

Registered pharmacy inspection report

Pharmacy Name: Lakeside Pharmacy, Unit 6 & 7 (27-29) Amber Vista,
Clearwater Way, Cardiff, Caerdydd, CF23 6DZ

Pharmacy reference: 9012208

Type of pharmacy: Community

Date of inspection: 20/06/2024

Pharmacy context

This pharmacy is in a parade of shops 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 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	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	4.1	Good practice	The pharmacy team effectively promote the services they provide so that people know about them and can access them easily.
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 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 keeps the records it needs to by law. 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 the recording and review of dispensing errors and near misses. 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. Action had been taken to reduce risks that had been identified. For example, a highlight sticker had been used to alert pharmacy team members to the risk of selection errors with lorazepam and lormetazepam tablets, and cyclizine and cyanocobalamin tablets, following some near misses. And these medicines had been distinctly separated on dispensary shelving as a further precaution. However, the pharmacist explained that incorrect drug and strength errors had reduced dramatically since the recent implementation of the pharmacy's new software system. The software allowed most prescription items to be scanned so that the medicine field in the patient medication record was populated directly from the barcode. If the wrong item was scanned, the system would not generate a label, which helped to reduce picking errors.

A range of electronic standard operating procedures (SOPs) underpinned the services provided, and these were regularly reviewed. Pharmacy team members had signed to show that they had read and understood the SOPs, but the signature sheet covered all SOPs rather than individual procedures. This meant that if new versions or procedures were added it might not be clear whether individual pharmacy team members had been trained to follow them. Members of the team were able to describe their roles and responsibilities. A pharmacy technician who worked as an accuracy checker explained that he could check most repeat prescription items that had been marked as clinically checked by a pharmacist, as long as he had not been involved in dispensing or labelling these. He did not check compliance packs or acute prescriptions. Lists of daily and weekly workflow tasks were displayed in the dispensary for reference to help make sure that the pharmacy operated effectively. Pharmacy team members were able to correctly describe the activities that could not take place in the absence of the responsible pharmacist (RP).

The pharmacy team explained that verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place and was advertised in the retail area, as was the NHS complaints procedure, 'Putting Things Right'.

Evidence of current professional indemnity insurance was available. Records were up to date, and most were properly maintained, including responsible pharmacist (RP), private prescription, unlicensed medicines and controlled drug (CD) records. However, 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.

Members of the pharmacy team explained that they had signed confidentiality agreements as part of their contract of employment. They had recently undertaken an information governance training module provided by NHS Wales. And they were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately.

The pharmacists and all pharmacy team members had undertaken formal safeguarding training. Team members 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 appropriately trained for the jobs they do or are enrolled on a suitable training course for their role. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

A regular pharmacist worked at the pharmacy every day. He was assisted by one of two post-graduate foundation pharmacists on two days each week. The pharmacy team consisted of a pharmacy technician who was a qualified accuracy checker (ACT), three dispensing assistants (DAs), a medicines counter assistant and a trainee pharmacist. The ACT also managed the day-to-day operation of the pharmacy. The staffing level appeared adequate for the services provided and pharmacy team members were able to safely manage the workload. The trainee pharmacist and the two foundation pharmacists worked under the supervision of the regular pharmacist and other trained members of the pharmacy team.

Members of the pharmacy team working on the medicines counter were able to provide a coherent explanation of the WWHAM questioning technique and gave appropriate examples of situations they would refer to the pharmacist. They 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. The team had recently completed mandatory training modules provided by NHS Wales on mental health awareness and improving the quality of services provided. The pharmacy technician understood the revalidation process and based his continuing professional development entries on training he had undertaken and on issues he came across in his day-to-day working environment. 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 and had an obvious rapport with customers. They were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacist and superintendent pharmacist. All team members had read the pharmacy's whistleblowing policy, which was available in the SOP file.

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, tidy and well-organised, 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. Hand sanitiser was available for staff use. A lockable consultation room was available for private consultations and counselling, and this was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy team promote the services they provide so that people know about them and can access them easily. The pharmacy's working practices are safe and effective. It stores its medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy team offered a range of services which were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. Pharmacy team members said that they signposted people requesting services they could not provide to nearby pharmacies or other providers such as the local council, which offered a needle and sharps collection service. The pharmacist explained that he had recently visited local surgeries to discuss and promote the common ailments service, including the pharmacist independent prescribing service.

The pharmacy team had a good relationship with local GP surgery teams, which meant that queries and problems were usually dealt with quickly and effectively. The dispensary was well-organised with a logical workflow, and the atmosphere in the pharmacy was calm and professional. Dispensing staff used baskets to help ensure that medicines did not get mixed up during dispensing.

The pharmacy team processed people's prescriptions on a patient medication record (PMR) system that used barcode scanning technology. Dispensing labels generated using the system were not initialled by team members. This was because the PMR software provided an audit trail to show who had been involved in the dispensing process. Each member of the team, including the pharmacists, had an individual password to log into the system and their initials were printed in the 'dispensed by' or 'checked by' boxes of the dispensing label. Only the pharmacists were able to access the clinical check function. The pharmacist explained that a physical accuracy check was not performed for all prescription items as the software system would only generate dispensing labels if the correct product was selected and scanned. In this case the 'checked by' box on the dispensing label was simply marked with a tick. The pharmacist or ACT always performed a physical accuracy check for split packs and controlled drugs.

Prescriptions were not always retained for dispensed items awaiting collection, except for prescriptions for compliance packs and controlled drugs requiring 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. Most prescriptions were scanned, and the image remained available for reference. However, this was not the case for all prescriptions. There was a risk that an accurate and complete record of prescription details might not be available for reference at the time of supply.

Each prescription awaiting collection was assigned to a specific storage location in the dispensary. When pharmacy team members needed to locate a prescription, the patient's name was entered into the PMR system and this brought up a list of locations in which their items were being stored, including medicine fridges or the CD cabinet where applicable. In addition, stickers were placed on prescription bags to alert team members 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. Each bag label attached to a prescription awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail. A text messaging service was available to let people know that their medicines were ready for collection.

Prescriptions for people prescribed high-risk medicines such as warfarin, lithium and methotrexate were marked with a note which identified the patient for counselling. The pharmacist explained that he would ask these patients for relevant information about blood tests and dosage changes. However, this information was not recorded, which might lead to a lack of continuity. Pharmacy team members were aware of the risks of valproate use during pregnancy. They were also aware of the requirement to supply valproate products in original packs where possible. A risk assessment had been completed for a person who was supplied valproate in compliance packs. The pharmacist confirmed that people prescribed valproate who met the risk criteria would routinely be counselled and provided with educational information that was available in the dispensary.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. Compliance packs were labelled with descriptions of the medicines they contained so that individual medicines could be easily identified. Patient information leaflets were routinely supplied. One person was supplied a tablet that was added to their compliance pack in its blister packaging. A dispensing assistant said that the pharmacist had discussed the risks and benefits of this practice with the patient. A professional decision had been made to supply the tablets in this way, with regular review to ensure the situation was still safe and appropriate. Each patient had a section in a dedicated file that included their personal and medication details, collection or delivery arrangements, details of any messages or changes, and relevant documents such as hospital discharge letters. A list of people receiving their medicines in compliance packs was available at the front of the file for reference.

The pharmacy provided a technician-led discharge medicines review service and uptake of this was steady. Demand for the common ailments service was high, as it was a well-established service, and the pharmacy received frequent referrals from local GP surgeries and opticians. It was managed using an appointment system. The pharmacist was an independent prescriber and was able to provide the extended common ailments service, which included the supply of oral contraception and antibiotics for minor skin, throat and urinary tract infections. Demand for the emergency supply of prescribed medicines service was low, as the pharmacy kept similar opening hours to local surgeries, so people were usually able to obtain a valid prescription from a GP in an emergency. The pharmacy also offered an EHC (emergency hormonal contraception)/bridging contraception service and a seasonal influenza vaccination service for NHS and private patients.

The pharmacy provided a prescription collection service from 20 local surgeries. It also offered a medicines delivery service for a charge. Each prescription for delivery was scanned into an electronic device, and patients or their representatives signed the device to acknowledge receipt of the delivery as an audit trail. The device alerted the delivery driver if a controlled drug or fridge line was included in the delivery so that they could notify the recipient. In the event of a missed delivery, the delivery driver usually put a notification card through the door and brought the prescription back to the pharmacy.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in a large, well-organised medical fridge. Maximum and minimum temperatures for the fridge were checked and recorded daily. The recommended maximum temperature had been exceeded on a few occasions. The pharmacist explained that the team had managed this appropriately by resetting the thermometer and rechecking temperatures until they were within the required range, although they had not made records of this. CDs were stored in a large, well-

organised CD cabinet. Obsolete CDs were kept separately from usable stock.

Stock was subject to regular documented expiry date checks. Short-dated items were highlighted with stickers. Date-expired medicines were disposed of appropriately, as were patient returns, waste sharps and clinical waste. The pharmacy received safety alerts and medicine recalls via NHS emails, which were checked twice daily. The pharmacy team described how they would deal with a medicine recall by contacting patients where necessary, 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 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. 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. 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.