General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Vida Rogers Ltd, 26 Commercial Street, Aberbargoed, BARGOED, Mid Glamorgan, CF81 9BW

Pharmacy reference: 1043480

Type of pharmacy: Community

Date of inspection: 16/09/2019

Pharmacy context

This is a high street pharmacy and post office in a small town. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. It provides dispensing services to a large number of care homes. 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. 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	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 has written procedures to help make sure the team works safely. Its team members record some of their mistakes. But they do not take much action to stop them from happening again and they do not always review everything that goes wrong. 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. It 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 systems in place to record dispensing errors and near misses. No records of dispensing errors were available. However, the pharmacist said that only one had occurred since she had taken over the role of superintendent pharmacist about a year before. Notes of the error were seen but it had occurred very recently and had not yet been formally recorded. Near misses were routinely recorded. The pharmacist said that she tended to discuss near misses with relevant staff at the time of each occurrence rather than analyse them on a regular basis to identify patterns and trends. The team were unable to demonstrate any practical action that had been taken to reduce risks that had been identified. However, they said that a team discussion had been held following a series of picking errors with different forms of ramipril. As a result, dispensers understood they should take more care when selecting these items. Posters describing the process to follow for basic life support and in the event of anaphylaxis were displayed in the consultation room.

A range of written standard operating procedures (SOPs) underpinned the services provided. These were due for review in the next month. Two staff members had not signed the SOPs but said that they had previously been employed at a different branch of the company and had signed SOPs there. They were able to clearly describe their roles and responsibilities when questioned. Most staff understood which activities could not be carried out if there was no responsible pharmacist in charge of the premises. One staff member was unclear if assembly of medicines could take place in these circumstances but on discussion she understood that it could not. A responsible pharmacist notice was in place but it was not conspicuously displayed.

The pharmacy received regular customer feedback from annual patient satisfaction surveys. The results of the most recent survey displayed on the consultation room door showed that this was mostly positive. The pharmacy dealt with formal complaints using the NHS complaints procedure 'Putting Things Right'. Information about how to make complaints was included in the practice leaflet displayed in the retail area.

Evidence of current professional indemnity insurance was available. All necessary records were kept and they were generally properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. However, there were occasions on which the pharmacist had not signed out of the RP register to show the time at which they had relinquished responsibility for the safe and effective running of the pharmacy. Also, some private prescription records were missing relevant dates and some emergency supply records did

not include the nature of the emergency. These omissions meant that there might not be enough information available to provide a complete audit trail in the event of an error or incident.

Staff said they had signed confidentiality agreements, although there was no evidence of this available at the time of the inspection. They 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 at the medicines counter explained the way in which data was used and managed by the pharmacy.

The pharmacist and most staff had undertaken formal safeguarding training and had access to guidance and local contact details that were displayed in the dispensary and consultation room. The member of staff working on the post office counter had not been trained but was able to identify different types of safeguarding concerns and said that she would refer these to the pharmacist. The pharmacist said that she had recently contacted social services with concerns about a child and a vulnerable adult. Arrangements had been made for social services to visit the family and monitor the situation.

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 superintendent pharmacist worked at the pharmacy on four days each week. She was a locum pharmacist and other locum pharmacists covered her absences on Thursdays and Saturday mornings. There were enough suitably qualified and skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. The pharmacist was assisted by three dispensing assistants. Another dispensing assistant and a medicines counter assistant were absent. Staff members had the necessary training and qualifications for their roles. One member of staff worked solely at the post office counter, which was next to the medicines counter. She said that she always referred to a member of the pharmacy team if she received requests for medicines or advice and the pharmacist confirmed this.

There were no specific targets or incentives set for the services provided. Staff worked well together and said that they were happy to make suggestions within the team. They said that they felt comfortable raising concerns with the pharmacist or the non-pharmacist owner. A whistleblowing policy that advertised a confidential helpline for reporting concerns outside the organisation was available in the SOP file.

A member of staff working on the medicines counter was observed to use appropriate questions when selling over-the-counter medicines to patients 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 discussions with the pharmacist. There was no formal appraisal system in place but all staff could discuss performance and development issues with the pharmacist whenever the need arose. The lack of a structured training and development programme increased the risk that individuals might not keep up to date with current pharmacy practice and that opportunities to identify training needs could be missed.

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 was housed in an old building and the décor was in need of refreshment. However, it was clean, tidy and well-organised, with enough space to allow safe working. Some dispensed prescriptions awaiting collection were temporarily stored on the floor but did not pose a trip hazard. A separate room on the first floor was used for the assembly of medicines for care home residents. The dispensary sink had hot and cold running water and soap and cleaning materials were available. A consultation room was available for private consultations and counselling and its availability was clearly advertised. The pharmacy had a small gift section that was clearly separated from the area in which pharmaceutical services were provided. The lighting and temperature in the pharmacy were generally appropriate. However, the lighting in the stock area of the first-floor dispensary was a little dim and there was a risk that this might contribute to picking errors.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy for people to access. 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 most medicines appropriately and carries out some checks to help make sure that 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 range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. Staff said that they would signpost people requesting services they could not provide to nearby pharmacies or other providers such as the local council, which offered a sharps collection service. Lists of local sexual health clinics and drug and alcohol service providers were available for reference. A machine in the retail area measured people’s weight free of charge.

The pharmacist said that the dispensing workload was easy to manage as most of it was made up of care home and compliance aid prescriptions with very few walk-ins. Dispensing staff used a basket system to ensure that medicines did not get mixed up during dispensing. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Stickers were used on prescriptions awaiting collection to identify patients eligible for an MUR and to alert staff to the fact that a CD requiring safe custody 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. This meant that these medicines might be supplied against a prescription that was no longer valid.

The pharmacy dispensed medicines against some faxed prescriptions from local surgeries due to its rural location. The pharmacist said that medicines were not supplied against unsigned faxes and that Schedule 2 or 3 CDs were only ever supplied against the original prescription.

Patients prescribed 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 where possible she asked people prescribed warfarin for information about blood tests and dosage changes. She demonstrated that some information was recorded on the patient medication record (PMR). If a prescription for a delivery patient included high-risk medicines, a pre-printed label would be added to the bag asking the patient to telephone the pharmacy so that they could be counselled appropriately. The pharmacy team were aware of the risks of valproate use during pregnancy. The pharmacist said that the pharmacy currently had no patients prescribed valproate. However, she said that any person who met the risk criteria would be counselled and provided with patient information. The information pack for valproate could not be located and the pharmacist said that she would contact Sanofi and order another. She demonstrated that warning cards that included patient information on the risks of valproate use during pregnancy were now attached to all valproate stock items. The pharmacy carried out regular high-risk medicines audits 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.

Signatures were obtained for prescription deliveries. Separate signatures for controlled drugs were only obtained for deliveries to care homes. This might make it difficult for the pharmacy to resolve queries or manage complaints effectively. In the event of a missed delivery, the delivery driver put a notification card through the door and brought the prescription back to the pharmacy.

The pharmacy supplied medicines to residents of a large number of care homes. These medicines were assembled in a dedicated dispensary on the first floor which had its own telephone line. Each care home had its own clear perspex holder fixed to the dispensary wall that contained all the necessary documentation, including prescriptions, medicines order sheets, queries and changes from the previous month, discharge letters and a CD delivery book. A care home work schedule for each week was displayed in the dispensary. The pharmacy provided medicines in multi-compartment compliance aids to many people. These were labelled with descriptions to enable identification of individual medicines. Patient information leaflets were not always supplied, which does not comply with legislation, and so there was a risk that people might not always have all the information they need for them to make informed decisions about their own treatment. Each patient had a section in a dedicated file that included their personal and medication details, details of any messages or queries and relevant documentation, such as discharge summaries and current prescriptions or repeat order forms. A list of patients and their collection or delivery arrangements was available at the front of the file for reference. The pharmacist said that an assessment form would be used to make sure the service was suitable for any new clients. She said that she visited each of the nursing homes regularly to provide training on medicines management for care assistants.

The pharmacy offered a range of services. The pharmacist said that there was little uptake of the minor ailments service and the All-Wales EHC service, but that the smoking cessation service was popular. She said that she currently had six clients using the level three (supply and monitoring) service and a recent client had successfully given up smoking.

Medicines were obtained from licensed wholesalers and generally stored appropriately. Some different products and different strengths of the same product were jumbled together, which increased the risk of errors. Some bottles containing loose tablets that had been removed from their original packaging were not adequately labelled either as stock or named-patient medication. This increased the risk of errors and did not comply with legislative requirements. Medicines requiring cold storage were stored in a well-organised drug fridge. Maximum and minimum temperatures were usually recorded daily and were consistently within the required range. However, there were some gaps in the records and so there was not always a clear audit trail to show that these medicines were safe and fit for purpose CDs were stored appropriately in a fairly well-organised CD cabinet and obsolete CDs were segregated from usable stock. The CD key was in the door of the cabinet, compromising the security of these medicines. The pharmacist removed the key and secured it on her person as soon as this was pointed out.

Stock was regularly checked and 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 was able to describe how she had dealt with a recent drug recall by contacting patients to check if they had received affected stock. She said that any affected stock would be quarantined and returned to the relevant supplier. Drug recalls were printed, filed and signed to show that they had been actioned. The pharmacy had the necessary hardware to work in accordance with the Falsified Medicines Directive but

the software had not been installed and so the pharmacy was not yet in a position to comply with legal requirements.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. 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. Most were in good repair, although two 10ml measures had broken bases. Triangles were used to count tablets and a separate triangle was available for use with loose cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was clean and in good working order, but there was no evidence to show that it was regularly tested. 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.