

Registered pharmacy inspection report

Pharmacy Name: Well, 52 Russell Road, SALFORD, Lancashire, M6
8NR

Pharmacy reference: 1033923

Type of pharmacy: Community

Date of inspection: 25/07/2019

Pharmacy context

This is a traditional community pharmacy situated in a suburban residential area, serving the local population. It mainly prepares NHS prescription medicines and orders repeat prescriptions on behalf of people. It also prepares medicines in weekly compliance packs to help make sure people take them safely. The pharmacy also delivers medicines to people and provides other NHS services such as Medicine Use Reviews (MURs) and flu vaccinations.

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 generally manages its risks well. It provides the pharmacy team with written instructions to help make sure it provides safe services. The team records and reviews its mistakes so that it can learn from them. It keeps people's information secure. And the team understands its role in protecting and supporting vulnerable people.

Inspector's evidence

The pharmacy had written procedures that it kept under review. These covered safe dispensing of medicines, the responsible pharmacist (RP) regulations and controlled drugs (CDs). All the staff had passed knowledge tests on each procedure, except for a staff member training to be a medicine counter assistant (MCA) and dispenser who started in March 2019. So, nearly all of the team members understood the procedures that were relevant to their role and responsibilities. The trainee dispenser regularly worked in the dispensary, but had not read the key procedures. So, there was a risk that some team members may not fully understand how they should provide the pharmacy's core services.

The dispenser and checker initialled dispensing labels, which helped to clarify who was responsible for each prescription medication. And it assisted with investigating and managing mistakes. The pharmacy team discussed and recorded mistakes it identified when dispensing medicines. And, it addressed each of these mistakes separately. However, staff usually did not record the reason why they thought they had made each mistake. The manager, who was an accredited checking technician (ACT) reviewed each month's records. But their review was not always shared with the rest of the team. So, other staff could miss additional opportunities to learn and mitigate risks in the dispensing process.

The team received positive feedback in key areas in its recent satisfaction survey of people who used its services. A public notice explained how patients could make a complaint. And staff had completed the pharmacy's training on handling complaints, so it could effectively respond to them.

The pharmacy had professional indemnity cover for the services it provided. The RP displayed their RP notice, so the public could identify them. The pharmacy maintained the records required by law for the RP, private prescriptions and CD transactions. And it checked its CD running balances regularly, so could detect any discrepancies at an early stage. The pharmacy also maintained its records for MURs, flu vaccinations and specials medications it had supplied.

The RP, who was the regular pharmacist said that the pharmacy rarely received urgent medication requests from people. The team made records of these supplies in accordance with the law when it received these requests.

The pharmacy completed a data protection audit in May 2019. And it obtained people's written consent to access their summary care record (SCR). Staff securely stored and destroyed confidential material. However, whilst team members understood the basic principles of protecting people's information, the trainee had not started the pharmacy's data protection training. Staff used passwords to protect access to electronic patient data, but occasionally shared each other's security cards to access this data. So, there was a small risk that it could be unclear who had accessed this information.

The incoming manager who would also be the regular pharmacist had level two safeguarding

accreditation. And all the remaining staff had completed the pharmacy's safeguarding training, except for the trainee dispenser. The staff said that the pharmacy had the local safeguarding board's policies and procedures, but could not find them.

The team annually assessed the needs of people using compliance packs. This included whether they needed their medication limited to seven day's supply, which could help them to avoid becoming confused. The pharmacy also kept records of each compliance pack patient's care arrangements, including their next of kin details. So, the team had easy access to this information if needed urgently. And the team had reported safeguarding concerns to the GP when people exhibited signs of confusion. In some cases it led to it dispensing their medicines in compliance packs or limiting them to seven days' medication per supply.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to provide safe and effective services. Each team member has a performance review which helps to identify gaps in their skills and knowledge. But the pharmacy sometimes delays training of new team members, so their development may not progress as quickly as it could.

Inspector's evidence

The staff present were the RP who was the regular pharmacist, a trainee MCA/dispenser and a pharmacy undergraduate student on a summer placement. The other staff employed included the manager who was also an accredited checking technician (ACT), a dispenser employed for around twelve months and an MCA. The RP and ACT were due to leave and a new manager had been appointed to work alongside the trainee. So, the pharmacy's authorised total staff working hours overall remained unaffected.

The pharmacy had enough staff to comfortably manage its workload. The team said that they usually had repeat prescription medicines, including those dispensed in compliance packs ready in good time for when people needed them. The pharmacy received most of its prescriptions via the prescription ordering and electronic prescription services. And the pharmacy owner's hub pharmacy dispensed around a half of these prescriptions. So, these systems helped to reduce staff workload pressure. The pharmacy had a low footfall, so the team avoided sustained periods of increased workload pressure and it could promptly serve people.

The pharmacy owner's other pharmacies in the area had provided extra staff at short notice. So, the pharmacy had the option to cover unplanned staff leave. The pharmacy only allowed one of its staff to be on planned leave at any time. And it had a relief team of dispensers and pharmacists that was available to cover the leave. However, the RP explained that this team had vacancies, so the pharmacy could only get cover around half of the time it requested it. The pharmacy's senior management were addressing this.

The trainee had recently received their MCA and dispenser training material, but had not started the course. The incoming manager subsequently said that they would ensure the trainee started their training. And the trainee would be trained to support the main dispenser provide the compliance pack service.

Staff had an annual appraisal with the manager and newer team members had performance reviews six and twelve weeks after starting employment. Nearly all the team members were up-to-date with the pharmacy's mandatory e-learning training that covered its procedures and services. However, the trainee only completed one of these training modules and not started any others. And staff did not have protected study time, so had to find time during their working hours to complete their training.

The pharmacy had targets for the number of MURs it completed, people who used its prescription ordering and electronic prescription services and flu vaccinations. The RP said that the MUR target was realistic and achievable. They could manage the competing MUR and flu vaccination demands during the peak of the flu season by prioritising vaccinations over MURs or providing them both at the same time to the same person. The prescription ordering and hub pharmacy dispensing services also helped

to control dispensing workload. The RP spent around ten minutes on each consultation and always held them in the consultation room. So, they conducted them in an appropriate time and place and the target did not affect how well they provided the service.

The pharmacy obtained people's written consent to provide the MUR and electronic prescription services and flu vaccinations. However, several randomly selected records indicated that the pharmacy did not make clear if people had consented to the prescription ordering service, as the relevant box was not ticked.

Principle 3 - Premises ✓ Standards met

Summary findings

The premises are clean, safe, secure and spacious enough for the pharmacy's services. And it has a private consultation room, so members of the public can have confidential conversations.

Inspector's evidence

The level of cleanliness was appropriate for the services provided. The premises had the space that the team needed to dispense medicines safely. And staff could secure it to prevent unauthorised access. The consultation room provided the privacy necessary to enable confidential discussion. And its availability was prominently advertised, so patients were more likely to take advantage of this facility.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's working practices generally help make sure people receive safe services. It gets its medicines from licensed suppliers and it generally manages its medicines well to make sure they are in good condition, so are suitable to supply.

Inspector's evidence

The pharmacy opened 9am to 6pm Monday to Friday. It had a step-free access and the team could see people entering the premises. So, the pharmacy's services were easily accessible.

The pharmacy team prompted people to confirm the repeat medications they required. This helped it limit medication wastage and people received their medication on time. And the team made records of these requests, but they did not include the medications requested. So, it could find it difficult to effectively resolve queries if needed.

The pharmacy had a written procedure for dispensing higher-risk medicines that covered anticoagulants, lithium, insulin and valproate. It completed a valproate audit, which confirmed it did not have any patients in the at-risk group. The RP said that the pharmacy had the MHRA approved valproate advice booklets and cards to give people, but they could not locate them.

The RP had consistently checked if people on higher-risk medicines had a recent blood test. And they checked people on these medicines understood their dose, whether any of them were experiencing side-effects or medicine interactions and counselled them if necessary. The RP also counselled people on how to safely use and dispose of their fentanyl patches with the first prescription that they presented.

The pharmacy team scheduled when to order prescriptions for people who used compliance packs, so that it could supply their medication in good time. The team kept a record of these people's current medication that also stated the time of day they were to take them. This helped it effectively query differences between the record and prescriptions with the GP surgery, and reduced the risk of it overlooking medication changes. The pharmacy also kept detailed communications about medication queries or changes for people using compliance packs. So, it had a record that helped make sure these people received the correct medicines. The team labelled each compliance pack with a description of each medicine inside them. However, it sometimes did not include enough detail in each description, which could make it more difficult for people to identify each medicine.

The pharmacy team used baskets during the dispensing process to separate people's medicines. This helped it to avoid confusing each patient's medicines with others and organise its workload. And the team marked part-used medication stock cartons, which helped make sure it gave patients the right amount of medication.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers and stored them in an organised manner. The RP said that the staff had completed the pharmacy's training for implementing the Falsified Medicines Directive (FMD). However, they did not know when the pharmacy would have the software and hardware needed to comply with the FMD installed because

the pharmacy's head office was still testing it. So, the pharmacy's system for adhering to the FMD was not yet live, as required by law.

The pharmacy suitably secured its CDs and properly segregated its date-expired and patient-returned CDs. And it had destruction kits for destroying CDs. The team suitably monitored the medication refrigerator storage temperatures. Records indicated that the pharmacy monitored medicine stock expiry dates over the long-term. The team also took appropriate action when it received alerts for medicines suspected of not being fit for purpose and recorded the action that it had taken. And it disposed of obsolete medicines in waste bins kept away from medicines stock. So, the pharmacy reduced the risk of supplying its medicines that might be unsuitable.

The staff applied a 'CD' sticker to dispensed CDs which reminded the pharmacist to check the prescription issue date when they supplied them. However, they did not write the supply deadline date in the section for this purpose on the sticker. The RP also regularly reviewed the stored dispensed CDs each week, which helped to reduce the risk of the pharmacy supplying them by mistake. The team used an alpha-numeric system to store people's dispensed medication. So, it could efficiently retrieve patient's medicines when needed. And records showed that the pharmacy securely delivered medication to people. The pharmacist recorded their details against each supply entry in the CD register. So, the pharmacy had an audit trail identifying the supplying pharmacist, including for those it had delivered.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment and facilities that it needs to provide its services effectively.

Inspector's evidence

The pharmacy team kept the dispensary sink clean. It also had hot and cold running water and an antibacterial hand-sanitiser. So, it had facilities to make sure it did not contaminate the medicines it handled. The team had a range of clean measures. So, it could accurately measure and give people their prescribed volume of medicine. Staff used Stockley's drug interactions, medicines complete online and the latest BNF and cBNF to check pharmaceutical information.

The pharmacy team had facilities that protected patient confidentiality. It viewed electronic people's information on screens not visible from public areas. And the pharmacy regularly backed up people's data on its patient medication record (PMR) system. So, it secured people's electronic information and could retrieve their data if the PMR system failed. And it had facilities to store bags of people's dispensed medicines and their prescriptions away from public view.

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.