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: 06/12/2024

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. It provides other NHS services including emergency hormonal contraceptive (EHC), substance misuse treatment, Pharmacy First, urgent medication supply and palliative care. The pharmacy also supplies medicines in response to private prescriptions and over-the-counter treatment for erectile dysfunction.

Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.6	Standard not met	The pharmacy's Responsible Pharmacist records are often illegible or incomplete.
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 not all met

Summary findings

The pharmacy largely keeps the records in line with requirements, but its responsible pharmacist records are illegible or incomplete, so it is not always possible to identify who is responsible for the services it provides. The pharmacy team has written instructions to help make sure it provides safe services. But it cannot always demonstrate how its team reviews mistakes that occur, so they may miss some learning opportunities. Pharmacy team members have a basic understanding of their role in securing people's confidential information, and they demonstrate how to support vulnerable people.

Inspector's evidence

The pharmacy had written NHS patient group directions (PGDs) for pharmacists to supply ulipristal 30mg tablets and levonorgestrel 1500 micrograms tablets for emergency contraception in a community pharmacy following an in-person face-to-face consultation.

The pharmacy had written procedures introduced in April 2018 that covered safe dispensing, controlled drugs (CDs) and the responsible pharmacist (RP) regulations. However, the pharmacy did not have the latest versions of these procedures. The RP, who was the regular pharmacist employed as a locum and acting in a management capacity, confirmed that they had read these procedures. But not all the regular pharmacists and other pharmacy team members had signed to confirm they had read these procedures. So they may not fully understand the procedures that underpin the services they provide.

The pharmacist initialled dispensing labels, which helped to clarify who was responsible for each prescription medication they supplied. However, they did not initial the 'dispensed by' box when they had prepared the medication, which may make it more difficult to investigate and manage mistakes.

The pharmacy had written procedures for managing near misses and dispensing errors. The RP had recently introduced an electronic system for recording near misses, which did not yet include any entries. Staff could not locate the previous paper-based record. It was unclear how often the previous regular pharmacist reviewed these records because they no longer worked at the pharmacy and the other team members did not have any knowledge of this. So, the pharmacy could be missing additional opportunities to identify patterns and mitigate risks in the dispensing process.

The pharmacy had written complaint handling procedures, so staff members knew how to respond to any concerns. There was a public information leaflet that explained how people could make a complaint. But it was kept behind the pharmacy's front counter, so people may feel less encouraged to raise a concern.

The pharmacy had professional indemnity insurance for the services it provided. The RP displayed their RP notice so the public could identify them. The RP record keeping had significantly improved from the last inspection on 19 March 2024. But some discrepancies still remained. The pharmacy had three separate RP records, one paper-based and two electronic, none of which individually was a complete record. This made identifying an RP confusing. Checks across recent weeks highlighted several gaps where there was no identifiable RP in any of these records. Some entries in the paper-based record were illegible or did not include the time when the pharmacist started or ceased acting as the RP.

The pharmacy had recently transitioned from paper to electronic CD registers. Several randomly

selected registers indicated that the pharmacy kept records for CD transactions, except for one recent supply that had not been entered. Running balances were kept for all CDs. But balance checks were infrequent for most CDs, which may delay detecting missing stock or mistakes. Several randomly selected CD running balances, including palliative care treatments, were found to be accurate.

A significant number of the pharmacy's private prescriptions came from prescribers based across the UK using online portals. These portals either did not publicise if they checked the prescriber's registration status when they enrolled on the portal or periodically checked this post enrolment. The RP stated that they routinely checked the prescriber's registration status and the pharmacy's written procedures required the particulars of the prescriber to be checked. However, the pharmacy could not demonstrate that it consistently completed these checks.

The pharmacy kept an electronic register of medicines supplied against private prescriptions. A significant number of recent register entries did not include the prescriber's details, as required by law. Private prescription forms were organised into monthly bundles. But each bundle was unwieldy and not in any obvious order, and prescriptions did not have any reference number. So, there may be difficulties retrieving a specific prescription if needed.

The pharmacists accredited to provide the NHS EHC service completed a paper-based questionnaire with the patient during the consultation. The questionnaire covered the time since intercourse, menstrual and pregnancy history, the EHC options including discussing emergency post-coital intrauterine device, and the EHC supplied. It also had a list of counselling points to cover with the patient and safeguarding queries if they are under eighteen years. This information was transferred to an electronic record, and the questionnaire was immediately destroyed securely.

The RP stated that all the regular pharmacists were accredited to provide the NHS Pharmacy First service. The pharmacy maintained appropriate online consultation records for the service, which included that the patient had provided verbal consent for the service and any urgent medication supplies.

The RP explained that each week they checked that the pharmacy had the medication it was required to stock under the palliative care service. They made a record of these checks, including reviewing each medicine expiry dates, but did not retain them. So, it may be difficult to confirm the stock had been monitored in the event of a query. The RP notified the local commissioning NHS team of any unavailable medication, and they provided an example of this.

The pharmacy completed the medication manufacturer's consultation checklist when screening patients who requested Viagra Connect (sildenafil), which is an over-the-counter treatment for erectile dysfunction. However, the pharmacy did not record enough details of these consultations so it may not be able to easily identify people who requested a repeat supply. These records did not include the pharmacist's or patient's details. So, it was not possible to confirm whether the pharmacy consistently checked if the patient was over eighteen years, not already receiving treatment for the condition, understood not take more than 50mg daily, and to consult their GP within the first six months of use. This also meant, that the pharmacy could not check if a patient was returning for a repeat purchase and if anything had changed regarding their health or medicines usage, as stated on the consultation checklist.

Pharmacy team members recalled they had signed a patient confidentiality agreement and read the pharmacy's data protection policies. However, they could not locate these documents. Team members demonstrated that they had a basic understanding of protecting people's information when verbally communicating with the public. They secured and destroyed any confidential papers, the pharmacists

used passwords to access NHS electronic patient data and had their own security card to access this information. There was no publicly displayed information about the pharmacy's privacy policy. So, people may have more difficulty finding out how the pharmacy protects their data.

All the regular pharmacists had completed level three safeguarding training. The pharmacy liaised with the local NHS substance misuse team regarding any people who missed their methadone instalment. The pharmacists facilitated communications by passing telephone messages from the substance misuse team to patients and providing them telephone facilities. These arrangements helped to safeguard this group of vulnerable individuals.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide safe and effective services. The pharmacist works with a medicine counter assistant and dispenser most of the time, which helps alleviate service demand pressure during busier periods. Team members work well together.

Inspector's evidence

Since the end of September 2024 the RP, who had been the regular pharmacist four days a week, was acting in a managerial capacity. Four other regular pharmacists covered the majority of the other days in the week, including evenings and weekends. The pharmacy opened for 16 hours every day, so the pharmacists worked in shifts. Typically, during the week one of the regular pharmacists worked from 8am to 7pm, and another regular pharmacist covered 7pm to midnight. The pharmacist normally worked alone in the dispensary over the weekend. A trainee dispenser worked from 9am to 6pm during the week, and a dispenser covered the evenings. Six medicines counter assistants (MCAs) were employed, three who worked during the daytime Monday to Friday and three who covered most evenings and weekends.

The RP and trainee dispenser were able to comfortably manage the workload during the inspection. 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. Pharmacy team members worked well together, and they built a positive rapport with customers. The team were not set any formal performance targets for service volume.

The trainee dispenser, who recently started working at the pharmacy, had completed one year of a technician apprenticeship course at another pharmacy. The superintendent’s deputy explained that the trainee would be enrolled on an appropriate dispenser qualification course shortly.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are generally clean and tidy, and it provides a suitable environment for delivering the pharmacy’s services. A separate area is available exclusively for the substance misuse treatment service, which provides privacy for clients.

Inspector's evidence

All areas of the pharmacy were generally clean and tidy. Some of the fixtures and fittings were showing signs of age. For example, some of the dispensary drawer fronts were missing and there were areas of staining on the lino floor covering.

The large retail area and long counter design could usually accommodate the typical number of people who presented at any time, and it facilitated semi-private conversations. The consultation room was accessible from the retail area, and it could accommodate two people. It was suitably equipped.

Clients accessed the substance misuse treatment service via a separate booth that was exclusively for this service and had its own external entrance. So, they did not need to enter the pharmacy's retail area to obtain their medication. The pharmacist discretely supplied and communicated with clients via a small hatch between the room and dispensary.

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. 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.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s working practices are generally effective, which helps make sure people receive safe services. It gets its medicines from licensed suppliers, and the team makes some checks to make sure they are in good condition and suitable to supply.

Inspector's evidence

The pharmacy opened from 8am to midnight, seven days each week. It had a step-free wide entrance for easy access. Publicly displayed promotional material in the front window listed information about the pharmacy's services. The RP confirmed that they were accredited to provide all seven treatments under the NHS Pharmacy First service.

The pharmacy had written procedures that covered the safe dispensing of higher risk medicines such as methotrexate lithium and anti-coagulants. The pharmacy did not have a written procedure for dispensing some other medicines which were considered higher risk, such as fentanyl patches and valproate.

The pharmacy reviewed valproate prescriptions to identify anyone who was in the at-risk group. The team supplied valproate sealed in the original packaging unless otherwise appropriate, and this was confirmed with the prescriber. The RP knew to check that two specialists had agreed to initiate new patients in the at-risk group on valproate, but they did not know to confirm these people had their annual review. The updated MHRA guidance was dicussed with the RP.

The team prepared methadone instalments for more than one day were supplied in divided daily doses, which helped to make sure clients took the correct dose of their medication. Methadone supplies were prepared when clients presented to receive them, which did not usually significantly affect service demand pressure on the team.

The team used baskets during the dispensing process to separate people’s medicines and organise its workload. Staff members did not permanently mark part-used medication stock cartons, which might lead to selecting the incorrect quantity when dispensing and supplying medication.

The pharmacy used an alphabetical system to store people's bags of dispensed medication on separate shelves solely for this purpose. The corresponding prescription form was retained with each bag, so that it was available for reference at the time of supply.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers and generally stored them in an organised manner, including CDs and refrigerated products. The team suitably secured its CDs, and it used destruction kits for denaturing unwanted CDs. There were few stock medicines that did not have a batch number or expiry date. Some medication was temporarily stored in containers on the dispensary floor, mainly due to the pharmacy holding excessive or unnecessary stock.

Records indicated that team members regularly monitored and recorded the storage temperatures for the medication refrigerator. And records seen also demonstrated that the team had regularly checked medicine stock expiry dates for several recent consecutive months. A random check of numerous

medicine's expiry date found most of them had at least a reasonably long shelf life. There were a few medicines discovered that had expired across 2024 or due to expire shortly, which were removed from stock. Nevertheless, this was a marked improvement on previous inspections.

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

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.

Inspector's evidence

The team had a range of clean measures, including a separate set for preparing methadone supplies. So, it had the equipment to make sure it did not contaminate the medicines it handled and could accurately measure and give people their prescribed volume of medicine. The pharmacists had access to the British National Formulary (BNF) online, which meant they could refer to pharmaceutical information if needed.

The pharmacy team kept the dispensary sink clean, which had running hot water. The bathroom and staff room sinks did not have hot water available, which could make hand washing less effective and compromise hygiene. The dispensary was suitably lit. Fan heaters were fitted in the retail area and dispensary. Dispensary room temperature was not monitored.

The team had facilities that protected people's confidentiality. It viewed people's electronic information on screens which were not visible from public areas and regularly backed up people's data on its PMR system. So, it secured people's electronic information and could retrieve their data if the PMR system failed. The pharmacy had facilities to store people's 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.