

Registered pharmacy inspection report

Pharmacy Name: Adams Pharmacy, 2 Waterloo Road, Stalybridge, Greater Manchester, SK15 2AU

Pharmacy reference: 9010057

Type of pharmacy: Community

Date of inspection: 03/06/2019

Pharmacy context

This is a community pharmacy located on the edge of the town. It is in a building which also contains a medical centre and a police station. Most people who use the pharmacy are from the local area. The pharmacy dispenses mainly NHS prescriptions and sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment devices to help people take their medicines at the right time. The pharmacy stays open for longer than usual and opens through the night on some days.

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 adequately manages risks and takes action to improve patient safety. It keeps most of its records up to date, so it can show it is providing services safely and asks its customers for their views each year. The team members keep people's private information safe. And the pharmacists complete training so they know how to protect children and vulnerable adults.

Inspector's evidence

There were Standard Operating Procedures (SOPs) for the services provided, with signatures showing that members of the pharmacy team had read and accepted them. There had not been any documented reviews of the SOPs since December 2016, so they might not have been updated to reflect changes in the procedures following incidents and changes to legislation. Pharmacy team members were performing duties which were in line with their role. Some of the team were wearing uniforms, but there was nothing to indicate their role, so people might be unclear about this. The name of the responsible pharmacist (RP) was displayed as per the RP regulations.

The pharmacy manager said dispensing incidents would be discussed with one of the owners, who would make a report. Near misses were recorded on a log and one of the owners reviewed these each month. Actions were taken to prevent errors; separators were used for medicines with various strengths, e.g. atorvastatin and bisoprolol, and alert stickers were used to highlight look-alike and sound-alike drugs (LASAs), e.g. amlodipine and amitriptyline. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out. An annual patient safety report had been completed, but there weren't any regular discussions with the pharmacy team, so they may miss learning opportunities.

A customer satisfaction survey was carried out annually. The results of the latest survey were on display and available on the NHS choices website. The pharmacy was rated between 90 and 100% for all areas apart from giving advice on healthy living, which had a lower rating. The pharmacy's response to this was not published but there was a variety of healthy living information on display in the pharmacy. There was nothing on display to highlight the complaints procedure, so people might not know how to raise a concern or leave feedback.

Two complaints had been recorded in the last couple of months and action had been taken to address both of these. A prompt note had been added to a patient's medication record (PMR) to remind staff that their prescription for Gaviscon did not arrive electronically, due to a technical issue with the electronic prescription service (EPS), so a member of the team had to collect it from the patient's GP surgery each time. A prompt note had been added to the PMR of another patient who preferred a specific brand, to remind the team to supply the preferred brand where possible.

Insurance arrangements were in place. A current certificate of professional indemnity insurance was on display in the pharmacy. Private prescription and emergency supplies records, the RP record, and the controlled drug (CD) register were appropriately maintained. Records of CD running balances were kept

for most CDs and these were regularly audited. Three CD balances were checked and found to be correct. The pharmacy team confirmed that patient returned CDs were recorded and disposed of appropriately, but the designated book, used to record this could not be located.

Members of the pharmacy team had read and signed a confidentiality clause. Confidential waste was collected in a designated place and shredded. A dispenser correctly described the difference between confidential and general waste. Prescriptions awaiting collection were not visible from the medicines counter. Paperwork containing patient confidential information was stored appropriately. A privacy statement was on display, in line with General Data Protection Regulations (GDPR).

A dispenser said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. The pharmacists had completed centre for pharmacy postgraduate education (CPPE) level 2 training on Safeguarding. The pharmacy manager said he would report any concerns to social services by looking up their details on the internet. There was nothing on display advising people that they could have someone with them when using the consultation room, but the pharmacy manager said he would allow this if requested. Members of the pharmacy team had completed dementia friends training and so had a better understanding of patients suffering from this condition.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team members are qualified for the jobs they do. But ongoing training does not happen regularly, so their knowledge may not be always fully up to date. The team members work well together, and they are comfortable providing feedback to their manager.

Inspector's evidence

There was a pharmacy manager, a pre-registration pharmacist (pre-reg) and two NVQ2 qualified dispensers (or equivalent) 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.

Absences were covered by re-arranging the staff rota or transferring staff from the neighbouring branch. Workload could be re-arranged when necessary because multicompartiment devices were made up a week in advance of the supply date, so there was some flexibility. There were two pharmacists present for around an hour of the inspection. Both were regular locum pharmacists and one acted as pharmacy manager. The pharmacy was open 100 hours per week and there was a team of four or five regular pharmacists who covered the hours.

The pharmacy team did not have regular protected training time and there was no ongoing training for the dispensers when they had qualified. The pre-reg said she was on a structured course provided by Buttercups and she had monthly study days. She had meetings and appraisal with the pharmacy manager, who was her tutor. The rest of the pharmacy team did not have the opportunity for formal discussion of their performance and development, so learning needs might not be identified and addressed. Informal meetings were held where a variety of issues were discussed, and concerns could be raised, but these were not documented so concerns might not be addressed. 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 staff worked well as a team and could make suggestions or criticisms informally.

One of the pharmacists said he felt empowered to exercise his professional judgement and could comply with his own professional and legal obligations, e.g. refusing to sell a pharmacy medicine because he felt it was inappropriate. He said targets were set for medicine use review (MUR) and he tried to carry out five MURs per week, but he didn't feel targets ever compromised patient safety and he didn't feel under pressure to achieve them.

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 and in an adequate state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with four chairs. The temperature and lighting were adequately controlled. Maintenance problems were reported to the owners who arranged for a local contractor to attend and the response time was appropriate to the nature of the issue.

There was a consultation room equipped with a sink, which was uncluttered, clean and professional in appearance. The availability of the room was not highlighted by any signage, so people might not realise the facility existed for a private conversation.

The pharmacy was small and staff facilities were minimal. Staff used the WCs in the resource centre. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand sanitizer gel was available. The front door into the resource centre was closed overnight and people wishing to access the pharmacy had to ring a bell to gain access.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are generally well managed and easy for people to access. It sources, stores and supplies medicines safely. And carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy was accessible to all, including patients with mobility difficulties and wheelchair users. There was a ramp up to the front door of the building and there was an automatic door. An alert chime sounded when anyone entered the pharmacy.

Services provided by the pharmacy were not advertised, so patients might not know what services were offered. The pharmacy team were clear what services were offered and where to signpost to a service not offered, e.g. emergency hormone contraception (EHC). There was a range of healthcare leaflets and posters on display, e.g. raising awareness about bowel cancer and promoting children's oral health. There were posters advertising local services, e.g. Tameside pulmonary fibrosis support group. Providing healthy living advice and signposting was recorded in the form of a tally chart which gave an indication of the effectiveness of the health promotional activities. There had been one or two recorded interventions per month.

The pharmacy offered a repeat prescription ordering service for vulnerable patients only. The pre-reg confirmed that these 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 and an audit trail was in place. 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 quite limited in the dispensary, but the work flow was organised into separate areas with a designated checking area. The dispensary shelves were reasonably tidy and well organised. 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. 'Ask your Pharmacist' stickers were used to highlight counselling was required and high-risk medicines such as warfarin, lithium and methotrexate were targeted for extra checks and counselling. INR levels were checked but not usually recorded when dispensing warfarin prescriptions.

The team were aware of the valproate pregnancy prevention programme. A few patients in the at-risk group had been identified. A check had been made that these patients had discussions with their GP about pregnancy prevention, but the pharmacist did not think this had been recorded on their PMR. The valproate information pack was available, but the care cards had run out. The pharmacist

confirmed that he would re-order these to ensure female patients were supplied with the appropriate information and counselling.

Multi-compartment devices were well managed with an audit trail for communications with GPs and changes to medication. A dispensing audit trail was completed, and medicine identification was completed to enable identification of the individual medicines. Packaging leaflets were not usually included, despite this being a mandatory requirement, so patients and their carers might not always have all the required information to take their medicines effectively. Disposable equipment was used.

A dispenser knew what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

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. 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 had the software but no hardware and so were not scanning to verify or decommission medicines. The pharmacy manager thought it was being dealt with by the owners and believed the pharmacy had registered with SecurMed. 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 but a record of this was not made, so it was not clear whether appropriate action was always taken.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy generally uses the appropriate equipment for its services.

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

There were a couple of glass liquid measures which were accuracy stamped but most of the liquid measures were plastic, which did not provide assurance of accuracy and were harder to clean. This compromised accuracy and hygiene in the dispensing process. There was a separate plastic measure marked for measuring water for antibiotic reconstruction. The pharmacy had a range of 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.

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.