General
Pharmaceutical
Council

Registered pharmacy inspection report

Pharmacy Name: Seemed Pharmacy, 165 Waterloo Street, OLDHAM, Lancashire, OL4 1EN

Pharmacy reference: 1105391

Type of pharmacy: Community

Date of inspection: 19/11/2019

Pharmacy context

This is a quiet community pharmacy located in a residential area on the edge of the town centre. Most people who use the pharmacy are from the local area and some are non-English speakers from the Asian community. The pharmacy mainly dispenses NHS prescriptions and sells a range of over-the-counter medicines. It also carries out meningitis vaccinations, which is a popular service for people traveling to Saudi Arabia for Hajj or Umrah pilgrimages.

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	1.2	Good practice	The pharmacy records and analyses adverse dispensing incidents to identify learning points which it incorporates into day to day practice to help manage future risks.
		1.4	Good practice	The pharmacy gives people the opportunity to give feedback and raise concerns. It uses feedback to improve its services and working practices.
2. Staff	Standards met	2.4	Good practice	The pharmacy team work well together. Team members communicate effectively and openness, honesty and learning is encouraged.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy offers a range of services which are accessible over extended hours, and the services reflect the needs of the local community.
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 keeps the records required by law. It asks its customers for their views and uses this feedback to improve its services. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. They record their mistakes so that they can learn from them and act to help stop the same sort of mistakes from happening again. The team members keep people's private information safe. And they complete training so they know how to protect children and vulnerable adults.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided, with signatures showing that members of the pharmacy team had read and accepted them. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their role. The team were not wearing uniforms or anything to indicate their role so people might be unclear about this. The name of the responsible pharmacist (RP) was displayed as per the RP regulations.

There were SOPs dealing with dispensing errors and near misses. Dispensing incidents were reported electronically and the pharmacist superintendent (SI) was informed as soon as they were identified, so they could give advice on what actions to take. Actions taken to avoid a re-occurrence were recorded. For example, an incident when the wrong strength of mirabegron was supplied, due to unfamiliarity with the prescribed strength, the pharmacy team were all made aware of the incident so that they knew that two strengths were available. Near misses were reported and reviewed monthly by the SI. They were discussed with the pharmacy team and learning points shared with the other pharmacies in the group using a WhatsApp messenger system. Following an incident when the incorrect quantity of gabapentin was dispensed, the group were informed that it was now being supplied in two pack sizes, 56 and 84. They were reminded to take extra care when dispensing all controlled drugs (CDs), to ensure the correct quantity was dispensed and double checked. The team had completed training on look-alike and sound-alike drugs (LASAs) and risk management. Some alerts notes had been placed in front of some of the LASAs on the dispensary shelves, such as prednisolone and propranolol.

There was a 'Complaints' SOP and a notice on display with the complaints procedure and the details of who to complain to. The SI said customer complaints were rare and were usually from people not receiving their preferred brand of medicines. He explained that this was because of the problems with medicine shortages and out of the pharmacy's control, but the team tried hard to obtain the patient's preferred brand when possible. A suggestion box was on the medicine counter. It included notes with positive feedback about the service received and the pharmacy team. The SI reviewed these periodically. There was one suggestion in the box that people should be asked to take a seat when they had been served to keep the medicine counter area free. The SI said he would share this with the team. He explained that he had increased the number of phone lines and got a separate line for the fax machine, following feedback that people were struggling to get through to the pharmacy by phone. A customer satisfaction survey was carried out annually. The results from the 2018 survey were on display in the consultation room and available on www.NHS.uk website. Areas of strength (rated 100%) included waiting time to be served, providing an efficient service and being polite and taking time to

listen. An area identified which required improvement was the comfort and convenience of the waiting area. The SI had subsequently purchased some new chairs and increased the number of chairs for people to wait on from two to four.

Insurance arrangements were in place. A current certificate of professional indemnity insurance was on display in the pharmacy. Private prescription 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. Patient returned CDs were recorded and disposed of appropriately.

Members of the pharmacy team had received training on the General Data Protection Regulation (GDPR) and had read and signed the 'Confidentiality' SOP. Confidential waste was collected in a designated place and shredded. The trainee dispenser correctly described the difference between confidential and general waste and had signed a confidentiality agreement when she started working in the pharmacy. Assembled prescriptions awaiting collection were not visible from the medicines counter. Paperwork containing patient confidential information was stored appropriately. A privacy statement was on display, in line with the GDPR.

The pharmacists had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding and other members of the pharmacy team had completed level 1 training. Some of the pharmacists were in the process of repeating their training as it had been completed a couple of years ago, and this was acting as a refresher. The trainee dispenser had not yet completed the CPPE training on safeguarding but had a basic understanding and said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. There was a 'Safe guarding vulnerable groups' SOP with contact numbers of who to report concerns to in the local area and links to resources. The NHS A-Z safeguarding guidance was on display. The pharmacy had a chaperone policy and this was highlighted to patients on a notice. 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 receive training for the jobs they do. They work well together and communicate effectively. They are comfortable providing feedback to their manager and receive informal feedback about their own performance. The pharmacy enables the team members to act on their own initiative and use their professional judgement to the benefit of people who use the pharmacy's services.

Inspector's evidence

There was a SI, regular locum pharmacist and trainee dispenser 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 the patients. There was an additional part time qualified dispenser who worked at the pharmacy three days each week. Cover for absences was organised by re-arranging the staff hours or transferring staff from one of the neighbouring branches. There was a 'floating' dispenser in the group who could be requested to work when necessary. The SI visited the pharmacy most days and assisted when required. There were three regular pharmacists who worked in the pharmacy and they all helped the SI with the day to day management. There were three delivery drivers who covered the workload in the four pharmacies in the group.

The trainee dispenser was on an apprenticeship scheme through a local college which she believed was a BTEC or NVQ course. The SI confirmed it was an accredited course. Some training was recorded electronically and there were certificates on display showing completed training. Members of the team had completed CPPE training on children's oral health and sepsis. Other training resources were provided such as articles in trade magazines but this was not structured or recorded so gaps in the team's knowledge might not be identified and supported. The pharmacy team had informal discussions about performance and development and were given positive and negative feedback by the SI. The SI held a fortnightly meeting with the pharmacists in the group and information was shared on a WhatsApp pharmacist group such as information on drug shortages, flu vaccinations, and an article on red flag symptoms from a GP online journal, which one of the pharmacists had found useful. There was a WhatsApp dispensers' group for the rest of the team. There was a communication book which was used to share messages in the pharmacy and a notice on display showing the tasks which were to be completed each day. The trainee dispenser said she felt there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the pharmacist on duty or the SI about any concerns she might have. She felt comfortable admitting her mistakes and tried to learn from them. The team could make suggestions or criticisms informally and there was a whistleblowing policy .

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. The RP said targets were set for Medicines Use Review (MUR) and New Medicine Service (NMS). She was encouraged to do two each day and there was a financial incentive for achieving this. But she didn't feel targets ever compromised patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a professional environment for people to receive healthcare. The pharmacy has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations.

Inspector's evidence

The pharmacy premises including the shop front and facia were clean, spacious, well maintained and in a good state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with four chairs. A cleaning rota was used. The temperature and lighting were adequately controlled. The pharmacy had been fitted out to a good standard when it opened, and the fixtures and fittings were in good order. External maintenance problems were reported to the local council, who owned the building, such as a leak or blocked drains, and the response time was appropriate to the nature of the issue. The SI dealt with any internal issues such as the hot water not working.

Staff facilities include an accessible WC with a wash hand basin and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. The consultation room was equipped with a sink with antibacterial hand wash and was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. The team used the room when carrying out the services 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 and easy for people to access. The pharmacy team members are helpful and give advice and support to people in the community. The pharmacy sources, stores and supplies medicines safely. And it carries out some additional checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

There was a very slight step into the pharmacy but the door was wide and the SI confirmed that it was accessible to all, including patients with mobility difficulties and wheelchair users. The consultation room was accessible to wheelchair users. The pharmacy opened 6pm -11 pm on Sundays as no other pharmacy was open in the local area at this time. The pharmacy also opened Easter Sunday and Christmas Day to provide services as most pharmacies in the Greater Manchester area were closed on these days. There was a TV style screen in the window advertising the services provided by the pharmacy, the opening hours, health promotion such as flu vaccination and encouraging people to ask their pharmacist.

There was a healthy living zone with posters and a range of healthcare leaflets. The pharmacy team was clear what services were offered and where to signpost to a service not offered. For example, people requesting multi-compartment compliance aid packs were signposted to one of the other pharmacies in the group which specialised in this service. Signposting and providing healthy living advice was recorded in the form of a tally chart. The pharmacy served mainly Bangladeshi, Pakistani and Kashmiri communities many of whom were non-English speakers. The pharmacy team was multilingual. Along with English, Bengali, Urdu and Punjabi were spoken in the pharmacy, which assisted the non-English speaking people in the community. The SI specifically recruited a Bangla speaking member of staff to fulfil a need in the pharmacy. There was a high incidence of diabetes in the community and this was addressed by the pharmacy providing education to patients on how to use their diabetes testing equipment properly and giving advice about diet and medicines use. As well as helping the local people with health matters, the pharmacy team also helped with other issues. For example, helping them translate and complete passport application forms.

Several clinical audits were being carried out including ones on patients prescribed valproate, lithium and non-steroidal anti-inflammatory drugs (NSAIDs). There was an asthma audit and an audit of patients with diabetes. Different pharmacists were allocated the lead on the various audits to ensure they were fully completed and the action points followed through. Three people with diabetes had been referred for foot checks or retinopathy eye checks as it was identified that they had not had these checks during the last year.

The pharmacy offered a repeat prescription ordering service and patients were contacted before their prescriptions were due each month, to check their requirements. This was to reduce stockpiling and medicine wastage. There was a home delivery service. Signatures were not obtained from the recipient unless the medicine was a CD, which was not in line with the delivery SOP, and meant there was not a complete audit trail in case of a problem or query. 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 a designated checking area. The dispensary shelves 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. INR levels were requested when ordering or dispensing warfarin prescriptions but these were not always recorded. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out a couple of years ago and no patients in the at-risk group had been identified. Another audit was about to be commenced. The valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling. A poster was on display in the dispensary reminding the team about this.

Appropriate records were maintained for the vaccination service which included consent. One of the pharmacists carried out meningitis vaccinations. The patient group directive (PGD) for this service was available and the SI confirmed the pharmacists had completed the appropriate training prior to commencing the service.

CDs were stored in a CD cabinet which was securely fixed to the wall. The keys were under the control of the responsible pharmacist during the day and 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.

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 yet compliant with the Falsified Medicines Directive (FMD). They had the software and hardware needed to comply but had not started scanning to verify and decommission medicines. Medicines were stored in their original containers at an appropriate temperature. 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.

Alerts and recalls were received via e-mail messages from the MHRA. These were read and acted on by a member of the pharmacy team and then filed. A record of the action taken was recorded providing 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 copies of the British National Formulary (BNF) and BNF for children were available and several other reference books including Stockleys drug interactions. The pharmacy team could access the internet for the most up-to-date information. There was a clean medical fridge. 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.

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 used appropriately. 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.