General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Bargoed Pharmacy, 9 Under Cardiff Road, BARGOED, Mid Glamorgan, CF81 8WZ

Pharmacy reference: 1043486

Type of pharmacy: Community

Date of inspection: 27/02/2024

Pharmacy context

This pharmacy is near the town centre in Bargoed. 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. It also offers substance misuse services.

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	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. The pharmacy keeps the records it needs to by law. It keeps people's private information safe. And its 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 identify and manage risk, including the recording of dispensing errors and near misses. The pharmacist explained that he 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 some near misses with different strengths of diazepam tablets, these had been distinctly separated on dispensary shelves in boxes which had been clearly labelled to show each strength. The boxes had also been marked with the word 'CARE' as a further alert to team members. A poster listing the different signs of sepsis in adults and children was displayed in the consultation room for reference.

A range of standard operating procedures (SOPs) underpinned the services provided. Most pharmacy team members had signed these to show that they had read and understood them. The newest member of the team was still in the process of being trained on SOPs relevant to her role. 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 marked as clinically checked by a pharmacist, as long she had not been involved in dispensing or labelling these. A member of the team was 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 card received from a customer was displayed in the retail area and this thanked the team for providing a good service. A formal complaints procedure was in place, although this was not advertised. A poster advertising the NHS complaints procedure 'Putting Things Right' was displayed in the consultation room.

Evidence of current professional indemnity insurance was available. All necessary records were up to date, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed medicines and electronic controlled drug (CD) records. CD running balances were typically checked weekly by the ACT. Most records were properly maintained. 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. Some prescriber details were missing from the private prescription register and electronic records of emergency supplies did not always include the nature of the emergency. These missing details meant that it might be difficult for the pharmacy team to resolve queries or investigate errors quickly and effectively.

Members of the pharmacy team had signed confidentiality agreements. They were aware of the need

to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. A poster in the consultation room included information about the ways in which personal information was managed and safeguarded.

The pharmacists and ACT 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 via the internet. Posters that included comprehensive details of support services for people affected by mental health and domestic abuse issues were displayed in the pharmacy.

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

One of the pharmacist owners of the company worked at the pharmacy every day. He was assisted by the part-time pharmacist manager, who worked there for three days each week. The pharmacy team consisted of a full-time accuracy checking technician (ACT), four dispensing assistants (DAs) and a new member of staff who had only worked at the pharmacy for a few weeks. The new team member worked under the supervision of the pharmacist and other trained members of staff. She was in the process of completing induction training and the pharmacist confirmed that he planned to enrol her on a formal training course very soon. Pharmacy team members 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. A computer terminal situated at the medicines counter allowed team members to access patient medication records, which helped them to make decisions about sales of medicines or the provision of advice. 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 improving the quality of services provided and mental health awareness. The ACT understood the revalidation process and based her continuing professional development entries on situations she came across in her 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 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 said that they were happy to make suggestions within the team and felt comfortable raising concerns with the regular pharmacists and superintendent pharmacist. 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. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use. A plastic screen had been installed at the medicines counter to reduce the risk of viral transmission between staff and customers.

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. 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.

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 could use a portable ramp to help people using wheelchairs into the pharmacy. Push pads situated inside and outside the entrance door at wheelchair height could be used to open the door automatically. There was wheelchair access into the 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 provided a sharps collection service. A poster in the consultation room included contact information for local sexual health services. 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 most dispensing labels to provide an audit trail. However, the pharmacy team supplied some people's medicines using the 'Golden Tote' software system and dispensing labels for these medicines were not initialled. This was because the patient medication record (PMR) system software was able to provide an audit trail to show who had been involved in the dispensing process. A member of the dispensing team demonstrated the 'Golden Tote' process and explained that a physical accuracy check was not performed as the software system would only generate dispensing labels if the correct product was selected and scanned. As a safeguard, the dispenser was required to scan the product, the dispensing label and the bag label for each patient at the end of the dispensing process to confirm that their details exactly matched the details on the scanned prescription. The pharmacy team were unable to process prescriptions for split packs or controlled drugs using this system. A text messaging service was available to let people know that their medicines were ready for collection. Each bag label attached to a prescription awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail.

Prescription forms were not always retained for dispensed items awaiting collection, apart from prescriptions for Schedule 2, 3 and 4 controlled drugs. Most prescriptions were scanned, and the image remained available for reference. However, this was not the case for all prescriptions. This meant that it might be difficult for the pharmacy team to resolve queries or investigate errors quickly and effectively.

Each prescription awaiting collection was assigned to a specific storage location in the dispensary. When pharmacy team members needed to locate a prescription, the person's name was typed into a handheld device and this brought up a list of locations in which their items were being stored, including medical 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 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 high-risk medicines such as warfarin, lithium and methotrexate were not routinely highlighted, so there was a risk that counselling opportunities could be missed. 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 patients prescribed valproate who met the risk criteria would be counselled appropriately and provided with information at each time of dispensing.

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. A list of patients and their collection or delivery arrangements was available in the dispensary for reference. Each patient was allocated a section in an alphabetical file that included their personal and medication details. Pharmacy team members used a noticeboard in the dispensary to record recent messages or queries for communication purposes. A progress tracker showed the status of each patient's compliance pack at any given time. The pharmacy also provided an original pack and MAR chart service to some people.

Uptake of the common ailments service, sore throat test and treat service and UTI service was high, as the pharmacy received many referrals from nearby surgeries and opticians. Both pharmacists were independent prescribers and could provide the extended common ailments service. There was a steady uptake of the discharge medicines review service and the emergency supply of prescribed medicines service. The pharmacy also provided a smoking cessation service (supply and monitoring), an EHC service and a seasonal influenza vaccination service. The pharmacist owner offered a private period delay service for a charge, supplying treatment under a patient group direction (PGD). Substance misuse services were also provided, including supervised consumption and needle and syringe provision. People supplied substance misuse treatments against instalment prescriptions were allocated a section in a dedicated file. This included their personal details and any relevant documents, such as their current prescription and any notes authorising a representative to collect a dose on their behalf.

The pharmacy provided a prescription collection service from six local surgeries. It also offered a free prescription delivery service. Each prescription was scanned into a handheld electronic device. Patients or their representatives signed this device to acknowledge receipt of the delivery as an audit trail. Separate signatures were not obtained for CDs, but the device display could be marked to show that a CD was included in the package. This alerted the delivery driver to notify the patient that they were receiving a CD. In the event of a missed delivery, the driver put a notification card though the door and brought the prescription back to the pharmacy.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. Medicines requiring cold storage were kept in two medical fridges. One fridge was situated in the consultation room and could be locked to prevent unauthorised access. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored in three well-organised CD cabinets. Obsolete CDs were kept separately from usable stock. Some bottles of methadone oral solution were found present outside a CD cabinet during the inspection, compromising the security of these medicines. The pharmacist said that this was an oversight and secured them appropriately as soon as this was pointed out. The pharmacy team stored cash in one of

the CD cabinets. This could lead to unnecessary access, which might increase the risk of accidental loss or diversion of CDs.

There was some evidence to show that regular expiry date checks were carried out, but the frequency and scope of these checks were not documented. This created a risk that out-of-date medicines might be overlooked. However, short-dated items were highlighted with a marker pen, and no out-of-date medicines were found during the inspection. 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 branch and NHS email accounts. 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 it makes sure these are always safe and suitable for use. It's 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. A separate triangle was available for use with cytotoxics. 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.