General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Your Doctors Chemist, Unit 8, Howarth Court,, Oldham Broadway Business Park,, Chatterton, Oldham, Greater Manchester, OL9 9XB

Pharmacy reference: 9010049

Type of pharmacy: Closed

Date of inspection: 23/05/2019

Pharmacy context

This is a pharmacy which provides its services from a closed unit. People cannot visit the pharmacy in person, and their medicines are delivered to them. The pharmacy dispenses mainly NHS prescriptions and most people who use the pharmacy are from the local area. It supplies a large number of medicines in multi-compartment devices to help people take their medicines at the right time. The pharmacy has a website (www.yourdoctorschemist.com) which provides information about the pharmacy and people can purchase a range of over-the-counter medicines, which are supplied by a different pharmacy based in South Yorkshire.

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 generally manages risks and takes some action to improve patient safety. But team members do not make full records or review all their mistakes, so they may be missing out on some learning opportunities. The pharmacy asks its customers for their views and understands how it 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, with signatures showing that some members of the pharmacy team had read and accepted them. Two new members of the pharmacy team had not read and signed all the SOPs and some details in the roles and responsibilities SOP had not been completed, so the team may be unclear of the procedures, and who was accountable for what. The pharmacy team members were performing duties which were in line with their role and the name of the responsible pharmacist (RP) was displayed in the pharmacy as per the RP regulations.

Dispensing errors and near misses were discussed with the member of staff involved but were not routinely recorded so there was a risk that learning was not captured. Actions were sometimes taken to prevent a re-occurrence, e.g. ramipril capsules and tablets had been separated after an error when the wrong form was selected. Clear plastic bags were used for assembled CDs and insulin to allow an additional check before supply.

There was a complaints procedure and contact details of the pharmacy were on the website. The pharmacy manager said complaints which were resolved were not usually recorded, meaning opportunities to improve services might be missed. A customer satisfaction survey was carried out annually. The results of the most recent survey were available on the pharmacy's website. Areas of strength (100%) were service received from pharmacist and staff and answering queries. An area identified which required improvement (10% of respondents were dissatisfied) was waiting times for their call to be answered. The pharmacy's published response was to install a second telephone line for outgoing calls to free up the main line.

Insurance arrangements were in place. A current certificate of professional indemnity insurance was on display in the pharmacy. Private prescriptions and signed orders were recorded in a designated book, but the prescriptions for two supplies of antibiotics made in April 2019, could not be located, so the legality of the supplies could not be verified and could make it harder to understand what has happened if queries arise. The RP record and the controlled drug (CD) register were electronic and were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct. Patient returned CDs were disposed of appropriately, but some returned CDs had not been recorded in the designated book, so any diversion could go unnoticed.

A confidentiality clause was included in the employment contract and most members of the pharmacy team had read and signed the information governance (IG) and confidentiality SOP. Paperwork containing patient confidential information was stored appropriately and the pharmacy was registered with the Information Commissioner's Office (ICO). Confidential waste was collected in a designated place to be shredded. The shredder was broken but the pharmacy manager confirmed he would replace it. A dispenser correctly described the difference between confidential and general waste. The delivery drivers had not signed to confirm they had read and understood the information governance (IG) and confidentiality SOP and the delivery sheet was designed so that other patients' details were visible when the sheet was being signed by the recipient. The delivery driver on duty explained that he tried to cover other patients details to avoid them being seen, but said he would discuss a better way to do this with the pharmacy manager.

The pharmacist had completed centre for pharmacy postgraduate education (CPPE) level 2 training on safeguarding. The delivery driver on duty said he voiced any concerns regarding vulnerable adults to the pharmacist and had informed him when he was concerned about a patient, who used a c pap machine, did not answer his door. A member of the pharmacy team phoned the patient and found he was fine, but fallen asleep. There was a safe guarding SOP and NHS England Greater Manchester safeguarding resource pack containing guidance and the contact numbers of who to report concerns to in the area. Some members of the pharmacy team had completed dementia friends training and so had a better understanding of patients suffering from dementia.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members are qualified for the jobs they do, and they get some ongoing training. But this does not happen regularly, so their knowledge may not be always fully up to date. The team members work well together and have opportunities to discuss issues informally. And they are comfortable providing feedback to their manager and receive feedback about their own performance.

Inspector's evidence

There was a pharmacy manager, two NVQ2 qualified dispensers (or equivalent), three trainee dispensers and a delivery driver on duty at the time of the inspection. The staff level was adequate for the volume of work seen 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. If there were additional unplanned absences and the remaining staff were unable to manage the workload, then the pharmacy manager said he would contact part time dispensers from other pharmacies in the area, who he knew from his time as a locum pharmacist, to ask if they could work. He said this would be a very rare occurrence.

There was little documented training other than the accredited dispensing assistant training courses. A training matrix was on display, which the pharmacy manager said was used as guide, when training new staff, but it had not been completed to indicate the training had been received. The pharmacy team did not have regular protected training time. One of the dispensers was on the NVQ3 dispensing assistant course. She said she carried out some training at quiet times in the pharmacy, but mostly completed it in her own time. Two new members of the team, who started around a month ago had been enrolled onto accredited courses but not yet started the training. The pharmacy manager said these new members were being very closely monitored.

The pharmacy team members were given formal appraisals where performance and development were discussed and were given positive and negative feedback informally by the pharmacy manager. Informal meetings were held where a variety of issues were discussed, and concerns could be raised. This communication was not documented so issues raised might not be captured. A dispenser said she felt there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the pharmacy manager about any concerns she might have. She said the team could make suggestions or criticisms informally and were comfortable admitting and discussing errors to increase learning. There was a whistleblowing policy.

The pharmacy manager said he felt empowered to exercise his professional judgement and could comply with his own professional and legal obligations, e.g. refusing to supply a medicine because he felt it was inappropriate. He said targets were set by the owners, but they were supportive, and he did not feel under too much pressure. The pharmacy manager had recently started to offer the new medicines service (NMS), but he did not carry out medicine use reviews (MURs) due to the location of the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean and provide a safe, secure and professional environment for people to receive healthcare.

Inspector's evidence

The pharmacy premises were clean, spacious, well maintained and in a good state of repair. The pharmacy had been fitted out to a good standard when it opened around four years ago, and the fixtures and fittings were good. Internal maintenance problems were dealt with directly by the pharmacy manager and any external issues would be reported to the land lord.

Staff facilities were a small kitchen area and two WCs with wash hand basins and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. There was a large soundproof meeting room which could be used as a consultation room which was uncluttered, clean and professional in appearance.

Some information about the pharmacy which supplied over-the-counter medicines via the internet (Weldricks Pharmacy) was in the terms and conditions, privacy notice and MHRA logo, but the name and address was not clearly displayed on the website. This was misleading and potentially compromised patient confidentiality as the patient’s information might be supplied to the other pharmacy, without their knowledge or consent.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a small range of services which are generally well managed. It sources and stores medicines safely. And carries out some checks to ensure medicines are in good condition and suitable to supply. But the pharmacy doesn't always take extra care when a prescription is for higher-risk medicines. So, there is a risk people are not always getting all the advice they need to use their medicines safely.

Inspector's evidence

Services provided by the pharmacy were highlighted on the website. The pharmacy team members said they were not often asked for services they did not provide, so did not have much opportunity for signposting to services available elsewhere. Detailed information on medical conditions and their treatment was available on the website and there was some health promotion. Some health promotional leaflets were occasionally supplied to people with their medication, but providing healthy living advice and signposting were not recorded, so it was difficult to monitor the effectiveness of these activities.

The pharmacy offered a repeat prescription ordering service and this was well managed with an audit trial of what was ordered which was checked when the prescriptions arrived. Patients were contacted around seven days before their prescriptions were due, to check their requirements to help reduce stockpiling and medicine wastage. This phone call was documented as part of the audit trail.

All medicines were delivered to patients and an audit trail was in place for this service. 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.

The dispensary was spacious, and the work flow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat and tidy. Dispensed by and checked by boxes were 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. High risk medicines were not always targeted for counselling and extra checks. INR levels were not requested or recorded when dispensing warfarin prescriptions. The pharmacy manager had not carried out a valproate audit to identify any patients in the at-risk group but said he would do this as the next pharmacy audit. He was aware of the risks in pregnancy and the need for an appropriate prevention programme but could not locate the valproate information pack and care cards. So there was a risk that female patients would not be given the appropriate information and counselling.

There was a partial audit trail for changes to medication in multi-compartment devices, but it was not always clear who had confirmed the changes and the date the changes had been made. Medicine identification was completed to enable identification of the individual medicines. Packaging leaflets were included but cautionary and advisory labels were not always completed, so patients might not have all the information they required to take the medicines safely. The dispenser corrected this issue during the inspection, by re-setting the labelling programme. Disposable equipment was used.

Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Recognised licensed wholesalers were used for the supply of medicines and appropriate records were maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out.

The pharmacy was not compliant with the Falsified Medicines Directive (FMD). They did not have hardware or software so were not able to scan to verify products. The pharmacy manager said he was in the process of deciding which system to use, as there were many systems available.

Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short dated stock was highlighted. 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 from the NHS area team. These were read and acted on by a member of the pharmacy team and then filed.

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 was a clean medical fridge. The minimum and maximum temperatures were being recorded daily and had been within range throughout the month. All electrical equipment appeared to be in good working order.

There was a 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 appropriately capped to prevent contamination.

Patient medication records (PMRs) were password protected. Individual electronic prescriptions service (EPS) smart cards were used appropriately. 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.