

Registered pharmacy inspection report

Pharmacy Name: M W Phillips Chemist, Whitchurch Road Surgery,
Sachville Avenue, Cardiff, Caerdydd, CF14 3NY

Pharmacy reference: 9012097

Type of pharmacy: Community

Date of inspection: 30/05/2024

Pharmacy context

This pharmacy is in a medical centre in the north of Cardiff. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. The pharmacy offers a range of services including provision of emergency hormonal contraception, treatment for minor ailments and a seasonal 'flu vaccination service for both NHS and private patients.

Overall inspection outcome

Standards not all 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 not all met | 1.6 | Standard not met | The Responsible Pharmacist record is not properly maintained so it may be difficult to establish who was responsible at any given time. |
| 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 not all met | 4.3 | Standard not met | The pharmacy team does not record fridge temperatures regularly, which means they cannot provide assurance that medicines requiring cold storage are safe and fit for purpose. |
| 5. Equipment and facilities | Standards met | N/A | N/A | N/A |

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy has written procedures to help make sure the team works safely. Its team members record their mistakes so they can learn from them. And they take action to help reduce the risk of similar mistakes from happening again. The pharmacy generally keeps the records it needs to by law. But the Responsible Pharmacist record is not properly maintained, so it may be difficult to establish who was responsible for the safe and effective running of the pharmacy at any given time. Pharmacy team members know how to keep people's private information safe. And they 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 a recording process for dispensing errors and near misses. The dispensing team were unable to locate any dispensing error records but gave assurances that the regular pharmacist kept a log of these. The pharmacist present gave an appropriate description of the way in which she would record a dispensing error if this was necessary. Near miss records were available to view. The dispensing assistants explained that pharmacists discussed near misses with relevant team members at the time they came to light. And that any patterns or trends that emerged were discussed with the whole team. Some action had been taken to reduce risks that had been identified. For example, different strengths of Stexerol-D3 tablets had been distinctly separated on dispensary shelving, following some near misses.

A range of standard operating procedures (SOPs) underpinned the services provided, although some of these were overdue for review. Pharmacy team members had signed most of the SOPs to show that they had read and understood them. They were in the process of reading and signing new versions of SOPs for NHS-commissioned clinical services. Members of the team were able to describe their roles and responsibilities. A trainee dispensing assistant was able to describe the activities that could not take place in the absence of the responsible pharmacist (RP). The RP notice displayed was incorrect, but the pharmacist remedied this as soon as it was pointed out to her.

The pharmacy team explained that verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place. But this was not advertised in the retail area, so people using the pharmacy may not know how to raise a complaint.

Evidence of current professional indemnity insurance was available. Most necessary records were up to date, including private prescription, emergency supply, unlicensed medicines and controlled drug (CD) records. However, the electronic responsible pharmacist (RP) register was not well-maintained. The record showed that the regular pharmacist had signed in to show the time at which she had taken responsibility for the safe and effective running of the pharmacy on 20th May 2024 but no other entries had been made until the day of the inspection. The team confirmed that there were at least two occasions during this period on which other pharmacists had worked at the pharmacy but had not made an entry in the RP register. This meant that it might not be possible to identify the pharmacist accountable in the event of an error or incident. Some details were missing from records. For example, records for unlicensed medicines did not always include patient details. Electronic emergency supply records did not always include the nature of the emergency. And it was sometimes unclear if an emergency supply had been made at the request of the patient or the prescriber. This meant that it

might be difficult for the pharmacy team to fully resolve queries or deal with errors effectively. Running balances of controlled drugs (CDs) were usually checked at the time of dispensing, although medicines that were not frequently supplied were typically checked every two months. Infrequent CD balance checks could lead to concerns such as dispensing errors or diversion being missed.

Members of the pharmacy team explained that they had signed confidentiality agreements as part of their contract of employment. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately.

The pharmacists had undertaken advanced formal safeguarding training. Other team members explained that they had not yet undertaken safeguarding training whilst employed by the pharmacy but had done so in their previous jobs. They were able to identify different types of safeguarding concerns and explained that they would refer these to the pharmacist. The team had access to guidance and local safeguarding contact details via the internet.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. Pharmacy team members are properly trained for the jobs they do. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

A regular pharmacist worked at the pharmacy for four days each week. She was absent during the inspection and her role was being covered by a locum pharmacist. The pharmacy team consisted of a part-time and a full-time dispensing assistant (DA), a part-time trainee DA, and a pharmacy student who was employed on a zero hours contract. The staffing level appeared adequate for the services provided and pharmacy team members were able to safely manage the workload. The trainee DA and the pharmacy student worked under the supervision of the pharmacist or other trained members of staff.

The trainee DA working on the medicines counter was able to provide a coherent explanation of the WWHAM questioning technique and gave appropriate examples of situations she would refer to the pharmacist. Pharmacy team members had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They explained that much of their learning was via informal discussions with the pharmacist. They had also recently completed mandatory training provided by NHS Wales on mental health awareness. However, the lack of a structured training programme meant that individuals might not keep up to date with current pharmacy practice. There was no formal appraisal system in place, which meant that development needs might not always be identified or addressed. But all pharmacy team members could informally discuss performance and development issues with the pharmacists whenever the need arose.

There were no specific targets or incentives set for the services provided. Pharmacy team members worked well together. They were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist and members of the company's senior management team. A whistleblowing policy was available in the SOP file. It included details of confidential helplines that could be used to report concerns outside the organisation.

Principle 3 - Premises ✓ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was clean and tidy, with enough space to allow safe working. Some stock medicines were 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, although its availability was not advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy's services are easy for people to access. Its 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 be able to check that medicines are still suitable, or give people advice about taking them. It stores most medicines appropriately. But the pharmacy team does not record fridge temperatures regularly. This makes it difficult for them to know that medicines needing cold storage are stored properly and are safe and fit for purpose.

Inspector's evidence

The pharmacy offered a range of services that were advertised on the company's website. The website address was conspicuously displayed on a large board in the retail area. There was wheelchair access into the pharmacy and consultation room. Pharmacy team members signposted people requesting services that could not be provided to other nearby pharmacies or other providers such as the local council, which offered a waste sharps collection service.

Dispensing staff used baskets to help ensure that medicines did not get mixed up during the dispensing process. The dispenser and accuracy checker initialled dispensing labels to provide an audit trail. Stickers were placed on prescription bags to alert team members to the fact that a CD requiring safe custody or fridge item was outstanding. There was no process in place to routinely identify Schedule 3 or 4 CDs that were awaiting collection, so there was a risk that these items might be supplied past their 28-day validity period. Three bags of dispensed medicines awaiting collection could no longer be supplied, as more than six months had elapsed since the date on the corresponding prescriptions. The pharmacist admitted that this was an oversight and dealt with these appropriately as soon as this was pointed out. A text messaging service was available to let people know that their medicines were ready for collection.

Prescriptions for high-risk medicines such as warfarin, lithium and methotrexate were not routinely highlighted, so there was a risk that counselling opportunities could be missed. However, a dispensing assistant was observed asking a person collecting their prescription for warfarin about their most recent blood test result, and this information was relayed to the pharmacist. The pharmacy team were aware of the risks of valproate use during pregnancy. They were also aware of the requirement to supply valproate products in original packs. They confirmed that anyone prescribed valproate who met the risk criteria would be counselled and provided with information at each time of dispensing. Patient information about valproate was available in the consultation room.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. Most compliance packs were assembled off-site in another pharmacy owned by the company. However, the team explained that if a person required a compliance pack at short notice, they assembled it at the pharmacy. Compliance packs were accompanied by descriptions of the medicines they contained so that individual medicines could be easily identified. Patient information leaflets were routinely supplied with compliance packs assembled at the pharmacy. However, they were not included with compliance packs assembled off-site. Instead, the backing sheets for these packs included a statement which signposted people to the Electronic Medicines Compendium website to view the leaflets. This statement was printed in a very small font and was not very conspicuous, so

there was a risk that people might not see it and would not understand how to access this information. A list of patients receiving their medicines in compliance packs was displayed in the dispensary for reference.

The locum pharmacist was undertaking training to allow her to provide NHS-commissioned services but was unable to provide them on the day of the inspection. The pharmacy team explained that the regular pharmacist and other locum pharmacists were able to provide a range of services on most days. Uptake of the common ailments service was steady, and the pharmacy received regular referrals from the adjacent GP practice. Uptake of the emergency supply of prescribed medicines service was also steady and the team explained that it tended to be used by the large student population living in the surrounding area. The pharmacy also provided blood pressure measurement, an emergency hormonal contraception (EHC) service and a seasonal influenza vaccination service for NHS and private patients.

The pharmacy provided a prescription collection service from seven local surgeries. It also offered a free medicines delivery service. Patients or their representatives signed to acknowledge receipt of the delivery as an audit trail. The delivery sheet was marked with a sticker if a CD was included in the package, which allowed the driver to notify the patient that they were receiving a controlled drug. In the event of a failed delivery, the driver brought the prescription back to the pharmacy.

Medicines were obtained from licensed wholesalers. Medicines requiring cold storage were kept in two well-organised medical fridges. The larger of the two fridges was used to store stock medicines and another smaller fridge was used to store dispensed medicines awaiting collection. Maximum and minimum temperatures were within the required range for the large fridge, but there was no thermometer available to check the temperature of the smaller fridge. The pharmacist moved the contents to the large fridge as soon as this was pointed out. There were no recent temperature records available for the smaller fridge and only five records had been made for the large fridge in the previous two months. This made it difficult for the pharmacy to be assured that these medicines were safe and fit for purpose. CDs were stored in a well-organised CD cabinet. Obsolete CDs were kept separately from usable stock.

There was evidence to show that expiry date checks were carried out, but the frequency of these checks was not documented. This created a risk that out-of-date medicines might be overlooked. However, no out-of-date medicines were found. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. There was no separate bin for disposing of cytotoxic waste, but the pharmacy team said that they were in the process of ordering a bin from their waste contractor and would separate out any cytotoxic waste they received in the meantime. The pharmacy received medicines alerts and recalls via email. A dispensing assistant described how the team would deal with a safety recall by contacting patients where appropriate, quarantining affected stock and returning it to the supplier.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide the services that it offers. And it makes sure these are always safe and suitable for use. Its team members use the 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 loose tablets and capsules. The triangles were dusty, but the dispensing team confirmed that they would be washed before they were next used. A separate triangle was available for use with loose cytotoxics to prevent cross-contamination. 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 consultation room was used for private conversations and counselling. Some dispensed medicines could be seen from the retail area, but no confidential information was visible. The pharmacy software system was protected with a password, and computer screens were not visible to people using the pharmacy.

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. |