

# Registered pharmacy inspection report

**Pharmacy Name:** Knights Tremorfa Pharmacy, 21 South Park Road, adjacent to Cloughmore Medical Centre, Cardiff, Caerdydd, CF24 2LU

**Pharmacy reference:** 9011338

**Type of pharmacy:** Community

**Date of inspection:** 23/11/2021

## Pharmacy context

This is a pharmacy next door to a medical centre. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It offers a range of services including emergency hormonal contraception, smoking cessation, treatment for minor ailments and a seasonal 'flu vaccination service for NHS and private patients. A needle exchange service is also available. The pharmacy has recently changed ownership. This inspection visit was carried out during the COVID-19 pandemic.

## 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
<b>1. Governance</b>	Standards met	1.8	Good practice	Safeguarding is an integral part of the culture of the pharmacy
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	3.3	Good practice	Robust measures are in place to maintain a high level of hygiene in the pharmacy
<b>4. Services, including medicines management</b>	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
<b>5. Equipment and facilities</b>	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 review things that go wrong so that they can learn from them. And they take action to help stop mistakes from happening again. But they do not record all of their mistakes. 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. 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 are good at recognising and reporting 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. Pharmacy team members were able to demonstrate action that had been taken to reduce risks that had been identified: for example, different strengths of amlodipine tablets had been separated following a series of picking errors, and a note had been added to dispensary shelves to highlight the risk of errors with the similar-sounding drugs ropinirole and risperidone. A note had also been added to highlight the risk of errors with olanzapine and quetiapine, as some similarly packaged generic versions of these had recently been received from a new wholesaler.

A range of written standard operating procedures (SOPs) underpinned the services provided and were regularly reviewed. One team member present had not signed the most current versions but was observed to follow SOPs relevant to her role. The accuracy checking technician (ACT) said that she mainly checked repeat prescriptions. She explained that the pharmacist manager labelled all repeat prescriptions and clinically checked them during the labelling process. The ACT was then able to check these for accuracy without any restrictions. Prescriptions were not usually marked to show that they had been clinically checked, but the ACT said that she would always check with the pharmacist on duty if she had any doubts about this. The lack of an audit trail to indicate a clinical check may prevent a full analysis of dispensing incidents.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, but this process had been paused during the pandemic. The results of the most recent survey were displayed in the retail area and showed that feedback received prior to the pandemic had been mostly positive. A formal complaints procedure was in place and information about how to make complaints was displayed in the retail area, along with details of the NHS Wales complaints procedure 'Putting Things Right'.

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 electronic controlled drug (CD) records. However, it was not always clear whether an emergency supply had been made at the request of a patient or a prescriber, and this meant that it might be difficult for the pharmacy team to fully resolve queries or deal with errors effectively. Records of unlicensed specials were not marked with patient

details, which did not comply with legislation and meant that there might not be enough information available to provide a complete audit trail in the event of an error or incident. CD running balances were typically checked monthly. Patient-returned CDs were recorded appropriately in a paper register.

Staff had signed confidentiality agreements and 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 displayed near the medicines counter explained the way in which data was used by the pharmacy and gave details of the pharmacy's Data Protection Officer. The pharmacist and staff had undertaken formal safeguarding training and had access to guidance and local contact details that were available in the SOP file. A summary of the chaperone policy was advertised in a poster displayed near the consultation room. The team were able to give examples of how they had identified and supported potentially vulnerable people, which had resulted in positive outcomes.

## 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 pharmacist manager worked at the branch on most days. Regular locum pharmacists and a relief pharmacist employed by the company covered her days off. During the inspection the support team consisted of a full-time accuracy checking technician (ACT) and two full-time dispensing assistants (DA), one of whom worked mostly on the medicines counter. Another part-time DA was absent. There were enough suitably qualified and skilled staff present to manage the workload safely during the inspection, although the pharmacy had recently lost a part-time member of staff and were in the process of recruiting to replace her. Staff members had the necessary training and qualifications for their roles. One DA had been declared competent under the grandparent clause.

There were no specific targets or incentives set for the services provided. Staff worked well together. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist and the area manager. A whistleblowing policy was available in the branch manual and included contact details for reporting concerns outside the organisation.

Pharmacy team members were observed to use appropriate questions when selling over-the-counter medicines and they referred to the pharmacist on several occasions for further advice on how to deal with transactions. A computer terminal that allowed staff access to patient medication records to help them make decisions about sales of medicines or the provision of advice was situated at the medicines counter. No confidential information was visible from the retail area. Pharmacy team members 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 self-motivated or via informal discussions with the pharmacist. However, the lack of a structured training programme might restrict the ability of individuals to keep up to date with current pharmacy practice. All staff were subject to performance and development reviews although they had not received a review since before the pandemic began. They could informally discuss issues with the pharmacist whenever the need arose.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is very 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 was very clean, well-organised and spacious. Some bulky stock was being stored on the floor in the dispensary, but this did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. Strict hygiene measures were in place: team members cleaned and disinfected work surfaces five times daily according to a rota. A barrier was in place at the medicines counter to encourage customers to keep a safe distance from members of staff and only two people were permitted to enter the retail area at any one time. A plastic screen had been installed at the counter to reduce the risk of viral transmission between staff and customers. A consultation room was available for private consultations and counselling and its availability was clearly advertised. A semi-private hatch next to the medicines counter that opened into the dispensary was used by needle exchange clients. 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. The pharmacy's working practices are generally safe and effective. It stores medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply. 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.

### Inspector's evidence

The pharmacy offered a wide range of services and these were appropriately advertised. There was wheelchair access to the pharmacy entrance and consultation room. Team members signposted people requesting services they could not provide to other nearby pharmacies. A range of health promotional material was displayed in the retail area. Information about coronavirus and related safety procedures was displayed on the pharmacy entrance door and at the medicines counter. The pharmacist had recently spoken to the local surgery team to discuss and promote the common ailments service as part of a health board funded collaborative working initiative.

Dispensing staff used a basket system to help make sure that medicines did not get mixed up during dispensing. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Controlled drugs requiring safe custody and fridge lines 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. Stickers were attached to prescription bags to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. Stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was invalid and could no longer be supplied. This practice helped ensure that prescriptions were checked for validity before handout to the patient.

Patients on high-risk medicines such as warfarin, lithium and methotrexate were not routinely identified and there was a risk that opportunities for counselling might be missed. However, the pharmacist said that these medicines were not usually prescribed on a repeat basis: most local surgeries would only issue them as acute prescriptions when blood test results had been received. She said that if she was aware that a high-risk medicine was being handed out she would ask for relevant information about blood tests and dosage and record this on the patient medication record (PMR). She was able to show examples of these records. Steroid cards, valproate information and lithium, methotrexate and warfarin monitoring booklets were available to provide to patients. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacy did not currently have any patients prescribed valproate who met the risk criteria, but the pharmacist said that any new patients would be counselled appropriately and provided with information. The pharmacy carried out regular audits of high-risk medicines, which were 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. The pharmacy team were also currently participating in the local health board's antibiotic awareness campaign. They asked people receiving prescribed antibiotics to complete a short questionnaire about themselves and their knowledge of antibiotic use and provided them with information.

There had been an increase in demand for the delivery service as a result of the pandemic. Prior to this, signatures had been obtained for prescription deliveries. However, to reduce the risk of viral transmission, the procedure had been changed. The driver now placed a package on the patient's doorstep, knocked or rang the doorbell and waited until it was collected, confirming the recipient's name and address and signing a paper slip on their behalf as an audit trail. In the event of a missed delivery, a notification card was put through the door and the prescription was returned 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 to enable identification of individual medicines and patient information leaflets were routinely supplied. A list of patients that included collection and delivery arrangements and the day of the week on which each compliance aid was supplied was displayed in the dispensary for reference. Each patient had a section in a file that included their personal and medication details, collection or delivery details, details of any messages or changes and relevant documents such as hospital discharge summaries.

The pharmacy provided a range of services. There was a steady uptake of the common ailments, EHC and smoking cessation services. Uptake of the influenza vaccination service was currently high compared to previous years: the pharmacy had vaccinated about 75 people, most of whom were eligible for the free NHS service. The pharmacy had recently begun to offer the Welsh Government's COVID-19 lateral flow test supply service. It was not currently providing medicines use reviews, the sore throat test and treat service or the blood borne virus screening service, as these had been suspended by Welsh Government in light of the COVID-19 pandemic.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were stored in two well-organised drug fridges. Maximum and minimum temperatures for these were recorded daily and were consistently within the required range. CDs were stored appropriately in two well-organised CD cabinets. Two pharmacy technicians from the local health board had witnessed the destruction of the pharmacy's obsolete CDs the same morning.

There was some evidence to show that expiry date checks were carried out, but the frequency and scope of these checks were not always documented. This created a risk that out-of-date medicines might be overlooked, which was reinforced by the presence of two out-of-date medicines in the drug fridge and one on a dispensary shelf. However, the pharmacy team said that they always included a date check as part of their dispensing and checking processes to mitigate this risk. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. A separate bin was available for the disposal of cytotoxic waste and a list of cytotoxic medicines was displayed in the consultation room for reference. The pharmacy received drug alerts and recalls via secure NHS email, which was regularly checked. The pharmacist was able to describe how she had recently dealt appropriately with a recall for eye drops by contacting patients and returning quarantined stock to the relevant supplier.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. Pharmacy team members use these in a way that protects people's privacy.

### Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Triangles were used to count tablets and a separate triangle was available for counting loose cytotoxic tablets. The pharmacy had a range of up-to-date reference sources. Personal protective equipment was available for staff use and the pharmacy team were wearing face masks. Hand sanitiser was available. All equipment was in good working order, clean and appropriately managed. There was no evidence that it had recently been tested, but the pharmacist said that this was in the process of being arranged. 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.