General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Valkyrie Pharmacy, Valkyrie Road Primary Care Centre, Valkyrie Road, WESTCLIFF-ON-SEA, Essex, SS0 8BT

Pharmacy reference: 1117508

Type of pharmacy: Community

Date of inspection: 29/07/2024

Pharmacy context

The pharmacy is next to a surgery in a largely residential area. It provides NHS dispensing services, the New Medicine Service and the Pharmacy First service. And the pharmacy supplies medicines in multi-compartment compliance packs to a small number of people who live in their own homes and need this support.

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

Overall, the pharmacy adequately identifies and manages the risks associated with its services to help provide them safely. It protects people's personal information well. And team members understand their role in protecting vulnerable people. The pharmacy largely keeps its records up to date and accurate. But it doesn't always record mistakes that happen during the dispensing process. And this could mean that team members are missing out on opportunities to learn and improve the pharmacy's services.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs). Some team members had signed to show that they had read, understood, and agreed to follow them. And other team members were in the process of reading them. Team members' roles and responsibilities were specified in the SOPs. And team members knew what tasks they should not undertake if the pharmacist had not turned up in the morning. They knew that they should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was absent from the pharmacy.

Team members said that there had not been any recent dispensing errors, where a dispensing mistake had happened, and the medicine had been handed to a person. Team members were not sure where a dispensing error should be recorded. A team member said that she would speak with the pharmacy manager and ensure that everyone knew where to record these in the absence of the manager. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them. But near misses were not routinely recorded which may limit learning opportunities.

There was an organised workflow which helped staff to prioritise tasks and manage the workload. And workspace in the dispensary was free from clutter. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members initialled the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity insurance. The right responsible pharmacist (RP) notice was clearly displayed, and the RP record was completed correctly. Controlled drug (CD) registers examined were largely filled in correctly, but the address of the supplier was not routinely recorded. The CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were largely completed correctly, but the details of the prescriber were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The importance of maintaining complete rrcords about private prescriptions and emergency supplies was discussed with the team.

Team members had completed training about protecting people's personal information. And confidential waste was removed by a specialist waste contractor. Computers were password protected

and people using the pharmacy could not see information on the computer screens. Smartcards used to access the NHS spine were stored securely and team members used their own smartcards during the inspection. Bagged items waiting collection could not be viewed by people using the pharmacy.

The complaints procedure was available for team members to follow if needed. Team members said that they would refer any complaints to the pharmacy manager. They said that there had not been any recent complaints.

Team members had completed training about protecting vulnerable people. And the pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. One of the dispensers described potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. Team members said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to provide its services safely. They do the right training for their roles. And they are provided with some ongoing training. Team members can raise concerns to do with the pharmacy or other issues affecting people's safety. And they can make professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one locum pharmacist and two trained dispensers working at the pharmacy during the inspection. They appeared to work well together, and the pharmacy was up to date with its workload. Team members said that there was some flexibility to their working hours and other team members would provide cover where needed. And they said that there were contingency arrangements for pharmacist cover if needed.

Team members appeared confident when speaking with people. And they asked relevant questions to establish whether an over-the-counter medicine was suitable for the person it was intended for. One, when asked, was aware of the restrictions on sales of medicines containing pseudoephedrine. She said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be misused or may require additional care.

The pharmacist was aware of the continuing professional development requirement for professional revalidation. And he felt able to make professional decisions. He said that he had completed declarations of competence and consultation skills for the services, as well as associated training. A dispenser said that team members were not provided with ongoing training on a regular basis, but they did receive some. And she said that the pharmacy manager would regularly pass on relevant pharmacy-related information to them. She said that team members had informal ongoing appraisals and they felt comfortable discussing any issued with the pharmacy manager. Targets were not set for team members. Team members said that the services were provided for the benefit of people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

People can have a conversation with a team member in a private area. And the premises provide a safe, secure, and clean environment for the pharmacy's services.

Inspector's evidence

The pharmacy was secured against unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Air conditioning was available, and the room temperature was suitable for storing medicines. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. And pharmacy-only medicines were kept behind the counter.

There was seating in the shop area for people waiting for services. The consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped and well-screened. Conversations at a normal level of volume in the consultation room could not be heard from the shop area. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. And people with a range of needs can access the pharmacy's services. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People who get their medicines in multi-compartment compliance packs receive up-to-date information about their medicines.

Inspector's evidence

There was step-free access into the pharmacy through a wide entrance with a 'press-to-open' automatic door. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised, and a variety of health information leaflets was available in the shop area. And the pharmacy could produce large-print labels for people who needed them.

There were signed in-date patient group directions available for the relevant services offered. Dispensed fridge items were kept in clear plastic bags to aid identification. A dispenser said that team members checked CDs and fridge items with people when handing them out. The pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme (PPP). The pharmacy supplied these medicines in their original packs and team members knew they should not cover up any of the warning with the dispensing labels. The pharmacist said that they would refer people to their GP if they needed to be on the PPP and weren't on one. The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals. Prescriptions for higher-risk medicines were not highlighted. So, opportunities to speak with these people when they collected their medicines might be missed. A dispenser said that she would discuss this with the manager. Prescriptions for Schedule 4 CDs were not highlighted. This could increase the chance of these medicines being supplied when the prescription was no longer valid.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and the MHRA. The pharmacy kept a record of some alerts but did not record the action taken. This could make it harder for the pharmacy to show what it had done in response. One of the dispensers said that she would speak with the pharmacy manager about how the pharmacy recorded the action taken in future. Stock was stored in an organised manner in the dispensary. Expiry dates were checked regularly, and this activity was recorded. There were no date-expired items found in with dispensing stock and medicines were kept in their original packaging. And items due to expire within the next several months was marked.

CDs were stored in accordance with legal requirements. Denaturing kits were available for the safe destruction of CDs. Expired CDs were clearly marked and kept separated from dispensing stock. There were no returned CDs in the cabinet on the day of the inspection. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded. Fridge temperatures were checked daily, and maximum and minimum temperatures were recorded. Records indicated that the

temperatures were consistently within the recommended range. The fridges were suitable for storing medicines and were not overstocked.

Uncollected prescriptions were checked regularly, and people were sent a text message when their medicines were ready to be collected. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible. Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. And prescriptions for alternate medicines were requested from prescribers where needed.

The pharmacist said that people had assessments to show that they needed their medicines in multi-compartment compliance packs. Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested; the dispenser said that the pharmacy contacted people to see if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and it also kept any hospital discharge letters for future reference. Packs were suitably labelled and there was an audit trail to show who had dispensed and checked each pack. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. This meant people had up-to-date information about their medicines.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy generally has the equipment it needs to provide its services safely. It uses its equipment to help protect people's personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available but not for volumes less than ten millilitres. A dispenser said that she would order a suitable measure. Triangle tablet counters were available and clean, and separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor had been in use for less than one year. A dispenser said that it would be replaced in line with the manufacturer's guidance. The weighing scales were in good working order. And the phone in the dispensary was portable so it could be taken to a more private area where needed.

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.