General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Butler Green Pharmacy, Fields New Road, Chadderton, OLDHAM, Lancashire, OL9 8NH

Pharmacy reference: 1101083

Type of pharmacy: Community

Date of inspection: 14/12/2023

Pharmacy context

This busy community pharmacy is located next to a medical centre in a residential area. Most people who use the pharmacy are from the local area and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines. It provides Covid and Flu vaccination services.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 risks to make sure its services are safe. It acts to improve patient safety and completes the records that it needs to by law. Members of the pharmacy team are clear about their roles and responsibilities. The team keeps people's private information safe and understands how to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided, with signatures showing that members of the pharmacy team had read and accepted them. The delivery driver had not indicated that he had read the controlled drug (CD) delivery SOP, but the superintendent pharmacist (SI) confirmed that the driver had read the relevant SOPs and understood the pharmacy's delivery procedures. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their roles. Team members were wearing uniforms. There was a locum pharmacy technician (PT) on duty. She explained that the SI had been through the pharmacy's procedures with her, in particular with regard to the automated dispensing robot, which was new to her. And she had read a document entitled 'Information for locums'. The incorrect name of the responsible pharmacist (RP) was displayed, but the SI, who was working as RP, displayed her notice immediately when this was pointed out. Team members understood what duties they could carry out in the absence of an RP.

There was an error reporting SOP. The SI explained that the number of errors had been minimal since the introduction of the robot, and there had not been an error which had left the pharmacy for around a year. She recalled she had completed a full critical incident form with a root cause analysis at the time. The incorrect strength of Canagliflozin had been supplied which had been as a result of a loading error when the 2D barcode had been entered incorrectly into the robot. This type of error usually occurred when medicines were loaded into the robot as a batch, rather than individually, and a different medicine in similar packaging was incorrectly entered as the scanned medicine. This would normally be picked up as a near miss and corrected by removing all of the affected batch, checking the barcodes and re-entering them into the robot. Near misses were recorded on a log, which the SI reviewed periodically and discussed within the pharmacy team. The SI always asked the member of the team involved to correct and record their own mistakes, which helped them to reflect on the reason, and meant they were less likely to repeat it. A dispenser said that since the introduction of the robot, her near misses were usually quantity errors, because the robot was so accurate in selecting the correct medicine. There was a complaints SOP, and a notice was on display in the waiting area of the pharmacy which explained the complaint procedure and how people could leave feedback. The medicine counter assistant (MCA) described how she would deal with a customer complaint which was to refer it to the pharmacist. Professional indemnity insurance arrangements were in place. A current certificate of professional indemnity insurance was on display in the pharmacy.

Private prescription and emergency supply records, the RP record, and the CD registers were in an electronic format, and all records appeared to be in order. Records of CD running balances were kept and these were regularly audited. One CD balance was checked and found to be correct. Adjustments to methadone balances were attributed to manufacturer's overage following an assessment of whether

the adjustment was within a reasonable range. And the SI knew when a discrepancy should be investigated and reported. Patient returned CDs were recorded and disposed of appropriately.

Confidential waste was placed into designated bags which were collected by a third-party disposal company. The apprentice dispenser understood the difference between confidential and general waste and knew to use the designated waste bags. 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). 'How we look after and safeguard information about you' leaflets were on display, so people could read about this.

The SI had completed level three training on safeguarding. There was a safeguarding policy in place containing the contact numbers of who to report concerns to in the local area. The pharmacy had a chaperone policy, and this was highlighted to people. Pharmacy team members had been trained on 'Safe Spaces,' where pharmacies were providing a safe space for victims of domestic abuse. The SI confirmed that the consultation room was always available for anyone requiring a confidential conversation.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members work well together in a busy environment, and they have the right training and qualifications for the jobs they do. Team members are comfortable providing feedback to their manager and they receive informal feedback about their own performance.

Inspector's evidence

There was a pharmacist (SI), a locum PT, two NVQ2 qualified dispensers (or equivalent), a medicines counter assistant (MCA), an apprentice dispenser 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 and the team were observed working collaboratively with each other and people who visited the pharmacy. The locum PT had been booked for two or three days over the next couple of weeks to help manage the additional workload. The SI worked on at least three days each week and two regular locum pharmacists worked on the other days. The SI always ensured there was a second pharmacist on duty when she was running a covid vaccination clinic. Members of the pharmacy team carrying out the services had completed appropriate training. Training resources were available online and the team had completed training on a variety of subjects including infection control, antimicrobial stewardship, weight management and cancer awareness. The pharmacy team received feedback informally from the SI. The pharmacy closed for one hour each month for team meetings where a variety of issues were discussed, and concerns could be raised. A team member confirmed that there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the SI about any concerns she might have. She said the team could make suggestions or criticisms informally. The pharmacists 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.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a professional environment for people to receive healthcare services. It has private consultation rooms so people can receive services in private and have confidential conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy premises, including the shop front and facia, were clean and in a good state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with three chairs. The temperature and lighting were adequately controlled. Staff facilities were limited to a small kitchen area, and a WC, with a wash hand basin and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks. Hand sanitizer gel was available. There were two consultation rooms, one of which was equipped with a sink. The main consultation room was 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 such as flu vaccinations 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, so people receive appropriate care. It gets its medicines from licensed suppliers and the team carries out checks to ensure medicines are in suitable condition to supply.

Inspector's evidence

The pharmacy was accessible to everyone, including people with mobility difficulties and wheelchair users. The pharmacy provided a range of additional services including a smoking cessation service following referral from a local hospital. The pharmacy also offered flu and covid vaccinations and blood pressure testing. The flu and covid vaccination services were both provided under Patient Group Directions (PGDs). The blood pressure service included ambulatory testing and was free if the person was referred by their GP, otherwise there was a small charge. Services provided by the pharmacy were advertised on a TV style screen above the medicine counter. The pharmacy team was clear what services were offered and where to signpost people to a service not offered. A folder was available containing relevant signposting information which could be used to inform people of services and support available elsewhere. There was a range of healthcare literatures. For example, a poster encouraging people to ‘eat well’ and leaflets on diet and weight loss.

There was a home delivery service with associated audit trail. The delivery driver confirmed the safe receipt in their records. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was quite limited in the dispensary, but the workflow was organised into separate areas with a designated checking area. Most of the pharmacy’s stock was stored in the automated dispensing robot. Excess stock and items too large or too fragile to go into the robot were stored on the dispensary shelves which were well organised, neat, and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. 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 and high-risk medicines such as valproate were targeted for additional counselling. The team were aware of the requirements for a Pregnancy Prevention Programme to be in place and that people who were prescribed valproate should have annual reviews with a specialist. The SI said several audits had been carried out and the pharmacy did not currently have any patients in the at-risk group. She was aware that valproate was required to be supplied in its original pack to ensure people in the at-risk group were always given the appropriate information.

Multi-compartment compliance aid packs were well managed with an audit trail for communications with GPs and changes to medication. A dispensing audit trail was completed, and medicine descriptions were included on the packaging to enable identification of the individual medicines. Staff confirmed packaging leaflets were included so people were able to easily access additional information about their

medicines. Disposable equipment was used.

The MCA explained what questions she asked when making a medicine sale and when to refer the person to a pharmacist. She was clear what action to take if she suspected a customer might be misusing medicines such as a codeine containing product.

CDs were stored in two CD cabinets which were securely fixed to the wall. The CD keys were stored securely overnight. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

There was a large quantity of bottles on display in the pharmacy which were labelled with the names of pharmaceutical ingredients and chemicals. Some of these might fall under the amended Poisons Act 1972 and the introduced Control of Poisons and Explosives Pre-cursors Regulations 2015. The SI explained that many of the bottles were empty, but she confirmed that she would check them and arrange for the removal, safe storage, or safe disposal of any if necessary.

Recognised licensed wholesalers were used to obtain stock medicines and appropriate records were maintained for medicines ordered from 'Specials.' Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. The robot kept a record of the expiry dates of the medicines it contained so short-dated stock could be removed when necessary. Dates had been added to opened liquids with limited stability. Expired and unwanted medicines were segregated and placed in designated bins.

The pharmacy received alerts and recalls electronically. These were read and acted on by a member of the pharmacy team and the action taken recorded, so the team were able to respond to queries and provide assurance that the appropriate action had been taken. The SI also received emails directly from the Medicines & Healthcare products Regulatory Agency (MHRA).

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. They maintain the equipment so that it is safe, and they use it in a way that protects privacy.

Inspector's evidence

Martindale and Stockleys were available for reference and the pharmacist could access the internet for the most up-to-date information. The SI said she used an App on her mobile phone to access the electronic British National Formulary (BNF) and BNF for children. There were two clean medical fridges for storing medicines. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order. There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were marked and used for methadone solution. The pharmacy had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination. The robot was appropriately maintained, and the team could contact a helpline if problems occurred. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. 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.