General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cameolord Ltd, Oxford House, 16 Oxford Street, MANCHESTER, Lancashire, M1 5AE

Pharmacy reference: 1091123

Type of pharmacy: Community

Date of inspection: 27/04/2021

Pharmacy context

This city centre community pharmacy is situated on a busy main road. It is open extended hours late into the evening, seven days a week. The pharmacy mainly prepares NHS prescription medicines and it also dispenses a large number of private prescriptions. The other services it provides in a significant volume include repeat prescription management, substance misuse treatment and non-prescription erectile dysfunction consultations. This inspection was completed during the COVID-19 pandemic.

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 manages the risks associated with its services reasonably well. It provides the pharmacy team with written instructions to help make sure it provides safe services. But, the team inconsistently records and reviews its mistakes, so it may miss some learning opportunities. Pharmacy team members understand their role in securing people's confidential information, and they know how to protect vulnerable people. The pharmacy keeps the records it needs to by law, but these are sometimes difficult to read or lack detail. This could make it harder for the pharmacy to explain what has happened in the event of a query.

Inspector's evidence

The pharmacy had a full set of written procedures that were introduced in April 2018, and staff had signed most of the procedures relevant to their role. However, the medicines counter staff members had not signed the procedures for dealing with the absence of a responsible pharmacist (RP) and receiving prescriptions, so they may not fully understand all their responsibilities.

Floor markings and a publicly displayed notice reminded people to keep two metres apart. The spacious retail area supported people keeping a safe distance apart. A minimal number of people presented at the pharmacy during the inspection, and the RP said this was similar during the evenings. The pharmacist worked alone in the small dispensary, and only one front counter staff member was on duty at any time, which helped to maintain social distancing between the team members. Staff members wore a face mask when people presented, and they had access to hand wipes.

The RP, who was the main regular pharmacist, said that they did not always initial dispensing labels to identify when they had prepared a prescription medication. This could make it more difficult to investigate and manage mistakes. They explained that they reviewed any mistakes they identified when preparing prescription medication. They gave examples of action that they had taken to manage risks that they had identified. This included applying warning stickers to stock shelves adjacent to several medications that had similar names, packaging or liveries. Records indicated that the pharmacist did not always record these mistakes, because there were none documented between 10 March 2020 and 5 March 2021. The RP explained that they sometimes forgot to record these, which could be partly due to the increased workload during the pandemic. The RP explained that dispensing errors were recorded in a notebook, but they could not locate it. They could not recall anyone reporting an error to them since the last inspection in September 2019. The lack of recording meant that opportunities to share learning from mistakes with the other pharmacists and team members could be missed. The RP agreed to obtain an incident report form for documenting dispensing errors.

The RP's responsible pharmacist notice was displayed behind the medicines counter, but retail merchandise partly obscured it. So, people may not be able to easily identify the RP. The RP said that they would make sure that the public could clearly see it. Staff roles and responsibilities were described in the written procedures. The pharmacy had a complaints procedure, and practice leaflets explained how people could make a complaint or provide feedback. The superintendent said that the pharmacy had professional indemnity cover for the services it provided.

Recent records indicated that pharmacists were consistently making entries in the paper-based RP record, but the superintendent pharmacist's entries were sometimes difficult to read, which could

affect the record's reliability. Private prescription forms were kept in a file in an organised manner, separated by month of dispensing. The paper-based private prescription register was generally in order, but the prescription issue and medication supply dates were sometimes missing from recent entries. The pharmacists usually referred people who did not have a prescription but required their medication urgently, to NHS 111. This usually resulted in the pharmacy receiving a prescription via the NHS Community Pharmacist Consultation Service (CPCS) service that it could promptly dispense because it was open extended hours. This meant people were not left without their medication, and the pharmacy rarely had to supply medication under the emergency supply regulations. The RP could not locate the notebook that the pharmacy used for recording medications it supplied under these regulations, and they agreed to clarify where this record was kept with the superintendent.

The pharmacy kept a record of controlled drugs (CDs) that people had returned, and it had destroyed. It used suitable CD registers to record CD transactions. Randomly selected registers had the CD name, form and strength on each page heading, as required by law. However, entries in the MXL 200mg capsules register dated 20 March 2021 were illegible, which made it difficult to understand what had happened.

Leaflets in the retail area gave details about how the pharmacy handled confidential information. The team obtained people's written consent to acquire their information in relation to the repeat prescription management service. The pharmacists used passwords and their own NHS security cards to access people's electronic data. Team members gave examples of confidential information and they understood how it should be protected. The RP provided and had read the pharmacy's General Data Protection Regulation (GDPR) policy, so they could refer to it when needed. Staff securely stored and destroyed confidential material. However, the general and confidential waste bins were positioned next to each other, which risked private information being disposed via the incorrect route. The RP said that they would address this.

The pharmacy had a safeguarding policy, and the RP confirmed she had completed level two training. Other staff said they had also completed safeguarding training, but this had not been recorded. The RP explained that they would initially raise any safeguarding concerns with the superintendent pharmacist before deciding on an appropriate action.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy generallyt has enough team members present to safely manage the service demand. The pharmacist usually works alone in the dispensary, which may limit the service efficiency at busy times. Team members receive the training they need for their role, they work well together and ask for assistance when they need it.

Inspector's evidence

The pharmacy had enough staff to manage its workload. It usually had repeat prescription medicines, including those dispensed in compliance packs, ready in good time for when people needed them. The RP sometimes found working alone more challenging during sudden but brief increases in service demand. They took a mental break between preparing and checking prescription medication to reduce the risk of making a mistake.

Two regular pharmacists and the superintendent pharmacist worked at the pharmacy. The RP usually covered Monday to Friday 8.30am to 6pm or 6.30pm, then the superintendent took over until closing time at midnight. The other regular pharmacist covered the weekends. Two medicines counter assistants (MCA) were employed during the week, and a third worked across the weekend. The RP said all the MCAs were appropriately trained.

Staff members worked well collectively, and they had a positive rapport with people. The pharmacy had a whistleblowing policy, and the staff explained that they could raise concerns with the pharmacists or the superintendent if needed.

The team were not set any formal performance targets for service volume.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally clean and tidy, and it provides a suitable environment for the services it provides. It has suitable facilities to help protect people's privacy.

Inspector's evidence

The pharmacy was situated in a modern retail unit, which had shop and dispensary fittings. All areas were generally clean and tidy. The retail area and counter design could usually accommodate the typical number of people who presented at any time, and it facilitated semi-private conversations. The relatively small dispensary and available dispensing bench space was enough to safely prepare medication for the prescription volume, and to accommodate two people at any time. Some of the fixtures and fittings were showing signs of age. For example, some of the dispensary drawer fronts were missing, which made it look less professional.

The consultation room was accessible from the retail area and it could accommodate two people. It was clean, tidy and suitably equipped. Substance misuse clients had access to a separate booth with a hatch to the dispensary, via which the pharmacist could discretely provide their medication and consult with them. The booth had its own external entrance, so clients did not need to enter the pharmacy's retail area to obtain their medication. The dispensary's elevated position that was set back from the front counter meant it was difficult to view any confidential information from the public areas. The RP did not prepare or store any prescription medicines anywhere except in the dispensary.

An employed cleaner disinfected the floors, work surfaces, door handles, telephones and light switches each day. And the pharmacist cleaned the IT equipment each day.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easy to access, and it generally manages most of its services effectively. But the pharmacy could do more to make sure people receiving compliance packs have enough information to take their medicines safely. The pharmacy obtains its medicines from licensed suppliers and it completes some checks to make sure that they are in good condition. But it doesn't always store and manage some medicines as well as it could.

Inspector's evidence

The pharmacy was open 8.30am to midnight Monday to Friday and Saturday and Sunday. It had a step-free wide entrance for easy access. Publicly displayed leaflets listed information about the pharmacy's services and various healthcare topics.

The team kept its emails of people's repeat prescription requests, which acted as an audit trail to effectively resolve any queries if needed. It kept a record of people's current compliance pack medication that included the time of day to take each of them, which helped it effectively query differences between the record and prescriptions and reduced the risk of it overlooking medication changes. Each compliance pack tray was not always labelled with medication descriptions, so people or their carers may not be able to easily identify them. Patient information leaflets were not routinely supplied to these people. This means patients and carers may not always have easy access to all the information about their medicines that they need.

The pharmacy had just one person who was taking warfarin. The RP usually gave them appropriate advice when they supplied their medication, but they did not check their blood test results. The pharmacy had identified and counselled anyone in the at-risk group for valproate. The RP knew about the risks associated with taking this medication and the corresponding advice that they should provide to anyone in this risk category. The pharmacy referred people to the valproate advice cards attached to their supplied medicine's original packaging, but it did not have the advice booklet to give them. The RP agreed to obtain these booklets.

The pharmacy obtained its medicines from licensed wholesalers and it used a licensed specials manufacturer to obtain medicines that did not have a product license. The team suitably monitored the medication refrigerator storage temperatures. It quarantined date-expired CDs and had kits to denature them.

The pharmacy restricted its sales of non-prescription medicines liable to abuse. It mostly supplied methadone via the supervised service. The RP used a fresh dispensing bottle for each of these supplies, which they disposed after the dose had been consumed to reduce the risk of spreading any contaminants to others. The pharmacist did not prepare most people's methadone until they presented to collect it, which had the potential to increase workload pressure. And they did not prepare instalments for more than one day in divided daily doses, which could make it more difficult for people take their dose accurately. The RP explained that these people were given a measure to help them do this.

Most medicines stock was stored in an organised manner in the original manufacturer's containers. But some medicines that were not kept in their original pack had no identifiable batch number or expiry

date. The pharmacist said that they regularly checked stock expiry dates and they marked medication with a reduced time to their expiry date, but these checks were not recorded. Several randomly selected stock prescription medications each had a reasonably long shelf-life, except for the Travoprost eye drop stock which was due to expire at the end of April 2021. This could increase the risk of people receiving medication that was due to expire shortly or had expired.

The pharmacy disposed of obsolete medicines away from medicines stock, which reduced the risk of these becoming mixed with stock or supplying medicines that might be unsuitable. The pharmacist took appropriate action when it received alerts for medicines suspected of not being fit for purpose and kept confirmatory records.

The pharmacy used an alphabetical system to store people's bags of dispensed medication, which supported efficiently retrieving their medicines when needed. Their prescriptions were retained so that they were available for reference at the point of hand out. The RP asked people to confirm their name and address before medicines were handed out, but she did not do this on every occasion, which could increase the likelihood of an error.

The delivery driver wore a mask and used hand sanitiser when they delivered medication. They placed people's medicines at their front door, observed them being collected at a safe distance and they recorded each confirmed supply.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities that it needs for the services provided. The equipment is appropriately maintained, and it is designed to protect privacy. But the absence of an easily accessible hot water supply may make cleaning equipment more difficult.

Inspector's evidence

The dispensary and separate WC sinks both had mains water supplies, but neither were fitted with a hot water supply. The pharmacy had made hand sanitiser available to staff members.

The pharmacists used a range of measures, including a separate set for methadone. So, they could accurately measure and give people their prescribed medication volume. They had access to the latest version of the BNF and a recent cBNF, which meant they could refer to pharmaceutical information if needed.

The pharmacy team had facilities that protected peoples' confidentiality. It viewed their electronic information on screens not visible from public areas and it 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. The team had facilities to store people's medicines and their prescriptions away from public view. A cordless telephone was available which meant staff could hold conversations in a private area and maintain confidentiality.

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.