General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Vida Rogers Ltd, 18 Hanbury Road, BARGOED, Mid Glamorgan, CF81 8QS

Pharmacy reference: 1043483

Type of pharmacy: Community

Date of inspection: 29/02/2024

Pharmacy context

This pharmacy is in Bargoed town centre. 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, smoking cessation services, treatment for minor ailments and a seasonal 'flu vaccination service for both 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	1.8	Good practice	Safeguarding is an integral part of the culture within the pharmacy
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 their mistakes so they can learn from them. And they take action to help stop mistakes from happening again. But they do not always record all of their mistakes, so they may miss some opportunities to learn and improve. The pharmacy keeps the records it needs to by law. It keeps people's private information safe. And its 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 of dispensing errors and near misses. There had been no entries in the near miss log since September 2023. However, the pharmacist explained that she 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, following near misses involving bendroflumethiazide and bisoprolol 2.5mg tablets, penicillin and penicillamine 250mg tablets, and paroxetine and pantoprazole tablets, these items had been distinctly separated on dispensary shelves to help reduce the risk of selection errors. The team had also made a proactive decision to store different strengths of bendroflumethiazide tablets separately to help avoid selection errors. A poster describing the process to follow in the event of anaphylaxis was displayed in the consultation room for reference.

A range of standard operating procedures (SOPs) underpinned the services provided. Pharmacy team members had signed these to show that they had read and understood them. Team members were able to describe their roles and responsibilities. The accuracy checking technician (ACT) explained that she could check any prescription items that had been clinically checked by a pharmacist, apart from medicines that were to be supplied in compliance packs and newly prescribed items. The pharmacist explained that she would always clinically check prescriptions before they were labelled. But the prescriptions were not marked to show that a clinical check had been completed. So there could be a risk that the clinical check might be overlooked. Members of the team labelling prescriptions would identify any newly prescribed items by writing 'new' at the top of the prescription. This indicated to the team that the prescription could only be accuracy checked by a pharmacist. Members of the team were able to describe the activities that could and could not take place in the absence of the responsible pharmacist (RP). The RP notice on display was incorrect, but the pharmacist remedied this as soon as the inspection began.

Verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place, although this was not advertised. Leaflets advertising the NHS complaints procedure 'Putting Things Right' were available in the consultation room.

Evidence of current professional indemnity insurance was available. The superintendent pharmacist also had personal indemnity insurance arrangements. All necessary records were up to date, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed medicines and controlled drug (CD) records. Most records were properly maintained. However, electronic records of emergency supplies did not always include the nature of the emergency. This meant that it might be

difficult for the pharmacy team to demonstrate why the supply was appropriate.

Members of the pharmacy team understood the need to protect confidential information, for example by offering people the use of the consultation room for private conversations. They were able to identify confidential waste and demonstrated how they would dispose of this appropriately. A privacy notice displayed near the consultation room included information about the ways in which personal information was managed and safeguarded.

The pharmacists had undertaken advanced formal safeguarding training. All other team members had undertaken basic formal safeguarding training. They had access to guidance and local safeguarding contact details that were displayed in the dispensary. A poster that included comprehensive details of local support services for people affected by mental health issues was displayed in the pharmacy. The team were able to give examples of how they had identified and supported potentially vulnerable people, which had resulted in positive outcomes. They had recently dealt with a safeguarding incident involving an elderly person who lived alone and was supplied medicines in compliance packs. The team had concerns that she was not taking her medicines properly and that she was becoming increasingly confused. A member of the team visited her and discovered that she was not managing well at home. The pharmacist referred the concern to surgery team, who monitored her condition and subsequently arranged for her to be transferred to a care home.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. 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

The superintendent pharmacist worked at the pharmacy on Mondays, Tuesdays, Thursdays and Fridays. Two regular locum pharmacists provided cover on Wednesdays and Saturdays. The pharmacy team consisted of two part-time accuracy checking technicians (ACTs), a full-time pharmacy technician and a part-time dispensing assistant. A medicines counter assistant had recently left the business and the pharmacy was currently recruiting for a new member of staff as a replacement. However, the pharmacy team were able to comfortably manage the workload, and the staffing level appeared adequate for the services provided.

Members of the pharmacy team working on the medicines counter were observed to use appropriate questions when selling over-the-counter medicines to people. And they referred to the pharmacist on several occasions for further advice on how to deal with transactions. The team 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 informal discussions with the pharmacists. The lack of a structured training programme meant that individuals might not keep up to date with current pharmacy practice. All staff had recently completed mandatory training provided by NHS Wales on mental health awareness. The pharmacy technicians understood the revalidation process and based their continuing professional development entries on situations they came across in their day-to-day working environment. There was no formal appraisal system in place, which meant that development needs might not always be identified or addressed. But all team members could informally discuss performance and development issues with the pharmacist 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 said that they were happy to make suggestions within the team and felt comfortable raising concerns with the superintendent pharmacist and pharmacy owner. A whistleblowing policy was available in the dispensary. It included details of organisations that could be contacted if team members wished to raise a concern outside the company.

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 and dispensed prescriptions awaiting collection were being temporarily stored on the floor, but they 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 its availability was clearly advertised. The lighting and temperature in the pharmacy were appropriate.

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 medicines appropriately and carries out checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy offered a range of services that were appropriately advertised. There was a small step up to the pharmacy entrance, but the pharmacy team said that they would go out to people requiring assistance and help them into the pharmacy. There was wheelchair access into the consultation room. Pharmacy team members signposted people requesting services that they could not provide to nearby pharmacies or other healthcare providers. Details of the local council's waste sharps collection service were available in the dispensary. A list of local sexual health services was displayed in the consultation room. Some health promotional material was on display in the retail area.

Dispensing staff used colour-coded baskets to help ensure that medicines did not get mixed up during dispensing and to differentiate between different people's prescriptions. 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. Stickers were also attached to prescription bags to identify dispensed Schedule 3 and 4 CDs awaiting collection. These stickers were marked with the date after which the prescription was invalid and could no longer be supplied.

Prescriptions for people prescribed high-risk medicines such as warfarin, lithium and methotrexate were marked with stickers to identify the patient for counselling. The pharmacist said that she asked people prescribed high-risk medicines about relevant blood tests and dose changes but did not always record these conversations. 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 wherever possible. The pharmacist confirmed that any people prescribed valproate who met the risk criteria would be counselled appropriately and provided with information at each time of dispensing. A poster that listed actions to be taken by the pharmacy team when dealing with valproate prescriptions was displayed in the dispensary.

The pharmacy provided medicines in disposable multi-compartment compliance packs to some people in the community. New patients requesting the service were assessed for suitability. 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. Each patient was allocated a section in one of four files. It included their personal and medication details, details of any messages or queries for communication purposes and any relevant documentation, such as current prescriptions, repeat order forms and hospital discharge letters. A list of patients and their collection or delivery arrangements was available at the front of each file for reference. The pharmacy also provided an original pack and MAR chart service to some people.

Uptake of the common ailments service was steady, as the pharmacy had been providing the service for

many years and the community were aware that they could access treatment in this way. The pharmacy also received referrals for the service from nearby surgeries and opticians. The superintendent pharmacist was an independent prescriber and could provide the extended common ailments service. Uptake of the discharge medicines review service and the emergency supply of prescribed medicines service was relatively low. The pharmacy provided a smoking cessation service (supply only), an EHC service and a seasonal influenza vaccination service. Substance misuse services, including supervised consumption, were also provided. People supplied substance misuse treatments against instalment prescriptions were allocated a section in a dedicated file. This included their personal details, current prescription, claim form and contract if supervised, and any other relevant documents and notes.

The pharmacy provided a prescription collection service from eight local surgeries. It also offered a free medicine delivery service. Signatures were obtained for medicine deliveries. Prescription bags containing CDs were marked with a sticker, which alerted the driver to notify the person that they were receiving a controlled drug. In the event of a missed delivery, the delivery driver put a notification card though the door and brought the medicines back to the pharmacy.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. Some medicines that had been removed from their original packaging were not marked with the batch number or expiry date. This meant that it might be difficult for the pharmacy to respond effectively to a query or safety recall. The pharmacist said that this was an oversight, and disposed of the medicines appropriately as soon as this was pointed out to her. Medicines requiring cold storage were kept in a medical fridge. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored in two well-organised CD cabinets. Obsolete CDs were kept separately from usable stock.

Medicine stock was subject to regular expiry date checks. These were documented, and short-dated items were highlighted. Date-expired medicines were disposed of appropriately, as were patient returns, waste sharps and clinical waste. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacy team described how they would deal with a drug 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 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. Separate measures were used for methadone to prevent cross-contamination. Triangles and a capsule counter were used to count loose tablets and capsules. They were washed after use with cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was clean and in good working order, although there was no evidence to show 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.