General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, Unit 1, Elms Square Precinct, Whitefield, MANCHESTER, Lancashire, M45 7TA

Pharmacy reference: 1087088

Type of pharmacy: Community

Date of inspection: 21/02/2024

Pharmacy context

This pharmacy is located in a shopping parade in close proximity to a medical centre and serves a diverse population. The pharmacy dispenses NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines. It also provides a COVID-19 vaccination service, the NHS Pharmacy First service and a blood pressure check service.

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 effectively manages risks to make sure its services are safe, and it completes the records that it needs to by law. It records and responds appropriately when mistakes happen during the dispensing process so that its team members can learn from them. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. The pharmacy team keep people's private information safe. And team members understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

Standard operating procedures (SOPs) were kept electronically and were available on team members personal training accounts. They were provided with time to read through the SOPs and there was a quiz at the end of each SOP to check their understanding. The pharmacy manager was able to track their progress. Managers were required to sign an extra declaration to help make sure their teams would follow the SOPs.

Dispensing mistakes which were identified before a medicine was supplied to people (near misses) were highlighted to the team member involved in the dispensing process and recorded electronically. The Responsible Pharmacist (RP), who was also the pharmacy manager, also recorded these mistakes on a paper log. When a dispensing mistake had happened and the medicine had been supplied (dispensing errors), the team completed an investigation and recorded the incident electronically. The RP explained there had been a few incidents that had occurred within a small timeframe and so asked all team members to complete one task at a time. And medicines that looked or sounded-alike were separated on the shelves.

The pharmacy sent some prescriptions electronically to be dispensed at the company's central fulfilment centre. Data from the prescriptions was entered into the computer system at the pharmacy and the prescriptions were then labelled, assembled, checked and packed at the fulfilment centre. Assembled prescriptions were delivered back to the pharmacy to be delivered or collected. Any mistakes which related to medicines dispensed at the central fulfilment centre were also reported. The fulfilment centre would then contact the team for more information and then carry out an investigation. The RP said that errors with medicines dispensed at the central fulfilment centre were very rare, but there had recently been one where someone else's medicines were inside another person's bag.

The team completed a monthly and yearly patient safety report. They reviewed all of the near misses, dispensing errors, complaints and MHRA drug recalls within that time period.

The correct RP notice was displayed. When questioned, team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. A complaints procedure was in place and a notice was displayed in the retail area which informed people of how they could raise a complaint. The team tried to resolve complaints in store where possible. Complaints were logged electronically, and the team referred to head office if needed.

Private prescription records, emergency supply records, records for unlicensed medicines dispensed, RP records and controlled drug (CD) registers were well maintained. Running balances for CDs were recorded and regularly checked against physical stock held in the pharmacy. A random balance was checked and found to be correct. CDs that people had returned were recorded in a register and appropriately destroyed.

Assembled prescriptions which were ready to collect were stored in the dispensary and not visible to people using the pharmacy. The pharmacy had an information governance policy available, and its team members completed annual training about it. The pharmacy stored confidential information securely and separated confidential waste which was collected by a third party. The RP had access to summary care records (SCR) and obtained verbal consent from people before accessing it.

All team members including the delivery drivers had also completed safeguarding training. When questioned, team members were able to explain the signs to look out for which may indicate a safeguarding concern. Contact details for the local safeguarding leads were available. The pharmacy had previously reported concerns to the safeguarding boards.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to manage the pharmacy's workload effectively and they receive appropriate training to carry out their roles safely. The pharmacy helps its team members keep their knowledge and skills up to date. And team members feel comfortable providing feedback and raising concerns relating to the pharmacy's services.

Inspector's evidence

The pharmacy team comprised of the RP, two trained pharmacy assistants, one of who was completing the pharmacy technician training and two trainee pharmacy assistants. The pharmacy also had a delivery driver. The RP felt there were a sufficient number of staff at the time of the inspection. A new team member had been recruited to help manage with the increase in workload. The team were observed working effectively together and although they were slightly behind with tasks such as date checking, they were up to date with the dispensing workload.

Team members had annual appraisals and were also provided with ongoing feedback by the pharmacist. Team members who were new, received weekly reviews to provide them with adequate support. Members of the team received feedback which highlighted what they had done well or what could have been done differently. Team members were able give feedback to the RP. Team members also described a process in which they were able to raise concerns or whistleblowing anonymously.

Team members asked appropriate questions and counselled people before recommending over-the-counter medicines. They were aware of the maximum quantities of medicines that could be sold over the counter. The new team member referred any requests for over-the-counter medicines to the RP. Team members completed training modules online to keep up to date. Training included both mandatory and optional modules. Recent training completed included an update on dispensing sodium valproate, the change in classification of codeine linctus and updated SOPs. Team members completing their formal training were well supported by the RP and colleagues and were provided with time in store to complete their training.

Team members held a meeting each morning to discuss the plan for the day, tasks that needed to be completed and any messages from head office which needed to be cascaded. Updates from head office were received via the intranet. Head office set targets for services; however, these were not for individual services. The RP confirmed that they did not allow the targets to compromise their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and provide a safe environment to deliver its services. People using the pharmacy can have a conversation with its team members in a private area.

Inspector's evidence

The premises were large, and the retail area was clean, tidy, and organised. Although the dispensary was clean, it was disorganised and cluttered in places, including some work benches and shelves. This could increase the risk of a mistake happening. The RP provided an assurance that this would be tidied. The dispensary had ample work space which was allocated for specific tasks. A separate room was used to manage and prepare the multi-compartment compliance packs. A clean sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by members of the team in accordance with a rota. The room temperature and lighting were appropriate.

The premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for private conversations; the room was locked when not in use.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely. It obtains its medicines from licensed sources and manages them appropriately so that they are safe for people to use. Team members take the right action when safety alerts are received, to ensure that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy was easily accessible from the street, there was a car park in front of the shopping parade which had disabled parking bays. And there was a ramp from the car park leading to the retail units. The shop floor was clear of any trip hazards and the retail area was accessed easily. Team members assisted people who needed help entering the pharmacy and the pharmacy provided a medicine delivery service. The pharmacy used electronic translation applications when needed and had two hearing loops available, one of which was on the retail counter and the other in the consultation room. When necessary, the pharmacy team used the internet to find out the details of local services so that they could signpost people who needed services that the pharmacy did not provide. A poster was also displayed in the dispensary with details of local healthcare services.

The pharmacy provided a COVID-19 vaccination service, and the RP felt the service had a positive impact. The RP explained that the service was over-subscribed and there were plans to train the pharmacy technician to be able to vaccinate people. The vaccinations were provided under a patient group direction (PGD). To help ensure the workload was managed safely, the service was provided for two hours a day on an appointment basis and the RP checked any prescriptions in between vaccinations.

The pharmacy had an established workflow in place. Prescriptions which were to be dispensed at the central fulfilment centre were labelled in the pharmacy. Prescription data sent to the central fulfilment centre by midday was received back to the pharmacy the following day. Some medicines had to be dispensed locally in store. The team carried out a quality assurance check on one or two bags sent from the fulfilment centre per day. Any issues were reported on an electronical system, which had an extra section to highlight if the medicines were dispensed at the central fulfilment centre which was also known as the hub. Prescriptions dispensed in store were assembled by one of the dispensers and then checked by the RP. 'Dispensed by' and 'checked by' boxes were routinely signed on dispensing labels, to create an audit trail showing who had carried out each of these tasks. Baskets were used to separate prescriptions, preventing transfer of medicines between different people. Baskets were also colour coded depending on whether the prescription was to be delivered, dispensed at the fulfilment centre or dispensed locally.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). Team members had all completed training about dispensing sodium valproate and had recently completed an updated training. The pharmacy supplied sodium valproate, outside of its original pack, to two people. Risk assessments had been completed for both individuals to confirm that it was safe to do so. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring. People who were starting on these medicines were provided with warning cards and leaflets. The pharmacy also completed clincial audits as part of which

people were called to discuss their medicines.

Some people's medicines were supplied in multi-compartment compliance packs to help them take their medicines at the right time. These packs were all prepared in the pharmacy. Individual records were kept for each person and detailed all their current medicines and any notes regarding changes. A workload tracker was used which detailed when people were due, whether their medicines were delivered or if they collected them. The pharmacy received discharge summaries when people were admitted into hospital. The discharge summary was reviewed, and changes were confirmed with the person's GP. Discharge notes were filed in the person's individual folders. Prescriptions were ordered by the pharmacy. Any changes were checked and confirmed with the surgery. Prescriptions were labelled and packs were prepared a week before they were due. Assembled packs were labelled with the product descriptions and mandatory warnings. There was an audit trail to show who had prepared and checked the packs, this would help to identify team members in the event that something went wrong. Patient information leaflets were issued each month.

The RP had completed training for the NHS Pharmacy First service and had signed PGDs for the service. Flow charts with the pathways were kept on hand so that they could be referred to during the consultation.

The pharmacy's medicine delivery service was provided by a designated driver. Deliveries were scanned into a delivery management system using a hand-held device and were scanned out when delivered. As the deliveries were scanned in people were sent a text message or voice automated message to inform them that their medicines were due to be delivered. Bags were handed to the named person. In the event that someone was not home, medicines were returned to the pharmacy and delivery was reattempted. Signatures were obtained if CDs were delivered.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines were stored on the shelves, but some areas were untidy which may increase the risk of mistakes. A few medicines were seen to be stored outside of its original packaging. The RP provided an assurance that the shelves would be tidied, and any medicines not stored in their original pack would be disposed. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of cold chain medicines. And CDs were kept securely. Head office assigned sections for team members to check the expiry dates of medicine stock on a weekly basis. All expired stock had to be entered on the pharmacy computer system which also needed to be updated once the section was checked. Short-dated stock was marked with stickers. The team were slightly behind with their date checking as a few team members had been on leave and there had been extra workload with new services being launched. The team had recently recruited a new team member to help manage the workload more effectively. Expiry dates were checked as part of the dispensing process and no date expired medicines were found on the shelves. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. MHRA drug recalls were received via the intranet, these were discussed with the team and actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Equipment is kept clean and is ready to use.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment. Separate labelled measures were available for liquid CD preparations to avoid cross-contamination. Equipment was clean and ready for use. Two medical fridges were available. A blood pressure monitor, ambulatory blood pressure monitor, otoscope and weighing scales were available and used for some of the services provided; these were calibrated annually. Up-to-date reference sources were available.

The pharmacy's computers were password protected and screens faced away from people using the pharmacy. A cordless telephone was also available to ensure conversations could not be overheard.

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.