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: 18/02/2020

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 it has a busy private travel clinic providing antimalarials and a wide range of vaccinations.

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	4.1	Good practice	People can access a wide range of services, and health and wellbeing are promoted to the community.
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 acts to improve patient safety. It completes the records that it needs to by law and asks its customers for their views and feedback. The team has written procedures on keeping people's private information safe and team members understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

There were up-to date standard operating procedures (SOPs) for the services provided and roles and responsibilities were outlined in the SOPs. They had been recently reviewed, but some members of the pharmacy team had not yet signed to say they had read and accepted the changes. The pharmacist superintendent (SI) confirmed the team were in the process of working through them. 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 SI was working as the responsible pharmacist (RP) and her name was on display, in line with RP regulations. A daily record of checks was completed by the trainee dispenser which included making sure the retail area was free of hazards and clean, the fridge temperature had been recorded, staff were using their own electronic prescriptions service (EPS) smart cards and date checking had been completed.

Near misses were recorded on a log and reviewed by the pharmacy manager as part of a monthly patient safety report. There had been a medication safety meeting in January and a notice encouraged members of the team to read the monthly patient safety report. The pharmacy had recently installed 'Pharmsmart' and there was a facility to report near misses and dispensing errors electronically on this. The team were getting used to using the new system and around five near misses had been recorded on it. The SI said there had been no dispensing errors recently, but said she would report any that occurred on the National Reporting and Learning System (NRLS) as well as on Pharmsmart. A recent near miss had been recorded on the NRLS as the pharmacy manager felt it was good to share as much as possible with others. The SI outlined some interventions which had been made to reduce the risk of errors, such as moving amlodipine away from amitriptyline. The pharmacy manager explained that he had liaised with the pharmacy's main wholesaler and requested them not to supply certain brands because of their similar packaging, which increased the risk or errors. For example, different brands were obtained for the different strengths of amlodipine, to emphasise the difference. He had also asked that they did not send any medicines with less than 12-months expiry dates to reduce the risk of short dated medicines being supplied. There was a patient safety file which included articles from various trade magazine which were shared with the pharmacy team, and the pharmacy manager said he would share them with other pharmacies in the community. For example, an article by the National Pharmacy Association (NPA) highlighting the top look-alike and sound-alike drugs (LASAs). The pharmacy manager said he asked locum pharmacists for incidents they had come across in other pharmacies to share learning. One pharmacist had highlighted an issue with promethazine hydrochloride and promethazine teoclate as they could be confused, so they had highlighted this on a notice in the dispensary.

There was a complaints SOP but there was nothing on display highlighting the complaints procedure or who to raise concerns with, so people might not know how to do this. The pharmacy manager confirmed that customer satisfaction surveys were carried out annually and one had just been

completed. The results of this survey were not yet available, but the results from the 2018/2019 survey were included on www.NHS.uk. website. Areas of strength (100%) included 'The service you received from the pharmacist', 'The service you received from the other pharmacy staff' and 'Providing advice on health services or information available elsewhere'. An area identified which required improvement (2.9% dissatisfied) was 'Comfort and convenience of the waiting areas'. The pharmacy's published response was 'Review waiting areas and consider if changes can be made'. The retail area was very small and there was only one chair available for people waiting for services.

Insurance arrangements were in place. A current certificate of professional indemnity insurance was available in the pharmacy. Private prescription records, the controlled drug (CD) register and the RP record were electronic and were appropriately maintained. Three CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately. Appropriate records were maintained for medicines ordered from 'Specials'.

Members of the pharmacy team had read and signed confidentiality clauses and these were available in the information governance (IG) file. There was a data security and IG policy, and a physical security risk assessment had been completed. Confidential waste was collected in a designated bin and shredded at the end of each day. A privacy statement was on display, in line with the General Data Protection Regulation (GDPR). The design of the record sheet used for deliveries to people's homes allowed recipients to see other people's names and addresses. The SI said the delivery driver covered other people's details up when possible, to minimise this. Verbal consent was received when summary care records (SCR) were accessed and this was recorded at the time the pharmacist accessed them.

There was a 'Safeguarding children and vulnerable adults' SOP. The SI, pharmacy manager and one of the dispensers had completed centre for pharmacy postgraduate education (CPPE) level 2 training on safeguarding. The trainee dispenser had completed level 1. One of the dispensers explained he would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time and then report it to the Oldham multi-agency safeguarding hub (MASH). Their details were in the SOP and on display in the dispensary. The dispenser explained that if he considered the concern was urgent then he would immediately contact emergency services such as the police. The pharmacy had a chaperone policy, and this was highlighted to patients. 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, and they get some ongoing training to help them keep up to date. The team members work well together, and they are comfortable providing feedback to their managers.

Inspector's evidence

There was a pharmacist (SI), two NVQ2 qualified dispensers (or equivalent) and a trainee dispenser on duty at the time of the inspection. One of the qualified dispensers was the pharmacy manager and he assisted in the dispensary when necessary. 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. There was also a Saturday assistant on the pharmacy team who carried out administration tasks such as filing and answering the telephone. The SI worked most days in the pharmacy and there was a regular locum pharmacist who worked the remaining time that the pharmacy was open.

The SI was fully trained to carry out the vaccinations and travel Patient Group Directions (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 team was given training time when it was convenient, but they did not have regular protected time. There were training records for one of the dispensers showing he had completed training on the Falsified Medicines Directive (FMD), diabetes, SCR, medicine counter and travel clinic call handling within the last year. The trainee dispenser had not carried out this additional training as she was concentrating on her accredited dispensing course, which was available online. She completed the practical aspects of the course at work, but the written parts were carried out at home, when she had more time, as she worked part-time. A formal system to discuss performance and development had been introduced, and a skill matrix had been recently completed with each member of the team as part of the appraisal process. Day-to-day issues were discussed as they arose. A dispenser said he felt there was an open and honest culture in the pharmacy and that 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, he thought restricting the main wholesaler to only supplying medicines with more than 12-months expiry dates meant that sometimes stock was unavailable, and the pharmacy was in danger of running out of medicines. So, he discussed this with the pharmacy manager and asked if this could be relaxed with fast moving lines such as levothyroxine, as a shorter expiry day would not be a problem. This suggestion was acted on for certain lines. There was a whistleblowing policy.

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 containing codeine because she felt it was inappropriate. She said they were not a target driven organisation and she sometimes refused to carry out vaccinations, when she did not feel they were necessary.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a professional environment for people to receive healthcare services. 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 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. 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.

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. There was a WC with a 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 consultation room was uncluttered, clean and professional in appearance. The availability of the room was not signposted but it 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, and a cleaning rota was in use.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a wide range of healthcare services which are easy for people to access. The pharmacy team members work hard to help improve the health and wellbeing of people living in the local community. The pharmacy sources, stores and supplies medicines safely. And it carries out appropriate checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

There was a step up to the front door of the pharmacy, but there was step free access to Subway next door and an interconnecting door between the two units. It was possible for customers with prams and wheelchair users to enter 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 stroke prevention and sepsis. Members of the pharmacy team were clear what services were offered and where to signpost to a service not offered.

The pharmacy staff were multilingual speaking different dialects of Bengali which assisted most of the non-English speaking patients in the community, and some leaflets contained Bengali translations. The SI frequently liaised with patients' GPs to improve outcomes and the pharmacy team worked with the local community and mosque, teaching people about pharmacy and medicines. The pharmacy manager said he and the SI were working out what advice to give people planning to take part in Hajj and Umrah pilgrimages about the Corona virus as there would be large numbers of people from around the world. The team gave people advice about diabetes, healthy living, diet and encouraged use of the local gym. Around 82 people had been included in an audit of patients with diabetes and 34 of these referred for retinopathy eye or foot tests, as they had not had one in the last 12 months. Some people preferred specific brands of medicines, especially if they could not read English as they recognised their medicine by the pack colour. Preferences for specific brands were recorded on the patient's medication record and the team tried to always obtain these.

Current 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 (measles, mumps and rubella). The SI carried out several vaccinations per day and around 200 meningitis vaccination each year as people prepared to travel for Hajj and Umrah. Hepatitis B vaccinations were provided to students at the local dental college and hepatitis A and B to some employees of the local council. 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. There was a SOP on infection control and the SI was observed washing her hands before carrying out vaccinations and wiping the benches before preparing vaccinations. Patients were provided with a record of the vaccination and a certificate for some vaccinations, and asked to give a copy of the record to their GP. The pharmacy had introduced '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 trainee dispenser who was a qualified phlebotomist. The SI said demand for this service had been low with only around six tests being carried out so far, mainly for Hepatitis B.

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. The SI explained that most people received their medication by delivery, so if counselling was required she would phone the patient and speak to them over the telephone. One or two people had been counselled as part of an audit on lithium. INR records were requested when warfarin was dispensed, but the SI said most people were reluctant to provide this information as they believed it to be their GP's role to monitor them. The team were aware of the valproate pregnancy prevention programme. An audit had been carried out and three patients in the at-risk group had been identified. The SI had discussed pregnancy prevention with these patients and recorded in on their patient medication record (PMR).

Around 50 patients had previously received their medication in multi-compartment compliance aid packs, which created a heavy workload and space commitment, and the pharmacy was reaching its limit of being able to manage the number safely. The number of patients had been recently reduced to around 30, following assessments to see if a compliance aid pack was the most appropriate intervention for their requirements. It was discovered that many of these people had been given compliance aid packs for convenience, rather than because they needed them. The SI had decided to dispense original packs for the 20 patients who didn't require compliance aid packs, placing the original packs in morning or evening 'pouches' to help the patient understand and remember their regimen. There was a partial audit trail for changes to medication in the multi-compartment compliance aid packs. The date the change had been made was usually recorded, but it was not always clear who had confirmed the change. A dispensing audit trail was completed. Medicine descriptions were not usually completed making it harder to identify individual medicines, but packaging leaflets were usually supplied, which contained additional information about the medicines. Disposable equipment was used.

A dispenser explained what questions he asked when making a medicine sale and knew when to refer to the pharmacist. He 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, one was for general stock and the other was used to store vaccines. The minimum and maximum temperatures were being monitored for both fridges and had been in range over the last month. Recognised licensed wholesalers were used to obtain stock medicines. No extemporaneous dispensing was carried out. The pharmacy was compliant with FMD and were scanning to verify and decommission medicines. Dispensary shelves were neat and tidy and well organised. Date checking was carried out and documented. 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 messages on Pharmsmart and the action taken was recorded on this system, providing an audit trail in case of a query.

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. The SI said she used her phone to access the electronic BNF and also used the NHS fit for travel and NaTHNaC websites for the travel clinic. 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. Medicine containers were stored 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. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy. All electrical equipment appeared to be in good working order.

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.