General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Treorchy Pharmacy, 126 -127 Bute Street, Treorchy, Rhondda Cynon Taff, CF42 6AY

Pharmacy reference: 9012032

Type of pharmacy: Community

Date of inspection: 10/06/2024

Pharmacy context

This pharmacy is on a high street in a busy town 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, treatment for minor ailments and a seasonal influenza vaccination service. Substance misuse services are also available.

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 and review their mistakes so they can learn from them. And they take action to help reduce the chance of similar mistakes from happening again. The pharmacy 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 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 the recording of dispensing errors and near misses. The pharmacist explained that he reviewed near misses on a monthly basis. And any patterns or trends that emerged were discussed with the whole team. Action had been taken to reduce some risks that had been identified. For example, levothyroxine tablets and losartan tablets had been distinctly separated on dispensary shelving following some near misses with these medicines. Different forms of ramipril had also been separated in the same way following a near miss.

A range of standard operating procedures (SOPs) underpinned the services provided and these were regularly reviewed. Pharmacy team members had signed the SOPs to show that they had read and understood them. Members of the team were able to describe their roles and responsibilities. A dispensing assistant who worked as an accuracy checker explained that he could check any repeat prescription items that had been marked as clinically checked by a pharmacist, as long he had not been involved in dispensing or labelling these. He did not check compliance packs or acute prescriptions. He explained that as there was usually a second pharmacist and/or an accuracy checking technician present, he was not often required to carry out accuracy checks. There were two responsible pharmacist notices on display, which was confusing. The pharmacist removed the incorrect notice as soon as this was pointed out. A trainee dispensing assistant was able to describe activities that could not take place in the absence of the responsible pharmacist.

The pharmacy team explained that verbal feedback from people using the pharmacy was mostly positive. A formal complaints procedure was in place, although this was not advertised in the retail area.

Evidence of current professional indemnity insurance was available. Most records were up to date, including responsible pharmacist, private prescription and emergency supply records. However, there were occasions on which the pharmacists 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 emergency supply records did not always include the nature of the emergency. This might make it difficult to resolve queries or investigate errors. CD registers were generally properly maintained. The pharmacist explained that running balances were typically checked weekly. But there were no recent records to confirm this. Two running balances checked were correct. However, the running balance for sugar-free methadone solution showed a high volume of overage. So it was difficult for the pharmacy team to be assured that it was correct. And there was a risk that concerns such as dispensing errors or diversion might be missed.

Team members were aware of the need to protect confidential information, for example by identifying confidential waste and disposing of it appropriately. They had signed confidentiality agreements as part of their contract. The pharmacists and pharmacy technician 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 that were available in the SOP file.

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. And they feel comfortable speaking up about any concerns they have.

Inspector's evidence

A regular locum pharmacist worked at the pharmacy every Monday, Wednesday, Thursday and Friday. A relief pharmacist worked as a second pharmacist on Mondays and Wednesdays. Another regular locum pharmacist worked at the pharmacy every Tuesday and the superintendent pharmacist worked there on Saturdays. A part-time dispensing assistant (DA) was a director of the company and oversaw the operational running of the branch. The pharmacy team consisted of two pharmacy technicians, one of who was a qualified accuracy checker, a dispensing assistant who was also a qualified accuracy checker and was enrolled on a pharmacy technician training course, a trainee dispensing assistant (DA) and two medicines counter assistants (MCAs). The trainees worked under the supervision of the pharmacist and other trained members of staff. Pharmacy team members were able to comfortably manage the workload and the staffing level appeared adequate for the services provided.

A member of the pharmacy team working on the medicines counter was able to provide a coherent explanation of the WWHAM questioning technique and gave appropriate examples of situations she would refer to the pharmacist. Pharmacy 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. They had recently completed mandatory training provided by NHS Wales on mental health awareness and improving the quality of services provided. However, the lack of a structured training programme meant that individuals might not keep up to date with current pharmacy practice. All staff were subject to annual performance and development reviews. And they could informally discuss issues with the pharmacists whenever the need arose.

Targets were set for some services, but these were managed appropriately, and the pharmacist gave assurances that they did not affect his professional judgement or compromise patient care. Pharmacy team members worked well together. They said that they were happy to make suggestions within the team and felt comfortable raising concerns with the pharmacists, including the superintendent pharmacist. An electronic whistleblowing policy was available and included details of organisations that could be contacted if team members wished to raise a concern outside the organisation. The superintendent pharmacist agreed to print out the policy and display it in the dispensary for reference.

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. Some medicines awaiting collection were being temporarily stored on the floor and posed a potential trip hazard. A member of the pharmacy team moved them as soon as this was pointed out. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff use. Two lockable consultation rooms were available for private consultations and counselling, and they were 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. The pharmacy's working practices are safe and effective. It 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, some of which were advertised in the retail area. The pharmacist explained that the practice leaflet which listed all of the pharmacy's services was usually displayed but was in the process of being redesigned. There was wheelchair access into the pharmacy and consultation room. The pharmacy team signposted people requesting services they could not provide to other nearby pharmacies.

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. The pharmacist explained that the dispensing workload was easy to plan and manage as it mostly consisted of repeat prescriptions. 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 and reduce the risk of a person receiving the wrong medicine. Each bag label attached to a prescription awaiting collection included a barcode that was scanned at the handout stage to provide an audit trail. A text messaging service was available to let people know that their medicines were ready for collection.

Prescriptions were not always retained for dispensed items awaiting collection, except for prescriptions for compliance packs and controlled drugs, and any prescriptions that could not be scanned. However, most prescriptions were scanned, and the image remained available for reference. Each prescription awaiting collection was assigned to a specific storage location in the dispensary. When pharmacy team members needed to locate a prescription, the patient'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 needed to be added. Stickers were also used to identify dispensed Schedule 3 and 4 CDs awaiting collection and were marked with the date after which the prescription was invalid and could no longer be supplied. This practice helped ensure that prescriptions were checked for validity before handout to the patient. One bag of dispensed medicines awaiting collection in the CD cabinet could no longer be supplied, as more than 28 days had elapsed since the date on the prescription. The pharmacist dealt with it appropriately as soon as this was pointed out to him.

Prescriptions for people prescribed high-risk medicines such as warfarin, lithium and methotrexate were marked with stickers to identify the patient for counselling. Pharmacy team members were aware of the risks of valproate use during pregnancy. They were also aware of the requirement to supply valproate products in original packs where possible. A risk assessment had been completed for a person who was supplied valproate in compliance packs. The superintendent pharmacist said that one patient prescribed valproate who met the risk criteria had been identified. He explained that they were

routinely 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 labelled with descriptions of the medicines they contained. However, the descriptions did not always include enough detail to enable identification of individual medicines, with many described simply as 'tablet', or 'capsule'. So, there was a risk that patients might not always be able to make informed decisions about their own treatment. Patient information leaflets were routinely supplied. Each patient had a clear plastic wallet that included their personal and medication details and details of any messages or queries for communication purposes. An original pack and medication administration record (MAR) dispensing service was provided to some people.

There was a steady uptake of the pharmacy's discharge medicines review service. Uptake of the common ailments service and the sore throat test and treat service was high, as the pharmacy received frequent referrals from local GPs. The regular locum pharmacist and the superintendent pharmacist were independent prescribers and were able to provide the extended common ailments service, treating minor ear, throat, skin and urinary tract infections. A smoking cessation service (supply and monitoring) could be provided by the pharmacists and the accuracy checking technician. Uptake of the emergency supply of prescribed medicines service was high as the pharmacy was open at weekends when the GP surgery was closed. The pharmacy also offered an EHC (emergency hormonal contraception) service, a supervised consumption service, a free blood pressure measurement service and a seasonal influenza vaccination service.

The pharmacy provided a prescription collection service from two local surgeries. It also offered a free medicines delivery service. People received a text or a telephone call on the day of their delivery to let them know the time slot during which their medicines would be delivered. 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 prescription back to the pharmacy.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines requiring cold storage were kept in two medical fridges. Maximum and minimum temperatures for the fridges were usually recorded daily. There were occasional gaps in the records, but the pharmacist said that this was an oversight and gave assurances that temperatures were checked every day. Recorded temperatures were consistently within the required range. CDs were stored in two well-organised CD cabinets and obsolete CDs were kept separately from usable stock.

Stock was subject to regular expiry date checks. Short-dated items were usually highlighted with stickers. However, three out-of-date medicines that had not been marked in this way were found in the compliance pack dispensing area. The pharmacist said that this was an oversight and disposed of the items as soon as this was pointed out. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. The pharmacy received safety alerts and recalls via wholesalers 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 measuring 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 medical fridges had recently been calibrated. 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.