

Registered pharmacy inspection report

Pharmacy Name: Burys Healthcare Pharmacy, 46 Walmersley Road,
BURY, Lancashire, BL9 6DP

Pharmacy reference: 1126145

Type of pharmacy: Community

Date of inspection: 10/11/2021

Pharmacy context

This pharmacy is on a road close to the centre of Bury. It mainly dispenses NHS prescriptions, including some medicines in multi-compartment compliance packs. It delivers some people's medicines to their homes. The pharmacy sells over-the-counter medicines, including some through its website. It provides a substance misuse service, including supervised consumption. The inspection was completed during the COVID-19 pandemic.

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 mostly identifies and suitably manages the risks to its services. It appropriately manages people's private information to keep it secure. Pharmacy team members have sufficient knowledge to help protect the welfare of vulnerable people. They mostly keep the accurate records they should. And they record and discuss some of the mistakes they make when they dispense medicines to reduce the risk of repeating the mistake. The pharmacy has written procedures relevant to the pharmacy's services, however it does not use these in the training of team members. And it doesn't always update them when processes change. So, there is no accurate record of how team members should work.

Inspector's evidence

The pharmacy had made changes to help mitigate risks associated with the COVID-19 pandemic. It had posters up in the window and restricted the number of people accessing the premises at any one time. The pharmacy had hand sanitiser and personal protective equipment (PPE) available for team members. The pharmacist was wearing a face mask and the team member donned a mask once the inspector accessed the dispensing area. The pharmacy didn't have plastic screens up at the counter.

The pharmacy had standard operating procedures (SOPs) held electronically that were relevant to the pharmacy's services. These included SOPs relating to Responsible Pharmacist (RP) regulations, controlled drugs (CDs) and management of multi-compartment compliance packs. But the SOPs didn't have version control, implementation or review dates added to the SOP template. And the pharmacist couldn't locate the team members training records to evidence the team had read the SOPs. The SOPs indicated which team member role could perform which specified task by using different colours within the flow charts in the SOPs. The pharmacist and team member understood their roles and responsibilities and worked within their competence. The team member appropriately gave advice to people and referred queries to the pharmacist when needed. The pharmacy did not use the SOPs as part of ongoing training, instead often relying on individual coaching.

The pharmacy used the near miss error information recorded by the pharmacy's patient medication record (PMR) system. The system used barcode technology when labelling and for the final accuracy check. It recorded any time a team member selected and scanned an incorrect medicine. And it recorded any scanned errors with the final barcode verification and bagging checks. The pharmacist reported that near miss errors had reduced since this PMR system had been introduced and he demonstrated that there had been no recorded errors for that week. The pharmacy didn't run near miss error reports off the system to look for trends. The pharmacy team had stopped completing a separate paper near miss log for other errors, such as incorrect quantity and so did not have a complete record of near miss errors. The team member described how together they discussed any errors and if necessary, made changes such as separating different look-alike and sound-alike (LASA) medicines on the shelves such as prednisolone and propranolol. The pharmacy didn't have a separate form to record dispensing errors and had no records available to show. The team member described how they dealt with any errors in an open and transparent way.

The pharmacy displayed the correct RP notice. It displayed a notice in the retail area informing people how they could provide feedback about the pharmacy's services. The pharmacy had a written procedure to manage complaints. People had the opportunity to feedback by speaking with a member

of the team. And the team member described how they listened to people, so they had the opportunity to address the concern and improve their services for people. The pharmacy had a website, but people could not access the pharmacy's complaints policy or privacy policy on there. The team had not completed formal training relating to information governance (IG) and General Data Protection Regulation (GDPR) and there was no privacy policy displayed in the retail area. The team member demonstrated a good understanding of the importance of confidentiality, giving some good examples. The pharmacy kept people's private information in areas of the pharmacy with no public access and it used a shredder for confidential waste.

The pharmacy had up-to-date professional indemnity insurance. It kept an up-to-date electronic CD register that met requirements. The pharmacy completed checks of the physical quantity of stock against the register approximately monthly. There was evidence of a balance check in October 2021. Of two physical balances checked, both did not match the CD register balance. One mistake was due to the pharmacy not recording an out-of-date medicine in the register. A further three checks matched the register balance. The pharmacy didn't keep a record of the destruction of patient-returned CDs and there were a couple of patient-returned CDs awaiting destruction that were not accounted for in any records. The pharmacy held recent electronic private prescription records, although the records could not be checked for accuracy as the physical private prescriptions were not available. The pharmacy held an electronic RP record, and the entries were complete.

The RP had completed CPPE level 2 safeguarding training. The team member described how they completed safeguarding training as part of another role they held, and they demonstrated a good understanding. They were aware when and how to escalate to the pharmacist.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough suitably skilled team members who have the necessary knowledge to provide the pharmacy's services safely. The pharmacy is willing to listen and act on ideas that team members have to improve ways of working. Team members keep their knowledge up to date in an ad hoc way and receive occasional informal feedback about their performance.

Inspector's evidence

The RP was a director of the pharmacy and regularly worked there, managing the team. A dispenser supported the RP at the time of the inspection. The RP advised that the pharmacy was currently working on reduced staffing due to some self-isolation of some team members. The RP and team member worked well together to manage the workload and engaged with people who came into the pharmacy in a timely manner. They were slightly behind with the dispensing for that day, but it wasn't having an effect on people accessing services. The pharmacy had two full-time dispensers, a part-time dispenser, and a medicines counter assistant (MCA). A driver delivered medicines to people's homes.

The team member described how they individually kept up to date with their learning by reading. They researched any further training themselves, for example accuracy checking training. The pharmacy didn't have formal ongoing training for its team members and relied on the pharmacist keeping them updated with changes. Team members didn't have any training records. The team had received training on the PMR system when it was introduced. This included direct observation of dispensers completing the barcode verification checks. The RP assessed their competency in this way before signing them off to complete this task without direct supervision. The team member felt comfortable asking the director any questions, sharing ideas, and raising any concerns. They felt he listened and addressed any issues. Whilst discussing concerns over the lighting in the prescription collection area, the team member suggested an idea for additional lighting until the issue was fixed. This was agreed and taken forward. The pharmacy didn't have regular formal team meetings and team members didn't have formal appraisals. Feedback was ad hoc as they worked. The pharmacy didn't set any targets for services. The pharmacist kept his knowledge up to date for his continuous professional development (CPD) and professional revalidation. He had recently completed a pharmacist prescribing course and intended to provide an online prescribing service through his website within his competence.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are of an adequate size for the services provided. The pharmacy is suitably secure and hygienic. The team works in an organised way, so it provides services safely even though the pharmacy is quite cluttered. And this means it has reduced space available for dispensing. The pharmacy makes some provision for the team to have private conversations with people. But the consultation room is not suitable for this use.

Inspector's evidence

The pharmacy premises had a small retail area and dispensary. The premises were sufficient for the current workload and footfall, with generally only one person accessing the premises at any one time. The dispensary had limited bench space, a central island helped as the team stored prescriptions awaiting checking there. There was a degree of clutter on the benches. But with separate dispensing and checking areas the team managed the dispensing workload in a safe manner. The pharmacy had limited space to store medicines and some shelving appeared cluttered. It had made some effort to separate different strengths of medicines on the shelves. The pharmacy had a number of tote boxes and cardboard boxes on the floor in the dispensary and back area. There was a safe walkway through the dispensary, so risk of trips and falls were low. The pharmacy had experienced a small flood and the damage was visible on a wall and also the light in the back area was not in use due to this. The maintenance of this was planned but a date was not finalised. The pharmacy stored people's prescriptions awaiting collection in this area and the lighting wasn't sufficient in dim light to easily read people's names and addresses on the bags. The lighting elsewhere on the premises was sufficient. The temperature throughout the premises was suitable with electric heaters available. The pharmacy had toilet and handwashing facilities with hot water available. There was a separate sink for professional use.

The pharmacy had a consultation room with access from both the dispensary and the retail area. The room had not been used during the pandemic and currently wasn't suitable for people to access due to the clutter and items stored in there. The computer in there was not set up for use. The pharmacy didn't have signage indicating its use. The pharmacy had a moveable, medical screen in the retail area so team members could supervise consumption of medicines and have semi-private conversations with people. They kept the external shutter on that side down during the day to help maintain privacy.

The pharmacy had a website, where it advertised its NHS services, sold a small number of medicines including Pharmacy (P) only medicines and it advertised an online prescribing service. It was not clear from the website whether the online prescribing service was operational. It didn't have the required information about the treatment and conditions and although there were questionnaires for two treatments these did not appear active for orders. The RP confirmed the service was not live. This was very misleading for people wanting to access this service. The website did not indicate this area was under construction or that this service would be available in the future. The website indicated codeine linctus was for sale, but out of stock. The pharmacist confirmed that the pharmacy did not sell this either in the pharmacy or through the website.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy has sufficient safeguards in place for the team to manage and deliver its services safely. And it uses barcode technology to support its dispensing processes. The pharmacy obtains its medicines from recognised sources. And it adequately stores and manages them. Team members support easy access to its services by often speaking to people in their preferred language. But some of the information on the pharmacy's website is misleading to the services provided.

Inspector's evidence

The pharmacy had full length windows across the whole front of the premises and double doors that the team opened to allow for pushchairs and wheelchairs. There was a small step up into the premises from the pavement. The team member described how it was easy to see when people required some help. Both the pharmacist and team member spoke additional languages to English, including Urdu. This helped them communicate effectively with people in their preferred language. This was observed during the inspection. The pharmacy delivered medicines to people's homes and it kept a record of the deliveries made in case of queries. During the pandemic, the team followed the NHS SOP and didn't obtain signatures from people on delivery. There had been no reported issues with the process. The pharmacy provided private COVID-19 PCR and antigen fit to fly tests. It had checked that the diagnostic laboratory used was UKAS registered. The pharmacy supplied CE marked tests. People had the option for the pharmacy to post tests to the laboratory, where the results were processed for people. The pharmacist confirmed that team members did not administer the tests in the pharmacy, and the pharmacy did not need UKAS registration.

The pharmacy had separate areas for the dispenser and pharmacist to work. Due to limited bench space the team was observed completing one aspect of dispensing before starting the dispensing of multi-compartment compliance packs. Pharmacy team members used baskets during the dispensing process, to help reduce the risk of error. The pharmacy's PMR system utilised barcode technology. The system held an audit trail of all transactions, recording which team member had completed which task through individual log in. This included the clinical check, picking and labelling, barcode verification, final accuracy check and bagging. The system only released prescriptions for dispensing when the pharmacist confirmed the clinical check was complete. This ensured all required clinical checks were completed. The pharmacist and in certain circumstances, trained dispensers used the system's barcode verification technology in completing the final accuracy check. The pharmacist had trained each dispenser and completed additional accuracy checks on their work, until he signed off the dispenser as competent. But this process and sign off had not been documented. The pharmacist had assessed the risk of using barcode verification for all prescriptions. The RP therefore completed the final check for CDs and higher-risk medicines such as warfarin. He also completed the accuracy check on all non-original pack items and any items that did not have a valid barcode. These decisions had not been documented in the pharmacy's dispensing SOPs. Due to the system's unique log-in by role, if a non-pharmacist attempted to check these prescriptions or complete a clinical check, the system flagged them as not authorised and they could not proceed. The pharmacist was aware of the additional care needed when dispensing valproate to some people. And that the patient alert card details were printed on the manufacturer's packs. He did not have additional cards or stickers available. The PMR system printed additional warning labels when the team dispensed valproate. Team members had not identified if people in the at-risk group were on a pregnancy prevention programme. And they did not

know if people had their annual review with their prescriber.

A dispenser managed the dispensing of medicines into multi-compartment compliance packs. They kept the prescriptions for people who required their medicines weekly separate from those who received their packs monthly. They kept an up-to-date written record of each person's current medicines and the times of administration. The pharmacist and dispenser checked the prescriptions against this record and queried any changes with the prescriber, annotating changes on the written record and PMR. The team labelled the packs with printed backing sheets, and these contained the necessary medicine warning information. The dispenser added the descriptions of the medicines to the printed backing sheets by hand, so people could easily identify medicines in the pack.

The pharmacy had a reasonable number of people receiving their medicines by daily instalments. During the inspection the pharmacist systematically dispensed these prescriptions. Due to the reduced staffing levels the medicines had not all been dispensed before people came to collect their medicines, as they usually would. This did not adversely affect the service provision. The pharmacist described how usually the medicines would be transferred for safe storage along with the prescription.

The pharmacy obtained its medicines from licensed wholesalers. It positioned P medicines away from self-selection so team members could restrict sales. The pharmacist described the process for selling medicines through the website and the checks that he made before sales were confirmed. The pharmacy restricted sales of medicines liable for misuse such as codeine-containing painkillers and promethazine liquid. The number of sales for all medicines through the website were small, this information was re-enforced by the volume of stock the pharmacy held. The pharmacist gave assurance that he identified any repeat orders due to the volume of sales. But the pharmacy didn't have a written SOP or a documented risk assessment for this service. The pharmacist was observed refusing a telephone request for promethazine liquid, signposting the person to their GP.

The pharmacy stored medicines requiring cold storage in a domestic fridge and kept an electronic daily record of fridge temperatures. The records showed the temperature to be in range. The pharmacy team described the date checking process which included using the PMR system expiry date check. As the team member scanned the barcode on the manufacturer's pack, the system read the batch number and expiry date and alerted the team member to any out-of-date medicines. The expiry date and batch number were printed on the dispensing labels of split packs. This allowed the pharmacist to check the expiry dates as part of the final accuracy check. No out-of-date medicines were found on the shelves. The SOP had not been updated to consider this change in process. The SOP detailed splitting the dispensary into twelve sections and using the diary to record short-dated medicines. This was an example of the team not following the current SOPs.

Team members had transferred a small amount of its medicines out of the original manufacturer's packaging. They had handwritten the quantity, batch number and expiry on to the new packaging so they could refer to it for date checking and recall management. There was no indication, such as a signature on the label, that the transfer of these medicines had been checked for accuracy. The pharmacy had medicinal waste bins available for returned medication. It had appropriate processes to action medicine recalls and safety alerts utilising an electronic system with an audit trail of alerts actioned.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities to provide its services. It uses the equipment appropriately to keep people's private information secure.

Inspector's evidence

The pharmacy had reference resources and access to the internet for up-to-date information. It had password-protected computers, with individual log-in according to role. It had maintenance support for the PMR system. People couldn't view confidential information on the computer screens due to their positioning. The pharmacy stored people's medicines awaiting delivery securely in the dispensary. It had portable telephone handsets and team members moved to a more private area to have telephone conversations. The pharmacy team had a range of glass measures to help with accurate measuring, but one of the measures was plastic and not suitable for accurate measuring of liquid medicines.

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.