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: 21/11/2024

Pharmacy context

This 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 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

The pharmacy has written procedures to help make sure the team works safely. Its team members take some action to help reduce the risk of similar 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 a recording process for dispensing errors and near misses. The superintendent pharmacist explained that the team reported dispensing errors via the national electronic reporting system and printed these out for reference. There were no records available to view, but the pharmacist said that he could not remember the last time a dispensing error had been made. The most recent near miss records had been made in 2022. However, dispensing team members explained that the pharmacists 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. They agreed to record near misses going forward. Some action had been taken to reduce risks that had been identified. For example, following a near miss with different forms of aspirin tablets, these medicines had been distinctly separated on dispensary shelves.

A range of standard operating procedures (SOPs) underpinned the services provided. Pharmacy team members had signed these, or were in the process of signing them, to show that they had read and understood them. Following the inspection, the superintendent supplied SOPs and risk assessments for the pharmacy's private weight loss and Botox injection services. 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.

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 and covered the pharmacy's private weight loss and Botox services. Most necessary records were up to date, including responsible pharmacist (RP), private prescription, emergency supply and controlled drug (CD) records. 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. So, there was a risk that it would not be possible to identify the pharmacist in charge if something went wrong. And prescriber details for private prescription records were sometimes incorrect or missing. 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 or three months by the ACT, except for methadone running balances, which were checked regularly. Infrequent CD balance checks could lead to concerns such as dispensing errors or diversion being missed. The pharmacist agreed to review the pharmacy's record keeping processes going forward.

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 met

Summary findings

The pharmacy has enough staff to manage its workload. Pharmacy team members understand their roles and responsibilities. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

The pharmacy operated using four part-time pharmacists. The superintendent pharmacist usually worked on Mondays, Thursdays and Saturdays. An employee pharmacist worked at the pharmacy on Fridays and two regular locum pharmacists covered Tuesdays and Wednesdays. The pharmacy team consisted of a full-time pharmacy technician who worked as an accuracy checker (ACT), two dispensing assistants (DAs), a trainee DA, two medicines counter assistants (MCAs) and a trainee MCA. The trainees worked under the supervision of a pharmacist or another trained member of staff. One part-time DA was on a long-term leave of absence. The staffing level appeared adequate for the services provided and pharmacy team members were able to safely manage the workload.

Members of the 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. Most team members had completed health and safety training provided by an external company and all had 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 did not affect the pharmacists' 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 for safe working. There is a room where people can have conversations with team members in private.

Inspector's evidence

The pharmacy was clean, tidy and well-organised, with enough space to allow for safe working. 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. Its working practices are generally safe and effective. It stores medicines appropriately and carries out some checks to help make sure that 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 types of 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. The pharmacist explained that the pharmacy's software system highlighted expiry dates for Schedule 3 or 4 CDs awaiting collection when the corresponding prescriptions were scanned at the handout stage. This practice helped ensure that prescriptions were checked for validity before they were supplied to the patient. However, some prescriptions could not be scanned, and the pharmacist agreed to highlight these manually going forward if they included a Schedule 3 or 4 CD.

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 and topiramate 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 or topiramate who met the risk criteria 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. An original pack and medication administration record (MAR) chart dispensing service was provided to a large number of care home residents. This service was also provided to some people in the community as part of a local health board commissioned scheme.

The pharmacy's services were managed using a digital appointment system. Uptake of the common ailments service was high, as the pharmacy received many referrals from the nearby GP practice and local optician. All the pharmacists were independent prescribers and could provide the extended common ailments service. There was a steady uptake of the emergency supply of prescribed medicines service and the discharge medicines review service. The pharmacy provided blood pressure measurement, a smoking cessation service (supply and monitoring), an EHC service, a sore throat test and treat 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 superintendent pharmacist and the employee pharmacist prescribed Mounjaro injections as part of a private weight loss service that had been in place for about three months. People receiving this service had their weight and blood pressure checked and recorded regularly to monitor their progress and treatment was adjusted where necessary. Appropriate consultation records were kept, and prescribing information was shared with each person's GP. A locum pharmacist who worked at the pharmacy every Wednesday offered a private aesthetics service on the premises, administering Botox injections during pre-arranged appointments. The pharmacist wrote private prescriptions for each person receiving the service and Botox injections were supplied directly to the pharmacy against these prescriptions by a specialist private pharmacy in Cardiff. The injections were stored in the pharmacy's fridge until administration to the patient. The superintendent pharmacist was unable to locate consultation records for the Botox service, but examples of appropriate records were supplied following the inspection, as were the locum pharmacist's certificates of accreditation for the service, which were supplied by an accredited medical aesthetics training provider.

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. The delivery driver explained that these deviations from the delivery SOP had been discussed in advance with the patient and the pharmacist. However, this practice may compromise confidentiality and increases the risk of errors. On discussion, the superintendent pharmacist understood the risks and agreed to review the pharmacy's delivery process going forward.

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 both fridges and were consistently within the required range. CDs were stored in two well-organised CD cabinets. Obsolete CDs were kept separately from usable stock.

Medicines stock was subject to regular documented expiry date checks. However, three out-of-date medicines were found on dispensary shelves. The pharmacy team explained that this was an oversight and disposed of the medicines appropriately. Patient-returned medicines were also disposed of appropriately. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist described how the team 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. 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, a tablet counter and a capsule counter were used to count loose tablets and capsules. A separate triangle was available for use with cytotoxics. Some triangles were dusty, but the dispensing team confirmed that they were washed before each use. The pharmacy had a range of up-to-date reference sources. All equipment was in good working order 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.