General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Westwood Pharmacy Ltd, 69-71 Featherstall Road North, OLDHAM, OL9 6QB

Pharmacy reference: 1125265

Type of pharmacy: Community

Date of inspection: 29/07/2019

Pharmacy context

This is a community pharmacy located among retail outlets on a main road outside the town centre. It serves a mainly Asian community with many non-English speakers. The pharmacy dispenses NHS prescriptions and has a busy private travel clinic providing antimalarials and a wide range of vaccinations.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not have adequate standard operating procedures for the services it provides.
		1.6	Standard not met	The pharmacy's records are not legally compliant. Records including the RP log and private prescriptions records are incomplete, and records of unlicensed medicines obtained as 'specials' were not available.
		1.7	Standard not met	The pharmacy does not adequately separate and destroy confidential waste.
2. Staff	Standards not all met	2.2	Standard not met	One member of the pharmacy team is not qualified or appropriately trained for the activities they carry out.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.1	Good practice	People can access a wide range of services, and health and wellbeing are promoted to the community.
		4.2	Standard not met	The pharmacy assembles and checks multi-compartment devices without reliable audit trails and stores them unlabelled and unsealed for extended periods.
		4.3	Standard not met	Stock medicines are poorly organised and the pharmacy cannot provide assurance that the temperature of one of the medical fridges is appropriately monitored.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

The pharmacy does not have written procedures available, so team members may not have a clear understanding of the procedures, their roles and responsibilities and who is accountable for what. This introduces unnecessary risks into the way it delivers the services. Pharmacy team members do not make full records of their mistakes, so may be missing out on some learning opportunities. The team generally keeps the records required by law, but some details are missing or incorrect, which could make it harder to understand what has happened if queries arise. Confidential information is not always disposed of appropriately which risks breaching patient confidentiality.

Inspector's evidence

There were no standard operating procedures (SOPs) on the premises for the services provided. The pharmacist superintendent (SI) said she must have taken them home to review them and left them there. Subsequent to the inspection the SI stated that she had not been able to locate the file of SOPs and recalled the last time she saw them was in March 2019 when she was completing an information governance (IG) review. The dispenser confirmed he had seen and read the SOPs, but an assistant who had worked in the pharmacy for a year, and whose main role was to assemble multi-compartment devices, had not seen any written procedures. She said that she knew what procedures to follow because the SI had explained the processes to her when she trained her. There was no procedure on the premises outlining the roles and responsibilities of members of the pharmacy team or the identification of those who were competent to perform certain tasks such as giving advice about medicinal products. Members of the team were wearing uniforms but nothing to indicate their role or level of training. So, this might be unclear to visitors to the pharmacy including locum pharmacists. The name of the responsible pharmacist (RP) on display was not correct, which could cause confusion in the event of a problem or query, but this was remedied by the SI when pointed out.

The SI said there had been no dispensing errors but said she would report any that occurred on a national reporting website. She said incidents such as a fridge line missing from a patient's delivery, would not be recorded. This risked missing trends and identifying learning opportunities. There had been around six near misses recorded during 2019, but 'possible causes', 'things to consider' and 'action taken' had not been completed on the log. There had not been any formal review or analysis of near misses during 2019. The dispensary shelves were untidy with forms and strengths of some medicines mixed together, increasing the risk of picking errors. The SI outlined some interventions which had been made to reduce the risk of errors such as moving gabapentin products to separate shelving in the dispensary to give them more space, so different strengths and forms could be clearly separated. However, this area had also become untidy and disorganised.

The dispenser described how he would deal with a customer complaint which was to attempt to resolve the situation himself but involving the pharmacist or pharmacy manager if required. There was a notice displaying the pharmacy's complaint's procedure and how to raise a concern, but it was mostly covered by another poster. The SI said there had been no official complaints but most feedback was that people were not getting continuity of brands, which was due to manufacturer supply problems and outside the pharmacies control. She said where possible the preferred brands were recorded on the patient's medication record and the team tried to obtain these. She said this was particularly important as many

of the regular patients could not read, so they used the packaging to identify their medication. The SI confirmed that customer satisfaction surveys were carried out, but the results were not available in the pharmacy and the most recent survey on www.NHS.uk. website was from 2017.

Insurance arrangements were in place. A current certificate of professional indemnity insurance was available in the pharmacy. The SI confirmed that it covered all the activities carried out in the pharmacy. Three private prescriptions which had been supplied earlier in the month had not been recorded in the designated private prescription book. One of the private prescriptions did not contain the date of prescribing, so may not have been supplied in line with legal requirements. The RP record was incomplete and inaccurate, so did not provide a reliable audit trail. Most start times recorded for the RP were after the pharmacy's opening time of 9.30am, and on most days the time at which the RP ceased their duties had not been recorded. The SI said this was because the RPs were forgetting to sign in straight away when they arrived in the pharmacy and not signing out when they left. The dispenser said records were maintained for medicines ordered from 'Specials' including the name and address of the person receiving the medication and a copy of the medication label, but these records could not be located.

The SI confirmed that members of the pharmacy team had read and signed a confidentiality clause as part of their contract of employment, but these were not available in the pharmacy. She explained that all team members had read a training booklet on confidentiality which was also available on line. She said that confidential waste was collected in a designated place and then shredded. Confidential waste (medication labels and repeat prescription slips) was seen in four different general waste bins including a bin bag which was in the middle of the retail area. The SI said she could not understand why this occurred and explained that it was not usual practice and she had stressed the importance of confidentiality to the team. The delivery driver had a basic understanding about patient confidentiality, but the design of the delivery sheet allowed recipients to see other patient's names and addresses. The SI confirmed verbal consent was received when summary care records (SCR) were accessed and this was recorded at the time she accessed them.

The SI had completed centre for pharmacy postgraduate education (CPPE) level 2 training on safeguarding and her certificate was available. She said the two qualified dispensers had completed level 1, although the dispenser on duty was not able to verify this. The dispenser and the delivery driver said they would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. The SI confirmed she had the details of who to report concerns to in the local area. The pharmacy had a chaperone policy, and this was highlighted to patients.

Principle 2 - Staffing Standards not all met

Summary findings

The pharmacy has enough staff to manage its workload. But training is not well organised, and some members of the team are doing tasks that they aren't trained or qualified to do. Whilst the pharmacy team has opportunities to discuss issues informally, these communications are not always recorded, so it may not always act on any issues raised.

Inspector's evidence

There was a pharmacist (SI), an NVQ2 qualified dispensers (or equivalent), an untrained assistant and a delivery driver on duty at the time of the inspection. The staff 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. Absences were covered by re-arranging the staff rota. The pharmacy manager was not present at the inspection. He was a qualified dispenser and assisted in the dispensary when necessary. There was a current vacancy for a part time dispensing assistant for Saturdays. The SI worked most days in the pharmacy, but often for half a day only. Locum pharmacists worked the remaining hours. A locum pharmacist arrived towards the end of the inspection.

The SI confirmed she was fully trained to carry out the vaccinations and travel PGDs following completion of face to face and refresher training, including treatment of anaphylaxis. She said she kept up to date by reading resources provided by the National Travel Health Network and Centre (NaTHNaC). The pharmacy had recently introduced a new service 'new blood test centre' which was a private service which could include up to 200 different blood tests. For example, thyroid function and diabetes. This was carried out by the assistant who was a qualified phlebotomist. There had been two tests carried out so far, one of which identified that a person had got diabetes and was referred to their GP.

The untrained assistant had worked in the pharmacy for around a year. She did not have any qualifications in pharmacy and was not enrolled onto any accredited counter assistant or dispensing assistant courses. Her duties included assembling multi-compartment devices and assisting in the dispensary, which she was not qualified to do. The dispenser said he had completed some ongoing training. For example, Epilim and pregnancy prevention programme, repeat dispensing, changes to generics, Alliance and AAH stock management. But this had not been recorded and the pharmacy team did not have regular protected training time.

The pharmacy team had informal discussions about performance and development and other issues were discussed as they arose, but these discussions were not recorded, so issues raised might not be addressed. The dispenser said he felt there was an open and honest culture in the pharmacy and said he would feel comfortable talking to the SI or pharmacy manager about any concerns he might have. He said the staff could make suggestions or criticisms informally. For example, they decided to always ensure the prescriptions that were going to be delivered were given priority, so the delivery driver could start the deliveries on time each day.

The SI 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 because she felt it

was inappropriate. She said targets were not set for herself and she did not set targets for locum pharmacists, so they were not put under any pressure.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide an adequate environment for people to receive healthcare. But the use of the retail area to store excess stock and waste detract from the professional image. The pharmacy team use a consultation room for services and if people want to have a conversation in private.

Inspector's evidence

The pharmacy was next door to a Subway fast food restaurant, which was also owned by the SI and her husband. The pharmacy premises including the shop front and facia were in good repair. The retail area contained boxes of stock, empty plastic tote trays, empty cardboard boxes, bin bags of general waste and a broken shredder. This presented a poor professional image and created a potential health and safety hazard. The SI said they had been having a clear out at the weekend and the dustbins had not been emptied which was the reason the waste was in the middle of the retail area. There was a waiting area with one chair. The temperature and lighting were adequately controlled. The SI and her husband owned the building and any maintenance problems were dealt with by them, using local tradesmen. For example, a carpenter was called to repair the consultation room door when it was not closing properly.

Excess stock and some medicine containers were stored in a separate stockroom on the first floor which was fitted with a digital lock to prevent unauthorised access. Staff used the WCs shared with Superdrug staff. There were wash hand basins 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. The SI was observed washing her hands before carrying out vaccinations and wiped the desk in the consultation room with antibacterial wipes. The consultation room was uncluttered, reasonably clean and professional in appearance. The availability of the room was not highlighted but was used when carrying out the services and when customers needed a private area to talk. The dispensary was in a reasonable state of repair and cleanliness although the flooring was damaged in some areas and the dispensary shelves were very full.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy offers a range of healthcare services which are easy for people to access. The pharmacy team members engage people in quality conversations about their health and they work hard to help improve the health and wellbeing of people living in the local The pharmacy gets its medicines from reputable sources and generally manages them safely. But stock medicines are poorly organised and one of the fridge’s temperature is not properly monitored, so the pharmacy cannot show that it stores vaccines in appropriate conditions. And the pharmacy team does not prepare and store multi-compartment devices appropriately which could increases the risk of errors.

Inspector's evidence

There was a step up to the front door of the pharmacy. There was a step free access to the Subway and an interconnecting door between the two units. And it was possible for customers to enter with prams and wheelchair users via this route. Not all the services provided by the pharmacy were advertised in the pharmacy, so people might not realise that they were offered. There was a range of healthcare leaflets and some posters advertising local services. There was a health zone containing some information about breast screening. Members of the pharmacy team were clear what services were offered and where to signpost to a service not offered. For example, needle exchange.

The pharmacy staff were multilingual speaking different dialects of Bengali which could assist most of the non-English speaking patients in the community. There were some leaflets in Bengali, but the SI explained that most of the patients would not be able to read or understand the particular dialect used in the leaflets, and the most effective way of communicating with the patients in the community was visually or by spoken word. She gave lots of examples of how she had helped patients from the community with health problems and compliance issues. She helped a non-English speaking man during the inspection who was confused about his medication for diabetes and his blood sugar was very high. He had been prescribed insulin for the first time but did not know when and how much to use. The SI liaised with the patient, his GP and the diabetes nurse about the medication and explained that poor communication and the language barrier had caused the confusion. The SI said the pharmacy team frequently liaised with other health professionals on behalf of the patients. For example, the local GP practice, opticians and chiropractors to improve outcomes for patients. She said this was very time consuming and not usually recorded anywhere as she did not have time to record all the times she intervened. The SI worked with the community centre and mosque teaching people about pharmacy, prescriptions and the potential dangers of medicines if not used properly. She gave people advice about diabetes, healthy living, diet and encouraged use of the local gym.

Current Patient Group Directives (PGDs) were in place for antimalarials and vaccinations used in the travel clinic, including Cholera, Rabies, Hepatitis A and B, Typhoid, Japanese Encephalitis, Yellow fever and MMR. The SI carried out several vaccinations per day. The service took place in the consultation room and the appropriate equipment was in place including adrenaline injections, hand sanitizer gel and sharps bins. The SI retained full details of the vaccinations administered and a copy of the patients

consent.

The pharmacy offered a repeat prescription ordering service and patients were contacted before their prescriptions were due, to check their requirements. This was to reduce stockpiling and medicine wastage. There was a 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 limited in the dispensary, but the work flow was organised into separate areas with a designated checking area. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. 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. A note was written on the prescription if it contained a fridge line or CD, or if counselling was required, so this could be actioned at hand out or prior to delivery. INR records were not requested or recorded for patients taking warfarin. There was some recording of referral to GPs and interventions. For example, a patient who had been prescribed Brilique for more than 12 months. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out and one patient in the at-risk group had been identified. The SI had discussed this with the patient's GP and the patient's carer had been involved in the discussion about pregnancy prevention.

Around 50 patients received their medication in multi-compartment devices. Trays for around four or five patients had been made up on Saturday and left unlabelled and unsealed over the weekend. This was not in line with labelling regulations and increased the risk of mistakes. The SI explained that this was not usual practice and they would normally be labelled, checked and sealed on the same day. There was only a limited audit trail for changes to medication in the devices, so it was not always clear who had confirmed the changes and the date the changes had been made. A dispensing audit trail had not been completed for the trays completed on Saturday. Medicine descriptions were not completed to enable identification of the individual medicines and packaging leaflets were not usually supplied, despite this being a mandatory requirement. Disposable equipment was used.

The dispenser knew what questions to ask when making a medicine sale and said he would relay the information to a pharmacist or the other dispenser as he had not completed a medicine counter assistant training course. The dispenser was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if he suspected a customer might be abusing medicines such as a codeine containing product.

CDs were stored in a CD cabinet which was securely fixed to the wall. 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 were two medical fridges in the dispensary. Both were very full, untidy and disorganised, making it more difficult to find products, and the fridge door would be open for longer than necessary, compromising the fridge temperature. The smaller fridge was being used to store vaccines and its minimum and maximum temperatures were not being monitored. It was recording a maximum temperature of 13° Celsius and the current temperature was 9.8^{o} Celsius. The thermometer was reset and remained around 8° Celsius for the rest of the inspection. The temperature of the other fridge was being monitored daily and was within range.

Recognised licensed wholesalers were used for the supply of medicines. No extemporaneous dispensing was carried out. The pharmacy was not compliant with the Falsified Medicines Directive (FMD). They

had the required hardware and the software and were registered with SecureMed but had not started scanning to verify or decommission medicines. The SI said she would discuss it with the pharmacy manager as he was still working out the best way to proceed. Dispensary shelves were full and not very well organised. Date checking was carried out but not always documented. Some short dated stock had been highlighted and 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. These were read and acted on by a member of the pharmacy team and then filed, recording what action has been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely.

Inspector's evidence

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

There were two medical fridges for dispensing purposes. A third fridge was in the wholesale dealing area. All electrical equipment appeared to be in good working order.

There was a small selection of clean glass liquid measures with British standard and crown marks. 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. Some medicine containers were stored uncapped which risked 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. 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.