General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Ashton Road Pharmacy, 366 Ashton Road, Oldham, Greater Manchester, OL8 3HF

Pharmacy reference: 9010342

Type of pharmacy: Community

Date of inspection: 05/01/2023

Pharmacy context

This busy pharmacy is located on a main road. Most people who use the pharmacy are from the local area and it offers a home delivery service. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time.

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	1.1	Standard not met	The pharmacy does not have adequate standard operating procedures for the services it provides.
		1.6	Standard not met	The pharmacy does not always maintain accurate records in relation to controlled drugs and private prescriptions.
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 not all met	4.3	Standard not met	The pharmacy's stock medicines are poorly organised. It stores some medication outside its original container and these are not labelled adequately with batch numbers and expiry dates. It does not have adequate date checking procedures and medicines which have passed their expiry date are not always separated from current stock. The pharmacy does not properly restrict unauthorised access to some medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy keeps the records it needs to by law, but some records including CD registers, are not accurately maintained. And the pharmacy's written procedures are not regularly reviewed, so there is a risk that team members might not always work effectively. The pharmacy team has a basic understanding about keeping people's private information safe and the pharmacy has written procedures on protecting the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services provided, with signatures showing that members of the pharmacy team had read and accepted them. But some of the SOPs were incomplete and the roles and responsibilities of the pharmacy team were not clearly set out in them. There was no procedure stating the identification of members of the pharmacy team who were competent to perform certain tasks such as giving advice about medicinal products. There was no record that they had been reviewed since they were prepared in 2017. And some of the SOPs contained out-of-date information. For example, the delivery SOP. Team members were not wearing uniforms or anything to indicate their role, so this might not be clear to people using the pharmacy. The name of the responsible pharmacist (RP) was on display.

Dispensing incidents were reported on an electronic error reporting system and discussed with the pharmacy team. Learning points were included in the report, but these were minimal, such as 'check properly' and 'staff informed' following the incorrect strength of Ozempic being supplied. Some near misses were recorded on a near miss log, but there was no evidence that these were reviewed, so team members might be missing out on additional learning opportunities. The SI said errors were discussed at team meetings but there was no record made. A trainee dispenser confirmed that she felt comfortable admitting errors and explained that dispensers were asked to correct any errors that they made. She said this was important to help them avoid making the same error a second time.

The pharmacy had a complaint procedure. There was a notice on display highlighting this, but it contained out-of-date information which might mean the concern was not directed to the appropriate person or was not acted on. Insurance arrangements were in place.

There was an electronic register of private prescriptions. Entries were not always accurate. For example, the name of the prescriber was sometimes incorrect or missing, which could cause confusion in the event of a problem or query. The controlled drug (CD) register was electronic. CD running balances had not been audited regularly and checks of the CD registers found some inconsistencies which were not in keeping with the CD regulations. Unrequired CDs which had been returned by patients for destruction had not been recorded in the designated patient returned register. And records showed there had not been any destruction of patient returned CDs since 2019. The RP record was generally in order and appropriate records were maintained for medicines ordered as unlicensed 'Specials'.

Confidential waste was stored in a designated place until it was collected by an appropriate waste disposal company. A member of the team correctly described the difference between confidential and

general waste. She had a basic understanding about patient confidentiality and said this had been covered as part of her accredited dispensing course.

Members of the pharmacy team had completed training on safeguarding appropriate to their role. The accuracy checking technician (ACT) confirmed he had completed level 2 training on safeguarding. One of the trainee dispensers said she had completed training on safeguarding as part of her accredited course and said she would voice any concerns regarding children and vulnerable adults to the pharmacist working at the time. There was a safeguarding policy in place containing the contact numbers of who to report concerns to in the local area. The pharmacy had a chaperone policy and there was a notice highlighting this on the consultation room door. The SI was aware of the 'Safe Space' initiative, where pharmacies were providing a safe space for victims of domestic abuse. The pharmacy had not registered for this, but the SI said the consultation room would always be made available if necessary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload. Team members complete training relevant to their roles. They are comfortable providing feedback to their manager and they receive informal feedback about their own performance. But training is not always well organised so gaps in team member's knowledge might not be identified or addressed.

Inspector's evidence

There were two pharmacists, an ACT, three NVQ2 qualified dispensers (or equivalent) and five trainee dispensers on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection. The team were observed working collaboratively with each other and the people who visited the pharmacy. The SI was working as the RP. There was also a regular locum pharmacist on duty, who usually worked in the pharmacy two days each week providing additional pharmacist cover. Planned absences were organised and the SI used a holiday calendar to ensure holidays were covered. Most of the dispensers were part-time so there was some flexibility with their hours. And locum dispensers were used where necessary to ensure adequate staffing levels. Two of the dispensers working at the time of the inspection were locum dispensers.

Members of the pharmacy team had completed appropriate training or were on accredited training courses. But training records were not maintained to show what additional training each member of the team had completed, so it relied on people's memory. The SI explained that most members of the team had completed a programme of training on customer service in the last year. The team did not have regular protected training time and some team members had got behind with their courses. One dispenser was completing an NVQ3 course as part of an apprenticeship. Team member's performance and development were discussed informally with the SI. But the details of these meetings were not recorded, so it might be more difficult to monitor progress and support training.

Team meetings were held where a variety of issues were discussed, and concerns could be raised. These were not recorded, so matters raised might not always be addressed. The SI explained that he also sent electronic messages to members of the pharmacy team. For example, a link to information about antibiotics when they were having issues obtaining them. The locum pharmacist said he would be comfortable talking to the SI about any concerns he might have, and he knew where to escalate concerns if they weren't addressed by the SI. There was a whistleblowing policy in place. The locum pharmacist confirmed that he was empowered to exercise his professional judgement and could comply with his professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because he felt it was inappropriate. He said he was not under any pressure to achieve targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a suitable environment for people to receive healthcare services. But the lack of space and poor housekeeping affect the working conditions and detract from the professional image of the pharmacy. 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 premises, including the shop front and facia were in an adequate state of repair but the size of the premises was barely adequate for the volume of prescriptions dispensed and the number of staff working there. The retail area was reasonably clean, but other parts of the pharmacy were untidy and required cleaning. The retail area was generally free from obstructions, but there was a stack of empty plastic tote trays in the retail area, which detracted from the professional image. There was a waiting area with one chair. There was a separate room to assemble and store compliance aid packs on the first floor. There was a stock room on the first floor which was particularly cluttered and untidy. Staff facilities included a WC with a wash hand basin and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. The temperature and lighting were suitably controlled. The consultation room was small and cluttered, which further detracted from the pharmacy’s professional appearance.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy does not always store, organise and manage its stock medicines effectively, to make sure they are in good condition and suitable to supply. Overall, its healthcare services are generally well managed and easy for people to access

Inspector's evidence

The pharmacy was accessible to everyone, including people with mobility difficulties and wheelchair users. Not all the services available at the pharmacy were advertised, so people might not realise what was available. For example, the New Medicine Service (NMS). There was a small range of healthcare leaflets. Some of the staff were multilingual which helped some of the non-English speaking people from the Asian community. The pharmacy used an electronic system which provided an audit trail for the home delivery service, however the delivery SOP had not been amended to reflect this when it was introduced. The service had been adapted to minimise contact with recipients, during the pandemic.

Space was very limited in the dispensary, and stock was not always stored in an organised manner. Some of the dispensary shelves were untidy, which increased the risk of a dispensing error, and some stock had fallen onto the floor. Baskets were used to prevent prescriptions becoming mixed up, but so many baskets were piled up on the bench waiting to be checked, that medicines were falling out of the baskets, which risked mistakes being made. People who had items missing from their prescription did not always receive an owing slip, so might be confused about what they had ‘owed’ to them. The pharmacy supplied several people with methadone solution in daily instalments. Prescriptions were prepared the day before collection to improve efficiency but dispensed by and checked by boxes were not routinely initialled. So, there was not always an accurate dispensing audit trail, which might limit learning if something went wrong. The WC was used to store medicine containers, such as boxes and bags. This risked contamination and was not hygienic.

Stickers were put on assembled prescription bags to indicate when a fridge line or a CD was prescribed. Notes were added to highlight when counselling was required. The pharmacy team were aware of the valproate pregnancy prevention programme. The SI did not know if any of their regular patients were in the at-risk group but said that he ensured that the care cards on original packs were not covered by medication labels, but detached and included with the medicine, so people in the at-risk group could easily access the appropriate information. The pharmacy supplied many people with medicines in multi-compartment compliance aid packs. This was reasonably well managed. There was an electronic audit trail for changes to medication in the packs, but it was not always clear who had confirmed these and the date the changes had been made, which could cause confusion when assembling packs. Medicine descriptions were usually included on the labelling sheet to enable identification of the individual medicines and packaging leaflets were included. Cautionary and advisory warnings were not included on the labelling sheets, so people might not have all the information to take their medicine safely. The ACT resolved this issue during the inspection. Disposable equipment was used. The ACT carried out the accuracy check after a dispenser had assembled the packs. The ACT confirmed that a pharmacist always carried out a clinical check before allowing him to carry out the accuracy check. The locum pharmacist added his initials to the prescription to show that he had carried out the clinical check and the SI used a stamp to indicate he had clinically checked the prescription.

One of the trainee dispensers explained what questions she asked when making a medicine sale and she knew when to refer the person to a pharmacist. She was clear what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

CDs were stored in two CD cabinets. The keys were under the control of the RP during the day and stored securely overnight. Date expired, and patient returned CDs were segregated and stored securely. But these had been allowed to accumulate and a destruction was needed. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain medicines. Medicines stored in the dispensary and stock room were disorganised. Dispensary shelves were overfull, and some stock overflowed onto the floor. Some medicines were not stored in their original containers. There was a lot of loose foil strips on the dispensary shelves, some of which did not contain the expiry date and batch number of the medicine. The SI said routine date-checking was carried out, but there was no record of this, and several date expired medicines were seen on the dispensary shelves. They were removed when pointed out for destruction. Dates had not always been added to opened liquids with limited stability, so it was not clear if they were fit for use. There were two medical fridges. The minimum and maximum temperatures were being recorded regularly and appeared to have been within range over the last few weeks. But the maximum temperature of the fridge on the first floor was well above 8 degrees Celsius at the start of the inspection, indicating that the maximum temperature had not been accurately recorded that morning.

Alerts and recalls were received electronically. The SI said they were read and acted on by designated members of the pharmacy team and the response recorded on the system. However, he was not able to access these records so was unable to provide assurance that the appropriate action was always taken.

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.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date information. For example, electronic versions of the British National Formulary (BNF) and BNF for children. Electrical equipment appeared to be in good working order. Medicine containers were appropriately capped to prevent contamination. 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.