General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Knights Parkgate Pharmacy, 17 Berw Road, PONTYPRIDD, Mid Glamorgan, CF37 2AA

Pharmacy reference: 1043586

Type of pharmacy: Community

Date of inspection: 29/07/2024

Pharmacy context

This pharmacy is on the outskirts of a town centre in South Wales. 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 influenza vaccination service. 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	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
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 chance of similar mistakes 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 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 an electronic platform for recording dispensing errors and near misses. Patient safety incidents were reviewed monthly. Dispensing team members explained that the pharmacist discussed near misses with them at the time they came to light. And that any patterns or trends that emerged were discussed with the whole team. The superintendent's team regularly shared learning points from company-wide patient safety incidents with all branch teams via email. Action had been taken to reduce some risks that had been identified. For example, losartan and lamotrigine tablets had been distinctly separated in the dispensary following a dispensing error.

A range of standard operating procedures (SOPs) underpinned the services provided and these had been regularly reviewed. Pharmacy team members had signed the SOPs to show that they had read and understood them. An appendix of the Staff Roles and Responsibilities SOP showing the tasks that each staff member was expected to perform had not been completed. However, when questioned, members of the pharmacy team were able to clearly describe their roles and responsibilities. And they were able to describe activities that could not take place in the absence of the responsible pharmacist. The pharmacy technicians who worked as accuracy checkers (ACTs) explained that they could check most prescription items that had been marked as clinically checked by a pharmacist, provided they had not been involved in dispensing or labelling these. They did not check prescriptions for controlled drugs or cytotoxic medicines.

Cards displayed on the medicines counter encouraged people to leave an online review of the pharmacy. Pharmacy team members explained that verbal feedback from people using the pharmacy was mostly positive. Some cards from customers that were displayed in the dispensary thanked the pharmacy team for their helpful service. A formal complaints procedure was in place. Information about how to make complaints was included in the pharmacy's practice leaflet. This was displayed behind the medicines counter but was not accessible or visible from the retail area. So, people using the pharmacy might not understand the best way to raise concerns.

Evidence of current professional indemnity insurance was available. All necessary records were up to date, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and electronic controlled drugs (CD) records. However, it was not always clear whether emergency supplies had been made at the request of the patient or the prescriber. This meant that it might be difficult for the pharmacy team to demonstrate why the supply was appropriate. Running balances for controlled drugs were typically checked weekly.

Pharmacy team members had signed confidentiality agreements. They 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 disposed of this appropriately. The pharmacist had undertaken advanced formal safeguarding training. Other pharmacy team members had undertaken basic formal safeguarding training. All team members had completed Dementia Friends training. They had access to guidance and local safeguarding contact details that were available in the pharmacy's safeguarding SOP. Leaflets that included information and advice for people caring for people with dementia were available behind the medicines counter. A poster that included comprehensive details of local support services for people affected by mental health issues was 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 appropriately trained for the jobs they do or are enrolled on a suitable training course for their role. Or they are scheduled to begin an appropriate training course soon. They feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacist manager worked at the pharmacy on most days. The pharmacy team consisted of a part-time pharmacy technician, who was also a qualified accuracy checker (ACT) and shared some managerial responsibilities with the pharmacist, another ACT, three dispensing assistants (DAs) and a trainee DA who worked under the supervision of the pharmacist. A newly recruited unqualified team member who worked on the medicines counter was absent. She was soon to be enrolled on an accredited training course and the pharmacist explained that she referred all requests for medicines or advice to trained members of the team. The pharmacy employed two part-time delivery drivers. One of the drivers had begun work at the pharmacy on the day of the inspection and had been verbally trained on the pharmacy's procedures. The pharmacist gave assurances that he was soon to be enrolled on an accredited training course. Pharmacy team members were able to safely 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 using 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 list of WWHAM questions was displayed near the medicines counter for reference. Team members 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 pharmacist. Both pharmacy technicians understood the revalidation process and explained that they based their continuing professional development entries on training they had undertaken and on issues they came across in their day-to-day working environment. They had online access to training modules provided by NHS Wales on clinical topics and pharmacy services. All staff except the newest team member had completed mandatory training provided by NHS Wales on mental health awareness and improving the quality of services provided. 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 felt comfortable making suggestions or raising concerns with the pharmacist and area manager. A whistleblowing policy was available on the pharmacy's intranet system and described the pharmacy's internal process for raising concerns. On discussion, team members understood that they could contact the GPhC if they wished to raise a concern outside the organisation.

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 clean, tidy and well-organised, with enough space to allow for safe working. Some stock medicines and dispensed medicines awaiting collection were being temporarily stored on the floor, but they did not pose a trip hazard. The sinks had cold running water, but there was no hot water available as the pharmacy’s boiler had recently broken. The pharmacist explained that the company were in the process of arranging for a new boiler to be fitted. The team were using a kettle to provide hot water in the meantime. Soap, hand sanitiser and cleaning materials were available. A plastic screen at the medicines counter had been installed 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 effectively promotes the services it provides so that people know about them and can access them easily. Its working practices are generally safe and effective. But members of the pharmacy team do not always know when some 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. The pharmacy stores 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, and these were clearly advertised at the pharmacy entrance. There was wheelchair access into the pharmacy and consultation room. Pharmacy team members 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. A poster displayed near the medicines counter included contact details for local sexual health services. A list of these services was also available in the consultation room. The pharmacist explained that she had recently emailed three local surgery teams with details of the pharmacy's services, to help them understand how to make appropriate referrals.

Dispensing staff used baskets to ensure that medicines did not get mixed up during the dispensing process. Dispensing labels were initialled by the dispenser and accuracy checker to provide an audit trail. Controlled drugs requiring safe custody and fridge lines were dispensed in clear bags to allow pharmacy team members to check these items at all points of the dispensing process. This helped to reduce the risk of a person receiving the wrong medicine.
Stickers were placed on prescription bags to alert team members to the fact that a CD requiring safe custody or fridge item needed to be added, or that the pharmacist wished to speak to the patient or their representative at the point of handout. Labels attached to prescription bags identified dispensed Schedule 3 and 4 CDs awaiting collection. The labels were marked with the date after which the prescription was invalid and could no longer be supplied. A text messaging service was available to let people know their medicines were ready for collection.

Some medicines dispensed for people receiving weekly supplies were being stored without labels, which increased the risk of mistakes. A dispensing assistant explained that medicines would always be labelled before they were supplied to a patient, and agreed to label the medicines accordingly. On discussion, the pharmacist understood the risks of this practice and agreed to review the pharmacy's dispensing processes going forward.

Prescriptions for people prescribed higher-risk medicines such as warfarin, lithium and methotrexate were not routinely identified. So, there was a risk that some counselling opportunities could be missed. The pharmacy team were aware of the risks of using valproate-containing medicines 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 educational information at each time of dispensing.

The pharmacy supplied medicines in disposable multi-compartment compliance packs to some people

in the community. Most compliance packs were assembled off-site in the company's hub pharmacy. The hub could not assemble bulk items, and these continued to be dispensed at the branch. Occasionally, a medicine that needed to be included in the compliance pack was out of stock at the hub and the pharmacy team added it to the partially assembled compliance pack when it was returned to the branch. An accuracy check was then carried out against the original prescription, which was retained in the pharmacy, and the compliance pack was marked with 'dispensed by' and 'checked by' initials as an audit trail. Compliance packs were labelled with descriptions of the medicines they contained. Patient information leaflets 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 available on the pharmacy's computer system for reference.

There was a high uptake of the pharmacy's discharge medicines review service, as the pharmacy actively promoted it to people that used the pharmacy. Uptake of the common ailments service, the smoking cessation (supply and monitoring) service, the sore throat test and treat service and the UTI (urinary tract infection) service was steady, as the pharmacy received frequent referrals from nearby GP surgeries. Demand for the emergency supply of prescribed medicines service was low, as the pharmacy was not open at weekends and kept similar opening hours to local surgeries on weekdays, so people were usually able to obtain a valid prescription from a GP in an emergency. The pharmacy offered an EHC (emergency hormonal contraception)/bridging contraception service, a seasonal influenza vaccination service and a free blood pressure measurement service. A supervised consumption service was also available, although the pharmacy currently had no people using this service. The pharmacy team provided an NHS-commissioned original pack and medication administration record (MAR) dispensing service for people with carers. People were referred to the pharmacy by the local health board. Each person had a section in a dedicated file that included their personal and medication details, collection or delivery arrangements and a service agreement form provided by the local health board which included relevant information about the individual for both the pharmacy team and the person's carers. A list of people who received their medicines via this service was displayed in the front of the file for reference.

The pharmacy provided a prescription collection service from three local surgeries. It also offered a free medicines delivery service. The delivery driver used a delivery sheet to record each delivery that was made. Patients or their representatives signed to show if they had received a controlled drug as an audit trail. 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 stored appropriately. Medicines requiring cold storage were kept in two well-organised medical fridges. Maximum and minimum temperatures for the fridges were recorded daily and were consistently within the required range. Controlled drugs were stored in two well-organised CD cabinets and 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 and waste sharps. The pharmacy received safety alerts and recalls via the company's intranet system and its NHS email account. The pharmacy team were able to describe 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 team has the equipment and facilities it needs to provide the services they offer. And it makes sure these are always safe and suitable for use. 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 to prevent cross-contamination. Triangles were used to count loose 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 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.