General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Withington Pharmacy, 8 Copson Street, Withington, MANCHESTER, M20 3HE

Pharmacy reference: 1112286

Type of pharmacy: Community

Date of inspection: 08/02/2024

Pharmacy context

This extended hour community pharmacy is situated in a suburban residential area, serving the local population. It mainly prepares NHS prescription medicines. The pharmacy orders people's repeat prescriptions on their behalf. A large number of people also receive their medicines in weekly multi-compartment compliance packs to help make sure they take them safely. The pharmacy provides other NHS services including emergency hormonal contraception (EHC) and substance misuse treatments. It also has a home delivery service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 manages its risks reasonably well. The pharmacy team follows written instructions to help make sure it provides safe services. The team reviews its mistakes which helps it to learn from them. Pharmacy team members receive training on protecting people's information, and they understand their role in protecting and supporting vulnerable people. And the pharmacy keeps the records it needs to by law.

Inspector's evidence

The pharmacy had written procedures that were regularly reviewed. These covered safe dispensing, the responsible pharmacist (RP) regulations and controlled drugs (CDs). Records indicated that staff members had read and understood the procedures relevant to their roles and responsibilities. Some of the written procedures had not been reviewed for several years, so they may not contain the most up to date information.

The dispenser and checker initialled dispensing labels for prescription medicines that the pharmacy prepared and supplied. This helped to clarify who was responsible for each prescription medication supplied and assisted with investigating and managing mistakes.

The pharmacy team recorded mistakes it identified when dispensing medicines, and it addressed each of these incidents as they arose. The team members regularly reviewed these records collectively, so they could consider learning points. The records did not always include details indicating why the team thought each mistake happened. So, the team might miss additional learning opportunities to identify trends and mitigate risks in the dispensing process.

The pharmacy had written complaint handling procedures, so staff members knew how to respond to any concerns. But there was no publicly displayed information explaining how people could make a complaint, so people may feel less encouraged to raise a concern. The pharmacy had not completed a patient survey since the pandemic.

The pharmacy had professional indemnity cover for the services it provided. The RP displayed their RP notice so the public could identify them. The pharmacy kept records of the RP in charge of the pharmacy, as required by law. It kept records for the medications prepared under a specials license or unlicensed medicines that it had supplied. But these records did not always include the patients details, which may be needed in the event of a query. The pharmacy kept two registers for private prescriptions. Private prescriptions from a local dental surgery were recorded in an electronic register, and all remaining prescriptions were recorded in a paper register.

Randomly selected electronic CD registers indicated that the pharmacy kept records for CD transactions, as required by law. The team regularly checked its CD running balances and made corresponding records, which helped it to identify any discrepancies. One randomly selected running balance checked during the inspection was accurate. Records of CDs returned to the pharmacy for safe disposal were kept.

Team members had completed training on protecting patient information, and they secured and destroyed any confidential papers. They each had their own security card used to access NHS electronic

patient data, or they had applied for one, and they used passwords to access this information. Information about the pharmacy's privacy policy was obscurely displayed. So, people may have more difficulty finding out how the pharmacy protects their data.

All the pharmacists who worked regularly at the pharmacy, had level three safeguarding accreditation. The pharmacy had written procedures for safeguarding children and vulnerable adults, and it had the local authority's safeguarding policy and procedures and contact details.

The pharmacy liaised with the GP practice about people using the compliance pack service, which included assessing whether they needed to be limited to seven day's medication per supply to avoid them becoming confused. But it did not keep corresponding records of these assessments to demonstrate this.

The pharmacy kept records of the care arrangements for people using compliance packs, including their next of kin's or carer's details and any special arrangements about who collected and when to supply their medication. This meant the team members had easy access to this information if they needed it urgently.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to provide safe and effective services. Team members work well together. The pharmacy does not always progress staff training in a timely fashion. So, team members may delay obtaining the knowledge and skills relevant to their role.

Inspector's evidence

The staff present included the RP, who was one of the regular pharmacists, the superintendent pharmacist who acted as a second pharmacist over different parts of the working day from Monday to Saturday, and three trainee dispensers. The pharmacy's other staff included three regular locum pharmacists, three trainee dispensers, one of who was a medicine counter assistant (MCA), two pharmacy undergraduates who worked on the weekend, and two delivery drivers.

The pharmacy had enough staff to comfortably manage its workload. The team usually had repeat prescription medicines ready on time, including compliance packs. The pharmacy's footfall varied throughout the day but the team effectively managed people visiting the premises, including during peak periods.

Staff worked well both independently and collectively and they used their initiative to get on with their assigned roles and they required minimal supervision. They effectively oversaw the various dispensing services and had the skills necessary to provide them. Two of the dispensers were trained and managed the compliance pack service under the regular pharmacist's supervision. The other dispensers were being trained to provide this service, which should help to improve the pharmacy's overall efficiency to provide services.

All the trainees were completing a dual MCA/dispenser training course. Most trainees' training was progressing well. But one trainee, who had been on the course for eight months, had only completed two out of six modules. The superintendent pharmacist explained that this was due to a significant increase in post COVID-19 service demand and challenges recruiting staff and retaining locum pharmacist. This limited the opportunities for the trainee to progress their training and the superintendent to support them. The pharmacy's staffing was now more stable, so the training issues were being addressed

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and suitable for the pharmacy's services. It has a private consultation room, so people can have confidential conversations with pharmacy team members and maintain their privacy.

Inspector's evidence

The pharmacy was situated in a traditional retail unit. The level of cleanliness was appropriate for the services provided. Shop and dispensary fittings were suitably maintained. The retail area and counter could accommodate the maximum number of people who usually presented at any single time. The premises had enough space so that the staff could dispense medicines safely. And the pharmacy had a separate area for preparing compliance packs.

The team could secure the pharmacy to prevent unauthorised access. The consultation room provided the privacy necessary to enable confidential discussion. But its availability was not prominently advertised, so people may not always be aware of this facility.

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 Monday to Saturday from 8.30am to 9pm, and Sunday 8am to 6pm. Staff could see anyone who needed assistance entering the premises, so it was easily accessible.

The pharmacy had written procedures that covered the safe dispensing of higher risk medicines including anti-coagulants, methotrexate, and lithium, but not for valproate. Staff had read guidance and a poster displayed in the dispensary on safely preparing valproate had been signed by all staff members to confirm they had read it.

The team had recently checked for any people at risk who were prescribed valproate, and it only supplied this medication sealed in the original packaging unless otherwise appropriate. The pharmacy had informally risk assessed at-risk patients prescribed valproate who used a compliance pack via discussions with the GP. The superintendent did not know where to obtain the booklets which should be given to anyone receiving valproate for the first time, as stated under MHRA guidance. They subsequently provided these to the at-risk patients. Valproate stock had the MHRA approved advice cards for people in the at-risk group attached.

The pharmacy limited offering the compliance pack service to people until an existing service user ceased using the service. This helped to make sure the service remained manageable. In the interim, the pharmacy accepted temporary patients who needed the service urgently.

The team had a scheduling system to make sure people received their compliance pack on time. It kept a record of people's current compliance pack medication that also stated the time of day they were to take them. This helped it effectively query differences between the record and prescriptions with the GP surgery and reduced the risk of it overlooking medication changes. The pharmacy also kept records of verbal communications about medication queries or any changes for people using compliance packs. The team issued the patient information leaflet with each compliance pack medication, which included a description of each medication. This helped people to identify them.

The team prompted people to confirm the repeat prescription medications they required, which helped the pharmacy limit medication wastage. The pharmacy retained electronic and paper records of the requested prescriptions. This meant the team could effectively resolve queries if needed and people received their medication on time .

The team immediately informed and kept the patient updated about any owed prescription medication, and it offered to deliver the item. The pharmacy suggested an alternative medication to the GP if necessary. These arrangements helped to make sure people maintained their treatment. The pharmacy routinely recorded all owed medicines on the patient's medication record. It did not always give people a written note for their owed medication if it was confident that the product would be available shortly.

The team had methadone instalments ready in advance of people presenting for them, which helped the pharmacy to manage its workload. The pharmacy prepared instalments for more than one day in divided daily doses. This supported people to take an accurate dose. The team had advised patients who preferred to have their methadone instalment in a single bottle to receive it in daily divided doses, and it provided a measuring cap. However, the pharmacy did not keep records of this advice to demonstrate that it had encouraged patients to take the most accurate dose possible.

Pharmacy team members understood what questions to ask people when selling medicines to makes sure requests were appropriate. They were trained to refuse to sell over the counter (OTC) opiate-based pain relief medication to people who repeatedly requested these products and they advised them to consult their GP.

The pharmacy used baskets during the dispensing process to separate people's medicines and help organise its workload. The team usually left a protruding flap on medication stock cartons to signify they were part-used. This might be easily overlooked and could increase the risk of not selecting the right quantity when dispensing and supplying medication. The superintendent pharmacist subsequently explained that the team had started permanently marking stock cartons and monitoring this.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers and stored them in an organised manner. The pharmacy had suitably secured CD cabinets. It quarantined obsolete CDs, and it used destruction kits for denaturing unwanted CDs. Team members monitored and recorded the refrigerated medication storage temperatures.

Records indicated that the team had checked the expiry dates for prescription medicine stock in January 2023 and June 2023. The superintendent pharmacist explained that the team had checked all the prescription and over the counter medicine stock every three months, but they were unable to locate the supporting records. The superintendent later confirmed that they had found these records.

The team had an efficient alphabetical storage system for people's bags of prescription medication. This meant it could quickly retrieve people's medicines when needed.

The pharmacy only accepted people onto the delivery service who lived within a fixed radius of it. This had helped to avoid any significant delay in supplying delivered medicines. The team kept records of prescription medicines that it delivered to people, and it obtained the recipient's signature for CD deliveries. This helped it to address any queries.

The pharmacy took appropriate action when it received alerts for medicines suspected of not being fit for purpose, and it kept supporting records that confirmed this. However, it only kept these records for one year, which may lead to difficulties in the event of a query. The team had facilities in place to dispose of obsolete medicines, and these were kept separate from stock.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has the equipment and facilities that it needs for the services it provides. The equipment is appropriately maintained and used in a way that protects people's privacy.

Inspector's evidence

The pharmacy team regularly cleaned different sections of the premises. It kept the dispensary sink clean and it had hot and cold running water and an antibacterial hand-sanitiser. The team had a range of clean measures and a separate set for preparing methadone supplies. So, it had facilities to make sure it did not contaminate the medicines it handled and could accurately measure and give people their prescribed volume of medicine. The team had access to the British National Formulary (BNF) online, which meant it could refer to pharmaceutical information if needed.

The pharmacy team had facilities that protected peoples' confidentiality. It viewed people's electronic information on screens not visible from public areas and regularly backed up people's data on its patient medication record (PMR) system. So, it secured people's electronic information and could retrieve their data if the PMR system failed. And it 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.