General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Valleys Link Pharmacy, 192-193 Gelli Road, Gelli, Pentre, Rhondda Cynon Taff, CF41 7NA

Pharmacy reference: 9011603

Type of pharmacy: Community

Date of inspection: 15/04/2024

Pharmacy context

This pharmacy is a village pharmacy in the Rhondda Valley. 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 not all met

Required Action: Improvement Action Plan

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 not all met	1.6	Standard not met	The Responsible Pharmacist record is not properly maintained so it may be difficult to establish who was responsible at any given time.
2. Staff	Standards not all met	2.1	Standard not met	Members of the pharmacy team are not all suitably trained for the tasks that they carry out which means they may not always complete tasks in an effective manner.
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 not all met**

Summary findings

The pharmacy has written procedures to help make sure the team works safely. Its team members take action to help stop mistakes from happening again. But they do not always record or review all their mistakes, so they may miss some opportunities to learn and improve. 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. Pharmacy team members know how to keep people's private information safe. And they 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 an electronic recording system for dispensing errors and a paper record for near misses. There were no records of dispensing errors available, but the dispensing team explained that errors were usually recorded on an individual person's patient medication record (PMR) rather than the electronic reporting system. They were unable to provide any examples as evidence of this. The most recent near miss records had been made in 2022. The pharmacist explained that he currently 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. Some action had been taken to reduce risks that had been identified. For example, following a near miss with loprazolam and lorazepam tablets, these medicines had been distinctly separated and were stored in different sections of the dispensary. A poster describing the process to follow in the event of anaphylaxis was displayed in the consultation room.

A range of standard operating procedures (SOPs) underpinned the services provided. Most pharmacy team members had signed these, or were in the process of signing them, to show that they had read and understood them. However, one team member who had worked on the medicines counter for about a year had not yet signed any of the SOPs relevant to her role. She explained that she had received verbal training on relevant procedures. Members of the team 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 dispensing assistant was able to describe the activities that could and could not take place in the absence of the responsible pharmacist (RP).

The pharmacy had a 'suggestions/complaints' box in the retail area, although team members said that this was rarely used. They explained that verbal feedback from people using the pharmacy was mostly positive. Cards received from customers were displayed in the retail area and thanked the team for providing a good service. A formal complaints procedure was in place, although this was not advertised, so people may not know how to raise a complaint.

Evidence of current professional indemnity insurance was available. Most necessary records were up to date, including private prescription, emergency supply and controlled drug (CD) records. However, the electronic responsible pharmacist (RP) register was not well-maintained. There were nine occasions during the previous six weeks on which the pharmacist had not made an entry in the RP register to show the times during which they had taken responsibility for the safe and effective running of the pharmacy. This meant that it might not be possible to identify the pharmacist accountable in the event

of an error or incident. The pharmacist had not completed the RP record on the day of the inspection, but he did so as soon as the inspection began. Electronic emergency supply records did not always include the nature of the emergency. And it was sometimes unclear if an emergency supply had been made at the request of the patient or the prescriber, as these entries were simply annotated 'script to follow'. This meant that it might be difficult for the pharmacy team to fully resolve queries or deal with errors effectively. Running balances of controlled drugs (CDs) were typically checked every two months by the ACT, except for methadone running balances, which were checked at similar intervals by a pharmacist. Infrequent CD balance checks could lead to concerns such as dispensing errors or diversion being missed.

Members of the pharmacy team explained that they had signed confidentiality agreements as part of their contract of employment. They were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. A poster near the medicines counter 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. A summary of the pharmacy's chaperone policy was displayed on the consultation room door. Posters that included comprehensive details of support services for people affected by mental health and domestic abuse issues were displayed at the pharmacy entrance.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy has enough staff to manage its workload. Most pharmacy team members understand their roles and responsibilities. But two team members are not suitably trained for the tasks that they do. Members of the pharmacy team feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacy operated using three part-time pharmacists. The superintendent pharmacist usually worked on Mondays, Fridays and most Saturdays. A locum pharmacist also worked at the pharmacy and was the previous owner of the business. He usually worked at the pharmacy on Tuesdays and Thursdays. Another regular locum pharmacist worked at the pharmacy every Wednesday. The support team consisted of a full-time accuracy checking technician (ACT), two full-time dispensing assistants (DAs), two medicines counter assistants and a part-time member of staff who had worked as a counter assistant at the pharmacy for a year but had not undertaken any formal training. She explained that she had received some internal training and always worked under the supervision of a pharmacist or another trained member of staff. A delivery driver had worked at the pharmacy for about two years but had not received any formal training. One part-time DA and a part-time trainee DA were absent. The staffing level appeared adequate for the services provided and pharmacy team members were able to comfortably manage the workload.

Members of the pharmacy team working on the medicines counter were observed to use appropriate questions when selling over-the-counter medicines and referred to the pharmacist on several occasions for further advice on how to deal with transactions.

The ACT had access to training provided by NHS Wales. She had recently completed training modules on antimicrobial stewardship and women’s health. She understood the revalidation process and explained that she based her continuing professional development entries on situations she came across in her day-to-day working environment. Other team members had access to informal training materials such as articles in trade magazines and information about new products from manufacturers. They explained that much of their learning was via informal discussions with the pharmacists. Members of the team had also recently completed mandatory training provided by NHS Wales on mental health awareness. However, the lack of a structured training programme meant that individuals might not keep up to date with current pharmacy practice. There was no formal appraisal system in place, which meant that development needs might not always be identified or addressed. But all pharmacy team members could informally discuss performance and development issues with the pharmacists whenever the need arose.

Some targets were set for the services provided but these were managed appropriately, and the pharmacist said that they did not affect his professional judgement or compromise patient care. 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 pharmacists, including the superintendent pharmacist. They understood that they could contact the General Pharmaceutical Council if they 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 dispensed medicines awaiting collection were being temporarily stored on the floor but 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 and customer use.

A consultation room was available for private consultations and counselling and its availability was clearly advertised. The lighting in the pharmacy was appropriate. The pharmacy team were using electric heaters to warm the dispensary and medicines counter areas as it was a cold day.

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 wheelchair access into the pharmacy and consultation room. Pharmacy team members signposted people requesting services that could not be provided to other nearby pharmacies or other providers such as local GP surgeries. Posters near the medicines counter included contact information for local blood borne virus screening services and local sexual health services. Some health promotional material was on display in the retail area.

The pharmacy team had a good relationship with the local GP surgery team, which meant that queries and problems were usually dealt with quickly and effectively. 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. There was no process in place to routinely identify Schedule 3 or 4 CDs that were awaiting collection, so there was a risk that these items might be supplied past their 28-day validity period. On discussion, the team agreed to highlight these items with stickers going forward.

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 ACT knew of only one patient prescribed valproate who met the risk criteria and confirmed that they were counselled 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 accompanied by a list of 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 a file that included their personal and medication details as well as relevant documents such as repeat prescription order forms and hospital discharge letters. A list of patients was available at the front of the file for reference. A progress tracker showed the status of each person's compliance pack at any given time. The pharmacy also provided a health board-commissioned original pack and medicines administration record service to some people.

Uptake of the common ailments service was high, as the pharmacy received many referrals from the nearby GP practice and local optician. Two of the pharmacists were independent prescribers and could

provide the extended common ailments service. The pharmacist present was undertaking prescribing training and planned to provide the service once this was complete. He was unable to provide the discharge medicines review service or the sore throat test and treat service, but these were available on days when other pharmacists were present. There was a steady uptake of the emergency supply of prescribed medicines service. The pharmacy provided blood pressure measurement, a smoking cessation service (supply and monitoring), an EHC service and a seasonal influenza vaccination service. It also provided a sharps waste disposal service for people who routinely use sharps as part of their treatment for an ongoing medical condition. A private blood glucose measurement service was available for a small charge.

The pharmacy provided a prescription collection service from five local surgeries. It also offered a free medicines delivery service. Patients or their representatives signed to acknowledge receipt of the delivery as an audit trail. Separate signatures were obtained for CDs. In the event of a missed delivery, the driver usually put a notification card though the door and brought the prescription back to the pharmacy. However, delivery signature sheets showed that some items were left in safe places and medicines had been posted through a letterbox on at least one occasion. The delivery driver explained that these deviations from the delivery SOP had been discussed in advance with the superintendent pharmacist. However, this practice may compromise confidentiality and increases the risk of errors.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in two medical fridges. Maximum and minimum temperatures were recorded daily for one fridge and were consistently within the required range. There were no recent temperature records available for the other medical fridge. The ACT said that this was an oversight and gave assurances that temperatures were checked every day. Maximum and minimum temperatures for this fridge were within the required range when checked. CDs were stored in two well-organised CD cabinets. Obsolete CDs were kept separately from usable stock. The CD key was being stored on the dispensary bench, compromising the security of these medicines. The pharmacist secured the key on his person as soon as this was pointed out.

There was some evidence to show that expiry date checks were carried out, but the frequency of these checks was not documented. This created a risk that out-of-date medicines might be overlooked. However, short-dated items were highlighted, and no out-of-date medicines were found. 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 pharmacist was unable to access this account, but the pharmacy team explained that the superintendent pharmacist received emails about drug recalls via his personal account, and that he would contact them to alert them about a recall if necessary. They described how they would deal with a drug recall by contacting patients where appropriate, 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. 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. However, two plastic measures and one glass measure were not validated, and the pharmacist removed these from use as soon as this was pointed out. Separate measures were used for methadone to prevent cross-contamination. Triangles, a tablet counter 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.