drafting the FMD SOP. Staff provided examples of medicines stock that included unique barcodes and anti-tampering seals, and a dispenser demonstrated how medicines were scanned.

Patient returned medicines were segregated and stored tidily. The date of opening was written on stock bottles of liquid medicines with limited shelf life. Date checking was carried out and documented on a matrix. A dispenser said that short dated medicines were highlighted with stickers and examples were available. No out of date medicines were found from several medicines sampled. Alerts and recalls etc. were received via email and post. Records were kept to show the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide the service safely.

Inspector's evidence

The BNF and BNFc were available. The staff said they used the internet to access websites for the most up to date information. e.g. electronic medicines compendium (EMC). There was a selection of liquid measures with British Standard and Crown marks.

There was a clean fridge for medicines with minimum/ maximum thermometer. The fridge was in the normal temperature range at the time. The minimum and maximum temperature was supposed to be recorded twice a day, although no records for May 2019 had been kept. Previous months fridge temperature records were complete, and the pharmacist explained that he will oversee this process in future. The lack of a fridge temperature record for May 2019 may indicate that the fridge temperature had not been monitored as it was supposed to be and may increase the risk of supplying a medicine that was not safe or fit for purpose.

Any problems with equipment were reported to the superintendent. The electrical equipment appeared to be in working order and had been PAT tested in February 2019. The pharmacy had equipment for counting loose tablets and capsules, including tablet triangles. The computer screens were positioned so they weren't visible from the public areas of the pharmacy. Cordless phones were available for private conversations with patients.

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.