General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Cannon Pharmacy, 5 Manchester Chambers, Manchester Street, OLDHAM, Lancashire, OL1 1LF

Pharmacy reference: 1101205

Type of pharmacy: Community

Date of inspection: 10/02/2020

Pharmacy context

This community pharmacy is located in the town centre opposite a large integrated care centre which has several GP practices, dentists, a walk in centre and other community health services and clinics. The pharmacy dispenses NHS prescriptions and sells a small range of over-the-counter medicines. It supplies some medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. The pharmacy changed ownership in November 2018.

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, and it takes some action to improve patient safety. It completes the records that it needs to by law and asks its customers for their views and feedback. Team members keep people's private information safe and understand how they can help to protect the welfare of vulnerable people. But they have not confirmed their understanding of the pharmacy's written procedures, so they may not always work effectively or understand who is accountable for what.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services provided. These indicated they were prepared in September 2017, and had not been reviewed since the change of ownership. The SOPs could not be located until the pharmacist superintendent (SI) arrived and found them in the office upstairs. There was nothing to indicate that the current staff including the SI, responsible pharmacist (RP) and pharmacy technician (PT) had read and accepted them. The SI confirmed he was comfortable using the SOPs, which had been prepared before he took over as SI, although he had not formally reviewed them. The RP said she had not read the SOPs as she was told by the SI that they were being reviewed. Roles and responsibilities were set out in the SOP. The pharmacy team members were clear about their roles and were performing duties which were in line with them. They were wearing uniforms, although nothing to indicate their role, so this might not be clear to members of the public. The name of the RP was displayed as per the RP regulations.

The SI explained that any dispensing errors were recorded electronically on the pharmacy's computer. Near misses were reported on a log and discussed with the team member who was involved. The SI said he didn't routinely review or analyse the near misses, due to time constraints, but he did look through them. Some members of the team had completed the Centre for Pharmacy Postgraduate Education (CPPE) training on look-alike and sound-alike drugs (LASAs), and they confirmed extra care would be taken when selecting these medicines. A dispenser pointed out small alert stickers which had been placed in front of some LASAs, and quinine sulphate and quinine bisulphate tablets had been placed on separate shelves to avoid confusion. The dispenser explained that if a medicine was available in different forms such as ramipril tablets and capsules, then these would be clearly separated. Hypoglycaemic medication was stored in a separate part of the dispensary as these were considered more high risk if there was an error.

There was a 'dealing with complaints' SOP, but there was nothing on display highlighting the complaints procedure to members of the public or details of who to complain to. A dispenser described how she would deal with a customer complaint and how she would refer it to the RP. A customer satisfaction survey was carried out annually. The results of the most recent survey were not on display but were available on www.NHS.uk website. Results indicated 90% of respondents had rated the pharmacy very good or excellent overall. Areas of strength included 'service received from other pharmacy staff'. An area identified which required improvement was 'providing advice on physical exercise'. The published response to this was 'We will actively advise our patients about the benefits of physical exercise and the importance of leading and maintaining a healthy lifestyle.' There was a small amount of healthy living information on display in the pharmacy.

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 controlled drug (CD) register were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct.

Members of the pharmacy team had completed training on information governance (IG) which included information about confidentiality. Confidential waste was placed in designated bags which were collected by a waste disposal company. A dispenser correctly described the difference between confidential and general waste. The delivery driver had a basic understanding about patient confidentiality, but the design of the delivery sheet allowed recipients to see other people's details, risking breaching their confidentiality. There was also a risk that they would see which people were receiving controlled drugs as stickers were used to highlight this on the delivery sheet. The RP confirmed that they would review this procedure to minimise the risk to confidentiality. Assembled prescriptions awaiting collection were not visible from the medicines counter.

There was safeguarding children and vulnerable adults' guidance and the contact numbers of who to report concerns to were available. The pharmacists, PT and one of the dispensers had completed CPPE level 2 training on safeguarding. The delivery driver described how he had reported a potential safeguarding concern about a regular patient to the pharmacy team. They contacted the patient's GP who carried out a home visit the same day and provided support. The patient now appeared to be coping better. The pharmacy had a chaperone policy, but this was not highlighted to patients, so people might not realise this was an option when using the consultation room. Members of the pharmacy team had completed Dementia Friends training, so had a better understanding of patients living with this condition.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications for the jobs they do. They are comfortable providing feedback to their manager and receive informal feedback about their own performance. They get some ongoing training to help them keep up to date. But this is not structured, so they could develop gaps in their knowledge.

Inspector's evidence

There was a regular locum pharmacist and two qualified dispensers on duty at the time of the inspection. One dispenser was qualified under the 'grand parenting' clause and the other was NVQ 2 qualified (or equivalent). A delivery driver was on duty for part 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 the patients. Planned absences were organised so that not more than one person was away at a time and absences were covered by re-arranging the staff hours. There was also a PT in the pharmacy team, who was not present at the inspection. The SI was present for a short time during the inspection. The regular locum pharmacist worked one day each week in the pharmacy and the SI worked the rest of the days. They mainly communicated by leaving notes for each other.

Training certificates were available showing some staff training had been completed. For example, CPPE training on LASA, sepsis, safeguarding and children’s oral health, but there wasn’t any structured ongoing training and the pharmacy team did not have regular protected training time. The pharmacy team discussed performance and development informally with the SI and received positive and negative feedback from the SI and RP. Issues were discussed as they arose, and the team felt comfortable discussing their concerns with the RP or SI. Two of the team members confirmed they felt there was an open and honest culture in the pharmacy and said they could make suggestions or criticisms informally. They felt comfortable reporting near misses and tried to learn from them.

The RP said she felt empowered to exercise her professional judgement and could comply with her own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because she felt it was inappropriate. She said she was encouraged to complete Medicines Use Reviews (MUR) but there were no targets which she was required to achieve and she didn’t feel under any pressure.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a professional environment for people to receive healthcare. The pharmacy has a private consultation room that enables it to offer members of the public the opportunity to have confidential conversations. But the room is not clearly signposted, and it is untidy which detracts from the professional image of the pharmacy.

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 two chairs. The temperature and lighting were adequately controlled. The pharmacy had been re-fitted since the previous inspection to address some confidentiality issues, and the fixtures and fittings were in good order. Maintenance problems were reported to the local council who owned the building and the response time was appropriate to the nature of the issue.

There was a separate stockroom, a kitchen area and a WC with a wash hand basin in the basement. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand sanitizer gel was available.

There was a consultation room, but there was nothing highlighting the availability of the room so people might not realise these facilities exist. It was cluttered and untidy and compromised the professional environment. The pharmacy team confirmed the room was used when carrying out services such as MURs and flu vaccinations and when customers needed a private area to talk. The room was offered to patients receiving supervised medication.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are generally well managed and easy for people to access. The pharmacy team members are helpful and give healthcare advice and support to people. The pharmacy gets its medicines from licensed suppliers and it carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchair users. Not all the services provided by the pharmacy were advertised, so people might not realise they were offered. However, the pharmacy team were clear what services were offered and where to signpost people to when asked for a service not offered, such as to the walk-in centre opposite. There was a range of healthcare leaflets, including some on cancer awareness, and there was some information on oral health. Signposting and providing healthy living advice were not routinely recorded apart from when audits were carried out. For example, an audit of patients with diabetes had been completed and around six people had been referred for either foot or retinopathy tests.

The pharmacy offered a repeat prescription ordering service and patients were required to indicate their requirements before ordering. This was to reduce stockpiling and medicine wastage. Patients receiving their medication in compliance aid packs were contacted to check their requirements before the pharmacy ordered their prescriptions. There was a home delivery service with associated audit trail. Each delivery was recorded, and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was adequate in the dispensary, and the work flow was organised into separate areas with designated checking areas. The dispensary shelves were well organised, neat and tidy. Dispensed by and checked by boxes were generally 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. ‘Pharmacist consultation request’ stickers were used to highlight when counselling was required and high-risk medicines such as warfarin and lithium were targeted for extra checks and counselling. INR levels were checked when dispensing warfarin prescriptions and around two patients had been counselled as part of an audit on patients prescribed lithium. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out and two patients in the at-risk group had been identified and the pharmacist had discussions with them about pregnancy prevention. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling. There was a supervised medication audit trail where the details of prescriptions were recorded along with the date it was brought into the pharmacy. The patient signed the record to confirm it was correct and this was used if there was any query about the prescription dates.

Multi-compartment compliance aid packs were reasonably well organised. There was a partial audit trail for changes to medication in the packs, but it was not always clear who had confirmed these and the date the changes had been made, which could cause confusion in the event of a query. A dispensing audit trail was not always completed, so it might be harder to identify what had gone wrong in the event of a problem. Medicine descriptions were usually included on the labels to enable identification of the individual medicines and packaging leaflets were included so patients and their carers could easily access all the required information about their medicines. Disposable equipment was used. The compliance aid pack SOP included an assessment by the pharmacist of the appropriateness of a pack, or if other adjustments might be more appropriate for the patient's needs. The RP explained that most referrals for compliance aid packs usually came from the patient's GP or social services who carried out an assessment.

A dispenser explained what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

CDs were stored in three CD cabinets which were securely fixed to the wall/floor. 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. Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out.

The pharmacy was not compliant with the Falsified Medicines Directive (FMD). They had the software needed to comply but were not currently scanning to verify or decommission medicines. The team was waiting for further advice from the SI. Medicines were generally stored in their original containers but there were around eight bottles of loose tablets and capsules which were not labelled with their batch number or expiry date. The RP said they had been popped out for use in compliance aid packs and then found not to be needed. She admitted that they weren't appropriately labelled and their expiry date would be unknown, and agreed to dispose of them. Date checking was carried out and documented. Short dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired medicines were segregated and placed in designated bins.

There was a clean medical fridge. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. However, around fourteen packets of insulin were seen in the non-medical fridge in the staff area. The temperature of this fridge was not monitored so there was no assurance that these were being stored at the correct temperature. The SI explained that they had been ordered for another pharmacy he owned, which was struggling to obtain them for a patient, so he wanted to keep them separate whilst he stored them for a day or two. The RP checked the temperature of the non-medical fridge and it was within range, so she felt they had been stored appropriately and it was safe to move the insulin into the medical fridge.

Alerts and recalls were received via e-mail messages. These were read and acted on by a member of the pharmacy team and then filed. A copy was retained in the pharmacy with a record of the action taken so the team were able to respond to queries and provide assurance that the appropriate action had been taken.

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 use it in a way that protects privacy.

Inspector's evidence

Current versions of the British National Formulary (BNF) and BNF for children were available and the pharmacist could access the internet for the most up-to-date information. 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 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.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Individual electronic prescriptions service (EPS) smart cards were in use. 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.