General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Whitefield Pharmacy, 2-4 Albert Place, Whitefield, Bury, Greater Manchester, M45 8NE

Pharmacy reference: 9010332

Type of pharmacy: Community

Date of inspection: 24/08/2022

Pharmacy context

This is a pharmacy on a parade of shops in a residential area of Whitefield in Manchester. It mainly dispenses NHS prescriptions and sells over-the-counter medicines. This includes dispensing medicines in multi-compartment compliance packs to help some people take their medicines at the right time. The pharmacy delivers medicines to some people at home.

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	1.6	Standard not met	The pharmacy does not keep its controlled drug registers up to date and accurate. This creates a risk to patient safety.
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 not all met**

Summary findings

The pharmacy mostly manages the risks with providing its services. But it doesn't keep all its records required by law up to date and accurate. Team members take some learning from the mistakes they make when dispensing to help prevent the same mistake happening again. And they mostly listen to people's concerns to improve services. Team members keep people's private information secure. And they understand their role in helping protect vulnerable people.

Inspector's evidence

The pharmacy had paper-based standard operating procedures (SOPs) relevant to the services provided and they had been updated in 2020 and 2021. Not all current team members had signed to confirm they had been read and understood. The pharmacy had SOPs for the management of controlled drugs (CDs), which specified making the CD entry in the register. This was not being followed as it should. The pharmacy had a COVID-19 policy, which had since been reviewed and the team had opted not to wear masks. It had hand sanitiser available.

Team members used near miss error logs to record errors that they identified during the dispensing process. But there were few entries seen, with the last entry being in May 2022. The team described their learning following near miss errors, such as selection errors between gabapentin and pregabalin. This included separating medicines on the shelves. The pharmacy displayed information about medicines that looked alike and had similar sounding names for team members to refer to. There were printed monthly patient safety report templates designed to help monitor and review error trends. But these had not been populated with any information from the near miss error logs. The pharmacy had a complaints procedure. A dispenser explained how she would listen to the person to try and resolve any complaints, such as prescriptions not being ready to collect and then escalate concerns to the usual Responsible Pharmacist (RP). The pharmacy had not responded to a concern raised about opening hours on the NHS website.

The pharmacy had up-to-date professional indemnity insurance. It had a written record of private prescriptions, but details were missing, such as the prescriber's name and sometimes the prescriber's address were not always recorded. And both the date of supply and the prescription date were not always present in the record. The pharmacy did not keep its CD registers up to date and accurate. The RP record was not always complete, with some omissions to the record, including when the RP signed out. Complete records for the dispensing of unlicenced specials were seen, but none from the last few months.

The pharmacy displayed a privacy notice in the retail area and had leaflets for people to read describing how the pharmacy handled their private information. The team separated confidential waste from other waste and the usual RP arranged disposal. The RP had completed level 2 safeguarding training and although team members hadn't completed formal training, they described scenarios they would escalate to the pharmacist to help protect vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the skills to perform their roles and to provide the pharmacy's services. And they are committed to complete their qualification training to improve their knowledge. They work together well but they sometimes struggle with workload pressure. And this means tasks sometimes remain outstanding.

Inspector's evidence

On the day of the inspection the RP was a locum pharmacist who had not worked in the pharmacy before. The usual RP was seen to be contactable to help sort out an issue with signing into the electronic RP record. The pharmacy had undergone a series of staffing changes over the last nine months and the dispenser described how this had sometimes put significant pressure on team to complete the dispensing workload and other tasks. A team member had recently left so there was a vacancy in the team. There were some tasks involving the management of CDs that were left to be completed by the usual RP, and these had not been completed in some time. The pharmacy had two part-time medicines counter assistants (MCAs), who had recently been enrolled on qualification training and a trainee dispenser also enrolled on qualification training. The MCA described how she referred all medicine sales to the pharmacist, and this was seen during the inspection. The most experienced member of the dispensing team was an apprentice, who was coming to the end of her dispenser's training. She was seen supporting the RP and other team members with queries and explaining the ways of working in the pharmacy. The team appeared to be managing the workload during the inspection, although some people's prescriptions were not ready to collect.

The pharmacy had employed a new delivery driver, who had not been enrolled on a qualification course. The usual RP confirmed after the inspection that this had been rectified. Other team members explained how they were focusing on completing their qualification training, and how the usual RP informally trained them on any new services and changes to ways of working. There was access to ongoing e-learning modules. They had recently received some training on how to use the new IT dispensing system, and additional onsite training was planned that week. The dispenser felt the usual RP was approachable to improvement ideas and explained how changes to the prescription collection area had been completed following discussions. The team didn't know of ways to raise professional concerns, apart from speaking to the usual RP. There was no evidence of a whistleblowing policy. The team didn't have regular team meetings. There were no targets to meet, and the emphasis was to provide a good dispensing service.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure, and suitable for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy.

Inspector's evidence

Following the changes to the pharmacy premises around September 2021, the pharmacy area was larger, with plenty of storage space for medicines and suitable bench space for dispensing and other tasks. The premises were clean and hygienic, although some stock room areas were a little cluttered. The pharmacy had several rooms off the main dispensary including a staff area with the facility for hot and cold running water. The dispensary didn't currently have a sink, so water was used from the staff area for reconstitution of medicines. The pharmacy had suitable toilet and hand washing facilities. The lighting was suitable and the room temperature appropriate. The pharmacy had a large and professional looking, soundproof consultation room to provide services and for people to have private conversations.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy adequately manages the delivery of its services, including having relevant information to give to people taking higher risk medicines. This helps ensure people take their medicines safely. The pharmacy mostly stores its medicines as it should. And it generally manages them to make sure they are safe to supply. But it doesn't keep some of its records up to date and so it may be difficult to evidence that the team is completing all tasks appropriately.

Inspector's evidence

The pharmacy had previously been open over seven days but had started closing on a Sunday. It displayed correct opening hours in the pharmacy but not on the NHS public facing website. One person had submitted feedback on the NHS website raising a concern about the pharmacy being closed on a Sunday, when it was advertised as open. The pharmacy's address had not been updated since the refit of the premises which saw the pharmacy move from inside the convenience store and post office to a newly converted standalone unit. This may cause confusion for people accessing services. There was step-free access into the pharmacy using an automatic door. The pharmacy displayed healthcare information in the form of leaflets and posters. This included information on recognising and treating sepsis. The pharmacy delivered some medicines to people's homes and used name and address labels on paper delivery sheets to ensure the pharmacy kept a record of this activity. The driver had stopped obtaining people's signatures during the pandemic, and this remained the process. The dispenser described when on occasion a person had queried receipt of their medicines then the delivery sheet had been used as evidence of delivery and to resolve the query.

The pharmacy had in the last few weeks installed a new IT dispensing system and the team had access to the old system to check people's medication records. There were separate areas for labelling, dispensing, and checking of prescriptions to manage the workflow. The pharmacy used baskets in the dispensing process to keep each person's medicines and prescriptions separate, to help prevent mistakes. Team members signed the dispensed by and checked by boxes on the dispensing labels to create an audit trail. Following the pharmacist's check, medicines were stored unbagged in the fridge. There were several similar medicines stored together, which increased the risk of an error at handout. The team member showed the medicines they selected from the fridge to the RP before handing it out. This helped in some way to minimise the additional risk. The usual RP reported a change to this process following the inspection.

The pharmacy didn't use owings slips when people's medicines were not in stock. This meant that people didn't have a record of the medicines owed to them. The pharmacist checked the prescriptions and if stock wasn't available attached the dispensing labels to the outside of the bag. These bags were kept in a different area of the pharmacy away from the retrieval area. This helped ensure the pharmacy processed the owings when a person came to collect their medicines. This was seen to delay the handout process on occasions when the team looked in several areas to find people's medicines. If the medicine was not in stock when the person came to collect, the prescription and dispensing labels were filed separately to dispense at a later time. This meant if the dispensing labels were misplaced there was no accurate record of the owing. The usual RP confirmed a change in process following the inspection.

The dispenser understood the checks to make when dispensing valproate for a person who may become pregnant. She described how she would highlight these prescriptions to the pharmacist and would make sure the warnings were not hidden when labelling the medicine. The pharmacy had a stock of valproate patient cards and booklets stored alongside insulin passport information and other higher risk medicine warning cards.

The pharmacy dispensed medicines into multi-compartment compliance packs for some people. And the team attached printed backing sheets to the packs to inform people of which medicines were in the pack and when to take them. The IT system didn't print the additional warnings on these sheets, which meant people would not have all the information they may need to take their medicines safely. This included for example if they needed to take a medicine after food or if it caused drowsiness. The usual RP confirmed this had been rectified on the new IT dispensing system after the inspection. The pharmacy kept individual baskets on designated shelving. These contained a record of person's current medication together with the manufacturer's packs awaiting dispensing. These were stored neatly and any changes to people's medicines were highlighted on this record. The team did not regularly provide patient information leaflets (PILs) with the packs, which means people may not always have up-to-date information about how to take their medicines.

Pharmacy-only (P) medicines were displayed behind the pharmacy counter and in glass cabinets. This prevented people self-selecting these medicines and helped ensure the pharmacist supervised sales. The pharmacy kept medicines tidily on shelves and team members used a date-checking matrix to record when expiry dates of medicines had been checked. But they had last recorded a check in January 2022. Some medicines due to expire were marked, but some were not. This could make it harder for the team to identify medicines that were due to expire in the near future. No out-of-date medicines were found on the shelves and there was evidence of dates of opening being annotated on liquid medicines. There was a small number of medicines in amber bottles on the shelves, which had patient names on the labels. These were described as being from prescriptions that had not been collected and were removed from the shelves during the inspection. The pharmacy stored medicines requiring cold storage in a suitably sized fridge. The team made a regular electronic record of the maximum and minimum fridge temperatures to evidence that medicines had been kept within the correct temperature range. The fridge temperature was within the correct range during the inspection. The pharmacy had evidence of receipt and actioning of medicine recalls and safety alerts and the dispenser described the pharmacy's process to action these. The most recent recalls had not been filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. And team members use them in a way that protects people's confidentiality.

Inspector's evidence

The pharmacy had reference books to refer to and access to the internet for up-to-date information. It had password-protected computers, and monitors were positioned to protect unauthorised viewing. The pharmacy kept medicines awaiting collection in the dispensary so people in the public area had no sight of people's private information. Team members used cordless telephone handsets, and this allowed them to move to a more private area of the dispensary to have sensitive conversations. The pharmacy had a range of equipment to support its services. It had CE marked glass measures for measuring liquids, counting apparatus for tablets and consumables for dispensing medicines in compliance packs.

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.