

# Registered pharmacy inspection report

**Pharmacy Name:** Broughton Pharmacy, 86 Devonshire Street,  
Salford, Greater Manchester, M7 4AE

**Pharmacy reference:** 9011844

**Type of pharmacy:** Community

**Date of inspection:** 15/11/2023

## Pharmacy context

This is a traditional community pharmacy, situated on a main road of a suburban residential area, serving the local population. It mainly prepares NHS prescription medicines, and it supplies several local care homes. The pharmacy orders people's repeat prescriptions on their behalf. A large number of people also receive their medicines in weekly multi-compartment compliance packs to help make sure they take them safely. The pharmacy provides other NHS services including flu vaccinations, the Community Pharmacy Consultation Service (CPCS), local minor ailment treatments and substance misuse treatment services. It also has a home delivery service.

## 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
<b>1. Governance</b>	Standards not all met	1.6	Standard not met	The pharmacy does not always keep appropriate records of controlled drugs (CD) medicines transactions in accordance with legal requirements.
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance Standards not all met

### Summary findings

The pharmacy does not always keep up to date records of controlled drugs (CD) transactions in accordance with legal requirements. And it does not have an effective way of monitoring the pharmacy's CD stock. It has some written instructions to help make sure the team provides safe services. But pharmacy team members do not confirm when they have read these instructions, so they might not always work effectively. The team reviews its mistakes which helps it to learn from them. And the team members understand the importance of protecting people's information, and their role in supporting vulnerable people.

### Inspector's evidence

The pharmacy had written procedures that covered safe dispensing, the responsible pharmacist (RP) regulations and controlled drugs (CDs). The responsible pharmacist, who was the regular and superintendent pharmacist, explained that pharmacy team members had read these procedures, but they had not always signed to confirm this.

The dispenser and checker initialled dispensing labels for prescription medicines that the pharmacy prepared and supplied. This helped to clarify who was responsible for each prescription medication supplied and assisted with investigating and managing mistakes.

The pharmacy team discussed and recorded mistakes it identified when dispensing medicines, and it addressed each of these incidents as they occurred to make sure team members learned from them. The team reviewed these records collectively every three months, but the records did not always include enough details indicating why the team thought each mistake happened. This meant the team might miss additional opportunities to learn from its mistakes and identify trends or mitigate risks in the dispensing process.

The pharmacy had written complaint handling procedures, so staff members knew how to effectively respond to any concerns. There was no publicly displayed information explaining how people could make a complaint, so people may feel less encouraged to raise a concern. The pharmacy had not completed a patient survey since the pandemic.

The pharmacy had professional indemnity cover for the services it provided. The RP displayed their RP notice so the public could identify them. The pharmacy kept records of the RP in charge of the pharmacy, but the records did not always state when the RP ceased acting in their role.

The pharmacy had electronic CD registers and it kept running balances for most of the CDs that it stocked. But it did not always keep a register of transactions for each CD that it had stocked and supplied in the last two years, as required by law. The pharmacy kept running balances for the CDs stocked. Records of CDs returned to the pharmacy for safe disposal were kept.

Records indicated that the pharmacy checked the methadone running balance weekly. The RP said that all other running balances were checked at time of each transaction, but corresponding records were not always made. Two randomly selected balances for regularly supplied CDs had not been checked for around eighteen months and were found to be inaccurate. So, it was unclear if the pharmacy had a system to help it identify any discrepancies promptly. Records of CDs returned to the pharmacy for safe

disposal were kept.

The pharmacy kept records kept for the NHS CPCS, local minor ailment and flu vaccination services, which included people's consent to provide the service and share relevant information about them with associated health care professionals.

The RP said that staff members had signed an agreement about protecting people's confidentiality, but they could not locate these agreements. They had discussed with each team member practical points on protecting confidentiality, which included keeping written and oral information private. So, the team had a basic understanding of protecting information. Team members secured and destroyed any confidential papers. They used passwords to access NHS electronic patient data. But not all team members had applied for their own security card to access this information. And there was no publicly displayed information about the pharmacy's privacy policy. So, people may have more difficulty finding out how the pharmacy protects their data.

The RP had level two safeguarding accreditation, and the pharmacy was a member of the 'Safe Spaces' programme. The pharmacy liaised with the local substance misuse team if people missed collecting consecutive methadone supplies.

The team liaised with the local GP practice about new patients who needed the compliance pack service, which included assessing whether they needed to be limited to seven day's medication per supply to avoid them becoming confused. However, it did not make corresponding records of these discussions to support this.

The pharmacy kept records of the care arrangements for people using compliance packs, including their next of kin's or carer's details and any special arrangements about who collected and when to supply their medication. This meant the team members had easy access to this information if they needed it urgently.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy is facing difficulties recruiting staff. This means team members frequently need additional support to make sure people receive their prescription medicines on time. And the pharmacy does not progress staff training in a timely fashion. So team members may delay obtaining the knowledge and skills relevant to their role.

### Inspector's evidence

The RP was the sole staff member present. The pharmacy's other staff included a dispenser, a trainee dispenser and a delivery driver.

The pharmacy was facing significant staffing challenges and it had not filled a dispenser vacancy created when a staff member had left around two months ago.

The pharmacy had enrolled the trainee dispenser on a dispenser qualification course when they started working at the pharmacy in October 2022. However, the trainee had not started any of the course modules, and their progress was not being effectively monitored or managed.

The low footfall and appointment only flu vaccination service meant that the team could promptly attend to people visiting the pharmacy. However, the staff shortages meant staff members had to regularly work additional hours to make sure repeat prescription medicines were ready on time.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The premises are clean, secure and suitable for the pharmacy's services. It has a private consultation room, so people can have confidential conversations with pharmacy team members and maintain their privacy.

### Inspector's evidence

The pharmacy was situated in a retail unit. The level of cleanliness was appropriate for the services provided. Shop and dispensary fittings were suitably maintained. The retail area and counter could accommodate the number of people who usually presented at any one time. The premises had the space that the staff needed to dispense medicines safely. The pharmacy had a separate area for preparing compliance packs. The team could secure the pharmacy to prevent unauthorised access.

The consultation room provided the privacy necessary to enable confidential discussion. But its availability was not prominently advertised, so people may not always be aware of this facility.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's working practices are generally effective, which helps make sure people receive safe services. It gets its medicines from licensed suppliers. The pharmacy team has some checks to make sure medicines are in good condition and suitable to supply, but it does not keep supporting records to confirm this.

### Inspector's evidence

The pharmacy opened on weekdays from 9am to 6pm. It had a permanent ramp and handrail leading to the entrance, which had a power-assisted door.

The pharmacy had written procedures that covered the safe dispensing of higher-risk medicines including anti-coagulants, methotrexate, lithium and valproate. In January 2023 the team had checked for people taking valproate who may be in the at-risk group. The pharmacy had the booklets which should be given to anyone receiving valproate for the first time, as stated under MHRA guidance. Valproate stock had the MHRA approved advice cards attached.

The team prompted people to confirm the repeat prescription medications they required, which helped the pharmacy limit medication wastage, and so people received their medication on time. The pharmacy retained records of the requested prescriptions. So, the team could effectively resolve queries if needed.

The team scheduled when to order prescriptions for people who used compliance packs, so that it could supply their medication in good time. It kept a record of these people's current medication that also stated the time of day they were to take them. This helped it to effectively query differences between the record and the prescriptions it received with the GP practice, and it reduced the risk of it overlooking medication changes. The team recorded any communications about medication queries or changes for people using compliance packs. Descriptions for different medicines contained inside compliance pack were included, which helped people to identify them.

The pharmacy supplied medication in the manufacturer's original containers for people staying at a care home, as recommended under local NHS guidelines. The pharmacy issued medicine administration records (MARs) for care homes to record medicines they had administered, but it did not provide them with a form to record missed doses or the reason for the missed dose. The pharmacy issued bespoke MARs for higher-risk medicines such as methotrexate and warfarin. It made body maps available to care homes to record externally applied medicines such as creams and patches. These records helped the carers administer and manage people's medicines more safely and effectively.

The pharmacy had methadone instalments ready in advance of people presenting for them and they prepared instalments for more than one day in divided daily doses. This helped the pharmacy to manage its workload and supported people to take an accurate dose. Pharmacy team members asked appropriate questions and gave relevant advice when people requested over the counter (OTC) codeine-based pain relief medication.

The pharmacy used baskets during the dispensing process to separate people's medicines and organise its workload. Team members permanently marked medication stock cartons to signify they were part-

used, which helped make sure they selected the right quantity when dispensing and supplying medication.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers and stored them in an organised manner. Some stock was temporarily stored in baskets on the dispensary floor in preparation for assembling medicines for a significant number of people resident at care homes. The pharmacy had a suitably secured CD cabinet. It quarantined obsolete CDs, and it used destruction kits for denaturing unwanted CDs.

The RP explained that the team had checked all the medicine stock expiry dates in February 2023, May 2023 and August 2023. They stated that corresponding records were made for the February 2023 checks. But they could not locate these records, and the pharmacy had not made any records for the May 2023 and August 2023 checks.

The RP checked the medication refrigerator temperature daily, which they stated was consistently within safe limits. But the pharmacy did not keep a corresponding record of these checks, and some foodstuffs were temporarily stored in the medication fridge.

The RP explained that the pharmacy took appropriate action when it received alerts for medicines suspected of not being fit for purpose. But they could not locate the records that confirmed this. The team had facilities in place to dispose of obsolete medicines, and these were kept separate from stock.

The pharmacy kept records of medicines that it delivered to people, which included the recipient's signature. Records of CDs delivered were kept for two years, which helped to resolve any queries if needed.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy team has the equipment and facilities that it needs for the services it provides. The equipment is appropriately maintained and used in a way that protects people's privacy.

### Inspector's evidence

The pharmacy team kept the dispensary sink clean and it had hot and cold running water and an antibacterial hand-sanitiser. The team had a range of clean measures, including separate ones for methadone. So, it had facilities to make sure it did not contaminate the medicines it handled and could accurately measure and give people their prescribed volume of medicine. The team had access to the British National Formulary (BNF) online, which meant it could refer to pharmaceutical information if needed.

The pharmacy team had facilities that protected people's confidentiality. It viewed people's electronic information on screens which were not visible from public areas and regularly backed up people's data on its patient medication record (PMR) system. So, it secured people's electronic information and could retrieve their data if the PMR system failed. And it had facilities to store people's medicines and their prescriptions away from public view.

### 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.