

Registered pharmacy inspection report

Pharmacy Name: Well, 104-106 King Street, Dukinfield, GREATER MANCHESTER, Cheshire, SK16 4JZ

Pharmacy reference: 1029625

Type of pharmacy: Community

Date of inspection: 16/06/2022

Pharmacy context

This busy community pharmacy is located on a main road in the town centre. Most people who use the pharmacy are from the local area. The pharmacy dispenses NHS prescriptions and it sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. Some prescriptions are sent to the company's hub to be dispensed.

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 adequately manages risks to make sure its services are safe, and it acts to improve patient safety. It generally completes the records that it needs to by law but some of the records are incomplete or inaccurate, which could cause confusion and makes audit more difficult. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. But the pharmacist has not confirmed their understanding of the pharmacy's written procedures, so they may not always work effectively. The team has written procedures on keeping people's private information safe. And team members understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided. Roles and responsibilities were set out in the SOPs. Members of the pharmacy team confirmed electronically via an online e-learning system that they had read and accepted the procedures. A dispenser demonstrated that she had read all the SOPs which she was required to read. But the responsible pharmacist (RP), who had worked regularly at the pharmacy for around six months, had only read around a third of the SOPs. So, there was a risk that he might not work effectively or fully understand his and the other team members' roles and responsibilities. Team members were performing duties which were in line with their role. There was an RP notice on display, but it contained the incorrect name of RP, which might cause confusion in the event of a concern or query. The RP printed out and displayed the correct notice when this was pointed out.

The pharmacy team recorded near misses and dispensing errors on a dedicated programme on the intranet, which could be viewed at the pharmacy superintendent's (SI) office. Actions which had been completed at the branch were included to show the appropriate action had been taken to avoid re-occurrence. Team members confirmed that they discussed any errors and tried to learn from them but said they didn't always get enough time to review their near misses, due to work force pressures. The SI and team at head office sent bulletins sharing learning within the organisation. For example, reminding the pharmacy team that changes in medication in compliance aid packs should be recorded in the patient's 'Events Diary and Medication Record' and reviewed by the pharmacist. Team members were required to confirm that they had read messages from the SI. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out. Common look-alike and sound-alike drugs (LASAs) had been highlighted to team members, so extra care would be taken when selecting these.

A 'Customer Care' notice was on display in the waiting area of the pharmacy which gave the details of head office, in case of a complaint and it also encouraged customers to give feedback. Professional indemnity insurance was in place. Private prescriptions were recorded electronically, but entries were not always accurate. The incorrect prescriber had been recorded on some of the entries and the private prescription forms had not been date stamped to indicate when they had been dispensed, so this might cause confusion. The RP record was generally in order, but the RP had entered the time he was going to cease his duties that day in advance, which compromised the accuracy of the record. The controlled drug (CD) register was maintained electronically. Records of CD running balances were kept and these

were audited periodically. Two CD balances were checked and one discrepancy was found. This was resolved during the inspection and was due to a missing entry. There were patient returned CDs in the CD cabinet, but none of the team knew if they were recorded. The RP thought they might be recorded electronically but was unable to locate the records.

Team members completed annual training on confidentiality. Confidential waste was collected in designated bins which were collected by a specialised disposal company. A dispenser correctly described the difference between confidential and general waste. The delivery driver knew what it meant to maintain patient confidentiality. Assembled prescriptions and paperwork containing patient confidential information were stored appropriately so that people's details could not be seen by members of the public. A privacy statement was on display, in line with the General Data Protection Regulation (GDPR).

The delivery driver confirmed he had received training on safeguarding children and vulnerable adults and said that he would voice any concerns to the pharmacist working at the time. There was a safeguarding policy in place containing the contact numbers of who to report concerns to. The pharmacy had a chaperone policy, and this was highlighted to people.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team members have the right qualifications for the jobs they do. The pharmacy encourages them to keep their skills up to date and supports their development by providing them with training materials. The team members are comfortable providing feedback to their manager and they receive feedback about their own performance.

Inspector's evidence

There was a pharmacist, three NVQ2 qualified dispensers (or equivalent) and a delivery driver on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection. Staff absences were covered by re-arranging the staff rota and one of the part time dispensers had come to work on her day off to help out, as there had been an unplanned absence. There were several other neighbouring branches, so there was a possibility of transferring staff from one of these in an emergency.

Pharmacy team members carried out training on the online e-learning system. A dispenser displayed a record of their completed training. She explained that sometimes she carried this out training at home, but she was given training time back when this occurred. Completion of training was audited by head office and the pharmacy manager was alerted to any outstanding modules. Team members were given formal appraisals where performance and development were discussed and they received feedback from the pharmacy manager. Communication within the company was via the intranet and there was an online alerting system, which highlighted when new information was available such as messages from the SI's office, and alerts and recalls. Daily, weekly and monthly tasks were assigned via this system.

The pharmacy manager held team huddles regularly where a variety of issues were discussed, including the branch's performance against targets. A dispenser said she was comfortable talking to the pharmacy manager or area manager about any concerns she might have. The pharmacy had a whistleblowing policy.

Team members were empowered to exercise their professional judgement and could comply with their own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because they felt it was inappropriate. Targets were set for various services including New Medicine Service (NMS) and the blood pressure checking service. They were considered very important in the organisation and the RP said there was always pressure to achieve these. One of the dispensers was promoting the blood pressure checking service. She said she had a target of 60 per month, which she usually achieved. It had been a successful service and it was something she enjoyed doing.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy generally provides a suitable environment for people to receive healthcare services. It has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations.

Inspector's evidence

The pharmacy premises were reasonably well maintained and the fixtures and fittings were in good order. The retail area was free from obstructions, professional in appearance and had a waiting area with two chairs. The temperature and lighting were adequately controlled. Maintenance problems were reported to head office and the response time was appropriate to the nature of the issue

There was a separate stockroom where excess retail stock was stored and there was a separate room for assembling and storing compliance aid packs. Staff facilities included a tea-room with a kitchen area and a WC with a wash hand basin and antibacterial hand wash. These areas were untidy and required cleaning. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand sanitizer gel was available.

There was a consultation room equipped with a sink, which was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. This room was used when carrying out services and when customers needed a private area to talk.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers a range of healthcare services, which are generally well managed and easy for people to access. It gets its medicines from licensed suppliers and the team carries out some checks to ensure medicines are in suitable condition to supply. But some medicines are not stored appropriately, which could increase the risk of things going wrong. The assembly of multi-compartment compliance aid packs is reasonably well organised. But people who receive their medicines in these packs might not always have easy access to all of the information they need to take their medicines safely.

Inspector's evidence

There were two entrances into the pharmacy and both had small steps. One of the doors was power assisted and the step was low, so it was possible for wheelchair users and people with prams to enter with assistance. There was a hearing loop in the pharmacy. Team members were clear what services were offered and where to signpost people to a service not offered. There was a small range of healthcare leaflets.

There was a home delivery service with an electronic audit trail. The service had been adapted to minimise contact with recipients, during the pandemic. The delivery driver confirmed the safe receipt on their handheld device. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was adequate in the dispensary but some of the bench space and dispensary shelves were disorganised and untidy. Dispensed by and checked by boxes were generally initialled on the medication labels to provide an audit trail. But the dispensed by box was not completed on compliance aid packs, which might limit learning if something went wrong. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. 'Speak to Pharmacist' stickers were used to highlight when counselling was required. The team were aware of the valproate pregnancy prevention programme. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling.

Multi-compartment compliance aid packs were generally well organised. But team members were recording communications with GPs and changes to medication on pieces of paper rather than the designated 'Events Diary and Medication Record' form. One of the dispenser's said she had not seen this form. Labelling sheets were not always fixed into the packs, so there was a risk they might fall out, leaving the packs without any labelling. Medicine descriptions were not added to the labelling and packaging leaflets were not usually included. So, people might not be able to identify the individual medicines or have easy access to all of the information they need. Disposable equipment was used. There was a SOP for new people requesting a compliance aid pack. A suitability form was available to record an assessment made by the pharmacist as to the appropriateness of a compliance aid pack, or if other adjustments might be more suitable to the person's needs.

One of the dispensers explained what questions she asked when making a medicine sale and when to refer the person to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

CDs were stored in a CD cabinet and a safe which were securely fixed to the wall/floor. The keys were under the control of the responsible pharmacist during the day and stored securely overnight. Patient returned CDs were segregated and stored securely, but some date expired CDs were kept alongside current stock, so could be accidentally supplied. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out. The medical fridge overfull and untidy. The minimum and maximum temperatures were being recorded most days and had been within range throughout the month. But, the RP said some stock was getting frozen as it stuck to the back of the fridge. He said he had reported the issue with the fridge to the pharmacy manager, but he had not considered defrosting the fridge. Some medicines requiring cold storage were stored in the fridge in the tea-room alongside the staff's food, as they would not fit in the medical fridge. This was unhygienic and the fridge temperature was not being monitored, so medicines might not be within the appropriate temperature range. The RP said he made a visual assessment as to whether the stock was fit to supply. He said he would not supply any medicine that appeared frozen or discoloured. Subsequent to the inspection a member of the SI's team at head office confirmed that he would discuss the storage of medicines requiring refrigeration with the pharmacy team, to ensure the proper procedure was followed.

Most medicines were stored in their original containers, but some foil strips were seen on the dispensary shelves without the appropriate labelling, batch numbers or expiry dates. The RP said they would not use these medicines. Team members confirmed that date checking was carried out and recorded electronically. Short-dated stock was highlighted. Expired medicines were generally segregated and placed in designated bins. One packet of antibiotics which had expired was seen on the dispensary shelves. This was removed for destruction when pointed out.

Alerts and recalls were received from head office via the intranet. These were read and acted on by a member of the pharmacy team and a response was sent back to head office. So, there was a record of the action taken and the team were in a position to respond to any queries or enquiries.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date information for reference. For example, the electronic British National Formulary (BNF) and BNF for children. All electrical equipment appeared to be in good working order and had been PAT tested. Equipment was ordered through head office and any problems with equipment (including IT) would be dealt with by them. There was a selection of liquid measures with British Standard and crown marks. Separate measures were marked and used for methadone solution. The pharmacy also had a range of equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. The triangles required cleaning to remove the residue from previously counted tablets and prevent contamination. Medicine containers were appropriately capped. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. PMRs were password protected. The pharmacy manager's individual electronic prescriptions service (EPS) smart card was in use and she was not working in the pharmacy on the day of the inspection. This might cause confusion in the event of a problem or query. Cordless phones were available in the pharmacy so staff could move to a private area if the phone call warranted privacy.

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.