General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ashton Medical Centre Pharmacy, Ashton Primary Care Centre, 193 Old Street, ASHTON-UNDER-LYNE, Lancashire, OL6 7SR

Pharmacy reference: 1105529

Type of pharmacy: Community

Date of inspection: 17/06/2024

Pharmacy context

This community pharmacy is located in a Primary Care Centre in the town centre. 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. And it provides covid and seasonal flu vaccination services and some other NHS funded services including the Pharmacy First Service. It supplies some medicines in multi-compartment compliance aid packs to help people take their medicines at the right time.

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. The pharmacy team understands how it can help to protect the welfare of vulnerable people and keep people's private information safe. The pharmacy keeps the records that it needs to by law, but some of the records are inaccurate, which could cause confusion and makes audit more difficult. And the pharmacy does not always act promptly to address people's concerns and improve its working practices.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided, with signatures showing which members of the pharmacy team had read and accepted them. The responsible pharmacist (RP) and the trainee dispenser, who were relatively new to the pharmacy, had not read the SOPs yet, so there was a risk that they might not fully understand the pharmacy's working procedures. The RP confirmed that both he and the trainee dispenser would make sure they read the SOPs. Roles and responsibilities were set out in SOPs and the pharmacy team members were generally performing duties which were in line with their roles. Team members were not wearing uniforms or anything showing their role, so people might not be able to easily identify them or tell who was responsible for what. The name of the RP was displayed as required by the RP regulations. A current certificate of professional indemnity insurance was on display in the pharmacy.

Pharmacy team members discussed near miss errors within the team when they occurred, and learnings were shared with the other pharmacies in the company via an electronic messenger group. The dispenser said he felt comfortable admitting to errors and confirmed that learning from mistakes was encouraged. He gave examples of changes which had been made following near misses. For example, the look-alike and sound-alike drugs (LASAs) quetiapine and quinine had been better separated and highlighted so extra care would be taken when selecting these, and there was a poster on display showing other LASAs. There was a near miss log, and some errors had been recorded, but it was not used consistently and there was no evidence of any formal reviews. So, there was a risk that team members might miss out on additional learning opportunities. A notice was on display in the retail area of the pharmacy with the complaint's procedure and the details of who to complain to. Team members had received several complaints over the last year about the pharmacy operating on a cash only basis. And this sometimes caused a delay in people being able to collect their medicines. Team members confirmed that they had reported this issue to head office several times and were told that it was being looked into, but the issue hadn't yet been resolved which led to frustrations in the pharmacy team.

Private prescription and emergency supply records, the RP record, and the controlled drug (CD) registers were in electronic format. The RP record appeared to in order. The private prescription records were generally in order, but the incorrect prescriber had been recorded for some of the private prescriptions, which could cause confusion in the event of a problem or query. Records of CD running balances were kept but they were not regularly audited, and two discrepancies were found in the sample checked during the inspection. Patient retuned CDs were not always recorded when they were

returned to the pharmacy. The RP carried out a full balance check of all CDs after the inspection and confirmed that CD balances would be checked more regularly going forward. He confirmed that he had entered the outstanding patient returned CDs into the register to create an audit trail.

Confidential waste was collected in a designated place and shredded. Assembled prescriptions and paperwork containing patient confidential information were generally stored appropriately so that people's details could not be seen by members of the public. The RP had completed level three training on safeguarding children and vulnerable adults. There was a safeguarding notice on display in the consultation room with 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. There were notices on display highlighting that the pharmacy provided a Safe Space for victims of domestic abuse and details of support groups in English, Urdu, and Punjabi.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team, and team members complete the essential training they need to do their jobs. They are comfortable providing feedback to their manager and they receive feedback about their own performance. But the pharmacy does not support them to complete regular ongoing training, so they may develop gaps in their knowledge and skills.

Inspector's evidence

The RP, an NVQ2 qualified dispenser and a medicines counter assistant (MCA) were on duty at the time of the inspection. The MCA carried out deliveries in addition to her role as an MCA. She occasionally put stock away in the dispensary. The RP didn't know if she was enrolled onto a delivery or dispensing assistant course but said he would check this with the pharmacist superintendent (SI) and ensure she only carried out the duties she was fully trained for. The team members were observed working collaboratively with each other and people who visited the pharmacy. The RP was running a covid vaccination clinic and carrying out occasional Pharmacy First consultations, so some people had to wait longer than they expected for their prescription to be dispensed. The RP explained that sometimes a second pharmacist worked when the covid vaccination clinics were held, but this wasn't always possible. There were three other pharmacies in the company and sometimes staff were transferred from one of the other pharmacies to cover absences or when workload was particularly high. Locum or relief dispensers were occasionally used to ensure adequate staffing levels. The SI worked at the pharmacy at least once every month and sometimes provided additional pharmacist cover. There was a human resources (HR) manager for the company who provided HR support to the pharmacy team.

The RP was not the permanent pharmacist, but he had worked at the pharmacy for the previous eight weeks. He explained that he had taken on the role of clinical lead for the covid vaccination service and was administering the vaccines under the National Protocol. He confirmed that he was competent to provide the vaccination services and the Pharmacy First service as he had completed all the required online and face-to-face training. There was a trainee dispenser on the pharmacy team. She had regular protected training time, but there wasn't any structured ongoing training for the rest of the pharmacy team. The qualified dispenser had expressed an interest to become a pharmacy technician and he hoped to start an NVQ3 course in the near future. He described himself as the dispensary supervisor and said he checked all of the trainee dispenser's prescriptions before they were accuracy checked by the pharmacist.

The pharmacy team had one-to-one meetings with the SI when she visited the pharmacy, and team members were given feedback and areas for improvement during these meetings. There were monthly management meetings with the SI, the HR manager, the dispenser, and the regular pharmacist where a variety of issues were discussed. The dispenser said he said he would feel comfortable talking to the SI about any concerns he might have and could make suggestions and give ideas to improve services. The pharmacy team kept in regular contact with the SI and the other three pharmacies in the company via an electronic messenger group.

The RP was empowered to exercise his professional judgement and could comply with his own

professional and legal obligations. He said there was additional pressure in the pharmacy since the introduction of the Pharmacy First service, but he could restrict appointments for the covid vaccination service and remove the walk-in element if workload became unmanageable.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises, including the shop front and facia, were reasonably clean and in an adequate state of repair. The retail area was free from obstructions. There were two step-free entrances into the pharmacy. There was an empty leaflet stand and two empty vending machines near one of the entrances, which detracted from the professional image of the pharmacy. There were two separate waiting areas, one had bench seating and the other one had around eight chairs. The temperature and lighting were adequately controlled. There was a small stockroom and a staff tearoom. The team used communal WCs in the primary care centre. 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 and disposable gloves were available. There were two consultation rooms which were equipped with sinks. One of the consultation rooms was mainly used for vaccinations. It was uncluttered, clean and professional in appearance. The other consultation room was used when carrying out any other services and when customers needed a private area to talk. An area of the counter was screened which allowed a degree of privacy when people were using the needle syringe provision or receiving supervised medicine.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's services are generally well managed and easy for people to access. The pharmacy provides healthcare advice and support to people. It 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 everyone, including people with mobility difficulties and wheelchair users. Services provided by the pharmacy were advertised. There were resources promoting healthy living such as posters on weight loss, and sexually transmitted diseases. There were leaflets highlighting the 'Be Well Tameside' campaign which contained the contact details which people could use to receive support for healthier living. A few books on common conditions were available for purchase.

There was a home delivery service. Each delivery was recorded. A signature was obtained from recipients for CDs, but not always for other medicines limiting the information available in the event of a problem. The RP confirmed he would review the delivery process and ensure the delivery SOP was being followed. 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 workflow was organised into separate areas. The dispensary shelves and drawers were reasonably well organised. 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. Higher-risk medicines such as valproate were highlighted for additional checks and counselling. The team were aware of the requirements for a Pregnancy Prevention Programme to be in place for people prescribed a valproate containing medicine in the at-risk group, and that original packs should always be used. The RP said that the pharmacy had carried out an audit and did not currently have any patients in the at-risk group.

The RP was observed measuring methadone solution directly into an unlabelled plastic cup which he gave to a person for supervised consumption. There was no check made by a second competent person and no dispensing audit trail completed, which increased the risk of inaccuracy and limited learning if things went wrong. The RP said he would review this process and ensure medicines were always labelled before being supplied.

Multi-compartment compliance aid packs were assembled in a designated area of the dispensary. Some packs were supplied on a weekly basis. The pharmacy received weekly prescriptions for these packs, but all four packs were assembled, from the first prescription of the month. This potentially increased the risk of errors. The dispenser explained that when the new prescription was received each week, it

was checked against the compliance aid pack and any changes were noted and the pack changed if required. The dispenser confirmed that packaging leaflets were usually included. Medicine descriptions were included on the packaging to enable identification of the individual medicines. Disposable equipment was used. There wasn't a clear audit trail for communications with GPs and changes to medication, which could cause confusion in the event of a query. Cautionary and advisory warnings were missing from the labelling, so people might not have all the information they need to take their medicines safely. Following the inspection, the RP confirmed that a communication sheet had been added to each patient's file, and he had changed the settings on the labeller so that cautionary and advisory warnings were now included.

The MCA explained what questions she asked when making a medicine sale and she knew when to refer the person 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 misusing medicines such as a codeine containing product.

CDs were stored in two CD cabinets which were securely fixed to the 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 stock medicines. Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out regularly and short-dated stock was highlighted. Expired and unwanted medicines were segregated and placed in designated bins. Alerts and recalls were received via email messages. The dispenser confirmed that the RP read and acted on these and retained them in a folder in the pharmacy, for reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to the equipment and facilities they need for the services they provide. But the pharmacy could do more to make sure that all the equipment it uses is fit for purpose.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date reference sources. The RP said he frequently referred to the electronic British National Formulary (BNF) and the electronic medicines compendium (eMC) websites. There were two clean medical fridges for storing medicines. Minimum and maximum temperatures were being recorded, but neither of the thermometers had been re-set and the minimum and maximum for both fridges were well outside the required range. Both thermometers were re-set during the inspection and the fridges remained within range. The RP confirmed that he would closely monitor the temperatures of the two fridges and ensure pharmacy team members accurately recorded the minimum and maximum temperatures and reset the thermometers after each reading.

Neither the electronic point of sale (EPOS) till nor the card machine were operational, and the pharmacy operated a cash only system. The problems with these systems had been ongoing for at least twelve months. The price of products in the retail area were written onto the packaging by hand, and a member of staff used a calculator to add up the bill when necessary. This was time consuming and reduced efficiency in the pharmacy. All other electrical equipment appeared to be in working order and had been PAT tested.

A sharps bin and other equipment required for the covid, and flu vaccination services were available in the consultation room. A poster was on display with information on the management of anaphylaxis, and adrenaline injections were available. There was suitable blood pressure testing equipment. An otoscope was available for use in the Pharmacy First service. There was a selection of clean glass liquid measures with British standard and crown marks, but some plastic measures were in use which were not accuracy marked and were more difficult to keep clean. The RP confirmed that he had ordered some new glass measures to replace these. Separate measures were marked and used for methadone solution. The pharmacy had a range of equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs.

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.