General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Futurecare Pharmacy, Bury Plant Hire, 14A Whitelegge Street, Bury, Greater Manchester, BL8 1SW

Pharmacy reference: 9011232

Type of pharmacy: Community

Date of inspection: 27/04/2021

Pharmacy context

The pharmacy is on the outskirts of Bury and provides its services at a distance. People do not access the pharmacy premises to obtain their medicines. The pharmacy mainly dispenses NHS prescriptions including to people living in care homes. And it delivers people's medicines to their homes. It dispenses medicines to some people in multi-compartment compliance packs to help people take their medicines correctly. This pharmacy was inspected during the COVID-19 pandemic.

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 suitably identifies and manages the risks with its services. It keeps the records it must by law, and it keeps people's private information secure. Pharmacy team members know the importance of their role in safeguarding vulnerable people. Pharmacy team members record some errors they make. But there is little evidence the pharmacy analyses these errors to learn from them and improve services.

Inspector's evidence

The pharmacy had identified risks associated with COVID-19 virus transmission. It had signs up at the entrance to the pharmacy to wear a mask on entering. It displayed a poster showing the team members how to wash their hands. The pharmacy was separated into specific working areas to support social distancing. The dispensers mostly worked in separate rooms and the pharmacist worked in the main room. The team members were not regularly wearing masks, but they did put masks on at the start of the inspection when requested to. Team members were observed socially distancing most of the time, but their tasks sometimes brought them into closer contact with each other.

The pharmacy had a set of standard operating procedures (SOPs) that were relevant to a distance selling pharmacy and the services the pharmacy provided. The pharmacy had SOPs defining processes involving controlled drugs (CDs), responsible pharmacist (RP) and the dispensing service. The team members had signed a log filed with each SOP to confirm they had read the SOP and when. The superintendent had authorised the SOPs and they were specific for the pharmacy. But the SOPs checked did not have a date of issue or review detailed. And the authorisation by the superintendent was not dated.

The pharmacy had a paper near miss log and a separate electronic near miss record. There were a few entries on both systems, although not for each month the pharmacy had been open. There wasn't one consistent method for recording near miss errors. The pharmacist and one of the dispensers both confirmed that after an error the pharmacist spoke individually with the dispenser to inform them and to discuss any learnings. The learnings were mainly specific to the team member but on occasions medicines had been moved on the shelves to minimise the risk of a further selection error. The team had received no specific training or been involved in ongoing learning relating to error management such as training about look-alike and sound-alike (LASA) medicines. The team hadn't been involved in discussions regarding trends or reviews of the near miss errors recorded. This would be more difficult with two systems for recording near miss errors. The pharmacy had a SOP for both near miss errors and dispensing incidents and the team members had signed to confirm these had been read. There was an example of a completed dispensing incident form with appropriate completed actions to minimise the risk of future similar errors.

The pharmacist working at the time of the inspection had their RP notice displayed in the pharmacy. The two dispensers explained their roles and responsibilities clearly and the apprentice and work experience student were being supervised. The pharmacy had its complaints policy on the website and people could feedback their experiences. There were several good reviews on the website from people accessing services, including a review from a care home. The pharmacy had a complaints management SOP. A dispenser reported receiving few complaints and described how good communication with the

care home staff reduced complaints.

The pharmacy had in-date indemnity insurance. It kept an up-to-date electronic CD register. Of the sample of records checked, the team mostly completed weekly balance checks of the physical quantity against the register entry. The physical balance matched the register for the one item checked. The pharmacy had a book to record the destruction of patient returned CDs and the entries were complete. Prior to a visit by the local CD Liaison Officer (CDLO) the destructions had not been witnessed but this had been rectified with all entries since. Private prescription records were held electronically, with all the required details. But the paper private prescriptions could not be located during the inspection to check the entry details. The pharmacy made some emergency supplies to people living in care homes and these were recorded on the electronic register. The RP record was complete, with lunch time absences recorded.

The pharmacy had a privacy policy on the website and a copy held in the pharmacy. There was an Information Governance (IG) SOP and a General Data Protection Regulation (GDPR) policy folder for team members to refer to. Confidential waste was separated and safely disposed of by a third party contractor. There was no confidential information in the general waste.

The pharmacist, who worked in the pharmacy three days a week, had completed Level 2 safeguarding training. One of the dispensers had completed some formal training and described scenarios where he would be alerted to potential safeguarding concerns in care homes. The other dispenser had not received formal training and would report any concerns to the pharmacist. The team used the local safeguarding website for information and contact information. The team could not find the pharmacy's safeguarding policy in the pharmacy and there was no SOP relating to safeguarding seen. This meant the team had no policies or procedures available to support them if a safeguarding incident occurred.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has team members with the skills to manage the services it provides. They support each other and manage the workload well. The pharmacy provides some informal ongoing training. But doesn’t always enrol its team members on required qualification training courses in a timely manner.

Inspector's evidence

The RP worked regularly three times a week in the pharmacy, with another regular pharmacist working the other two days the pharmacy was trading. The RP was supported by two dispensers, an apprentice and a work experience student. The pharmacy employed a driver to complete the deliveries of medicines. One of the directors of the pharmacy was present for part of the inspection. One of the dispensers who had been working in the pharmacy since it opened over a year ago had read the SOPs but was not enrolled on an appropriate dispenser's course. Following the inspection, the superintendent explained that the pharmacy was in the process of enrolment and subsequently provided evidence of this.

The team was seen working well together and managing the workload. Team members completed tasks in a competent manner, explaining clearly to care home staff about any queries they had about prescriptions. The team organised the workload to ensure the care home staff received people's medicines in good time to check for any missing items. This meant the pharmacy had time to resolve any queries without undue pressure. There was another pharmacy in the company, and this provided flexibility to arrange cover for absence and holidays. As the pharmacists worked part time this allowed flexibility to cover each other's holidays and absence.

The team members did not have any formal ongoing training, but the superintendent based in the other branch regularly sent information across of any changes and updates to help keep the team members up to date. Some of the team had completed an on-line suicide awareness training. A dispenser described how the director and superintendent were approachable with any concerns and openly received feedback to improve services. The team had changed the delivery collection area after seeing the practice adopted in the other branch.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are appropriate for the services the pharmacy provides. And they are suitably clean, hygienic and secure.

Inspector's evidence

The pharmacy provided its services at a distance and people could not access the pharmacy premises without using the intercom system. The dispensing area of the pharmacy was on the first floor accessed by stairs, with a handrail for safety.

The pharmacy had ample bench space to dispense medicines and shelving to store medicines.There was some clutter in the pharmacy with totes and boxes on the floor. The pharmacy had totes of patient-returned medicines from care homes in the storage area downstairs. This caused some of the walkways to be blocked. This area was not often accessed except to take some of the returned medication up to the dispensing area to transfer to medicinal waste bins. A dispenser explained that they were currently behind with this process, accounting for an increase of totes stored. The temperature in the downstairs storage area felt cold but no pharmacy tasks were completed in this area. The pharmacy had started constructing a consultation room downstairs, where it was planned to provide some NHS advanced services in the future. There was suitable lighting and an electricity supply though plug sockets being installed, which would allow for heating to this room.

The pharmacy had toilet facilities, with hot and cold running water. It had two sinks in the dispensing area, and these were clearly labelled for professional and personal use. The temperature and lighting in the dispensing and staff areas were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services easily accessible for people. And it mostly manages its services well to help deliver its services safely and effectively. But only some of its team members understand the importance of making additional checks for higher risk medicines. The pharmacy mostly stores and manages its medicines appropriately.

Inspector's evidence

People did not directly access the pharmacy premises to obtain their medicines. The door was locked and had an intercom system for authorised access. The pharmacy was in the process of building a consultation room on the ground floor to offer some advanced services. The pharmacy had a website and people telephoned the pharmacy to access services and for advice. The majority of the pharmacy's workload was providing medicines to care homes and there was good communication and processes for them to access both regular and acute medicines. The pharmacy delivered medicines to people at home and to care homes. Due to the pandemic, the driver wasn't entering the care homes and was not asking people at home to sign for the delivery of their medicines. The driver made sure the person had received their delivery before leaving the premises and made a record of the completed delivery. The pharmacy had recently signed up for the Pharmacy Collect service, supplying COVID-19 lateral flow kits to people, mainly the care home staff.

The pharmacy used dispensing baskets to keep people's medicines and prescriptions separate. The team initialled boxes on the dispensing labels to provide an audit trail of who had dispensed and checked the prescription. The team used the bench space well to reduce the risk of errors, including keeping the dispensing for different care home separate. There were separate areas for labelling, dispensing and checking. The pharmacy used stickers to highlight special storage requirements such as fridge lines. The pharmacist was aware of the professional requirements of valproate use in pregnancy. Most of the people the pharmacy dispensed to were elderly and so not in the at-risk group. But the pharmacy didn’t have any written literature and the dispensers had not received any training and had little knowledge of high-risk medicines and monitoring. The pharmacy hadn't completed any audits on the prescribing of higher-risk medicines such as valproate or lithium. The pharmacy had completed a recent audit in April 2021 to review its processes and services. The pharmacy had identified some areas of change that would improve services and standards in the pharmacy.

The pharmacy dispensed medicines into a range of different multi-compartment compliance packs suited to the requirements of the different care homes and different patients. The pharmacy dispensed to some care homes using the different coloured rack system. The team had an audit trail from ordering prescriptions to delivery of the medicines to the care homes. It had split the workload and supply up into four weeks, identified by different coloured notices on the wall and coloured dots on the calendar. This made it easy for the team members to refer to. And helped them make sure ordering and dispensing was up to date. The team members used a monthly sheet to identify any missing prescriptions so they could follow up with the care home. The records of times of administration, doses and directions were kept on the patient medication records (PMR) on the computer. The dispensers

and pharmacist used a series of checks during the dispensing process to reduce errors and highlight any changes in people's medicines. They annotated using ticks on the prescription token when these checks had been completed. They supplied patient information leaflets (PILs) with the medicines.

The pharmacy had suitable storage for its medicines in the dispensary. Medicines returned from care homes were stored for two to three days in the downstairs storage area before being transferred to medicinal waste bins for destruction. This had been implemented during the pandemic to reduce the risk of virus transmission. The fridge was of a suitable size and the temperature was recorded daily. The records showed the temperatures to be in range. The pharmacy had a suitably sized CD cabinet and the CDs were stored tidily inside. The pharmacy had some records of recent date checking but these were not complete. There were no out-of-date medicines identified in a sample checked. There were two short-dated medicines on the shelves for June 2021 and July 2021 and the packs were not annotated in any way to identify this. The pharmacy ordered its medicines through a centralised ordering system and obtained them from recognised wholesalers. The pharmacy used an electronic system to identify product recalls. The team actioned the recalls by printing a copy and annotating the action taken. Records were seen for recent recalls, but the most recent recall for trimethoprim tablets was outstanding on the electronic system.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for the services it provides. And the pharmacy uses its equipment in ways that protect people’s private information

Inspector's evidence

The pharmacy had resources such as the BNF and access to the internet for up-to-date information. It used CE marked glass measures for liquids. The computers were password protected and the phones had portable handsets so team members could have private conversations. The pharmacy ordered and stored the consumables for the care homes and compliance packs appropriately.

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.