General Pharmaceutical Council

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: 19/06/2024

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, Pharmacy First, local minor ailment treatments and substance misuse treatment services. It also has a home delivery service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 has written instructions to help make sure the team provides safe services. The team reviews its mistakes which helps it to learn from them. The pharmacy keeps records of controlled drugs (CD) transactions in accordance with legal requirements. And it monitors its CD stock. 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 CDs. Records indicated that pharmacy team members had read these procedures.

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 for any common mistakes, 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. Publicly displayed information explained how people could make a complaint. 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.

The pharmacy had electronic CD registers, which it maintained by law. CD Running balances were regularly checked. One randomly selected running balance selected was found to be accurate. The team kept records of CDs returned to the pharmacy for safe disposal.

The pharmacy kept records kept for the NHS Pharmacy First, 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.

Staff members had signed an agreement about protecting people’s confidentiality, but they could not locate these agreements. The RP subsequently said they had found these. The RP had discussed with each team member practical points on protecting confidentiality, which included keeping written and oral information private. Team members secured and destroyed any confidential papers. They used passwords to access NHS electronic patient data and team members had their own security card to access this information or they had applied for one. 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 pharmacy’s chaperone policy was publicly displayed.

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. The pharmacy recently started to keep 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.

The pharmacy used an external courier service, who was registered with the Information Commissioner's Office, to deliver people's medicines. The courier's delivery drivers signed an agreement that they understood they were handling people's confidential information. However, the pharmacy had not clarified the details of the confidentiality training that drivers had completed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload. Team members receive essential training for their roles. But the pharmacy does not always 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 staff present included the RP and a dispenser. The pharmacy's other staff included a trainee dispenser and a regular locum pharmacist on Tuesdays and Fridays.

The pharmacy had enough staff to comfortably manage its workload. The team usually had repeat prescription medicines ready in good time for when people needed them, including those who had their medication in compliance packs and delivered. The pharmacy received most of its prescriptions via the prescription management and NHS Electronic Prescription Service. The pharmacy had a low footfall and appointment only flu vaccination service. So the team avoided sustained periods of increased workload pressure and it could promptly serve people. The team did not have any official targets or incentives for the scale of services it provided.

The pharmacy had enrolled the trainee dispenser on a dispenser qualification course when they started working at the pharmacy in October 2022. They did not start completing the course until November 2023, but they had completed six out of fourteen modules since then. The RP was available two days per week to support the trainee and advance their progress when the locum pharmacist was covering the pharmacy. This had helped the trainee to make the recent significant progress, and the RP suggested that they should complete their training by December 2024. The pharmacy was also planning to recruit a trainee dispenser so that it could increase its dispensing and overall service capacity.

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. Its availability was prominently advertised, which helped people to know this facility was available.

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 completes some checks to make sure medicines are in good condition and suitable to supply, but it does not always 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 external 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. The valproate procedures included to supply full packs and check that people in the at-risk group had received their annual review. But the procedure did not include to check that two specialists had agreed to initiate valproate prescribing, and the RP did not know about this MHRA guidance. But they agreed to address this.

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, which included recording missed doses and 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 team 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 team knew that codeine linctus was now legally classified as a prescription only medicine.

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 using compliance packs.

The pharmacy had a suitably secured CD cabinet. It quarantined obsolete CDs, and it used destruction kits for denaturing unwanted CDs. Team members monitored and recorded the refrigerated medication storage temperatures. Records indicated that the team had regularly checked the expiry dates for prescription medicine stock.

The team had an electronic record system that it used to store and retrieve people's bags of prescription medication awaiting collection. This meant it could efficiently store and retrieve people's medicines and their prescription when needed. The RP explained that the pharmacy took appropriate action when it received alerts for medicines suspected of not being fit for purpose and had 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 used an external courier service to deliver medicines to people. The RP explained that the courier delivered medications the day after it collected them from the pharmacy. The courier's written delivery procedure covered the pharmacy's and courier's delivery driver and storage facility staff responsibilities to help make sure medicines were delivered safely and securely.

The pharmacy monitored the courier's online tracking system for medicines dispatched for delivery. This system included the estimated delivery date and time, and the medicine recipient's signature at the delivery address.

The courier's delivery procedure required the delivery driver to verify the delivery address at the point of handing over medication to people. The procedure included the delivery driver additionally signing the courier's electronic record to confirm they had verified the patient's identity for the CD they had delivered. However, the procedure did not clarify the action to take if the recipient of the CD did not have any proof of their identity. So it was unclear what happened under these circumstances. The RP subsequently explained that the courier returned CDs to the pharmacy if the recipient could not verify their identity, and they had asked the courier to review its procedure.

The courier's delivery procedure indicated that the courier had refrigeration and CD storage facilities. And the RP explained that the pharmacy appropriately marked the packages that required refrigeration for the courier's attention. However, the procedure was silent on how the pharmacy should communicate to the courier the delivery packages that required refrigeration.

Records indicated that the courier monitored its vehicle and storage facility refrigerators each day, which the RP understood were consistently operating within safe temperature limits. The storage facility records included the refrigerator temperature at the time it was checked, and the vehicle records verified that the refrigerator was functioning, but it did not include a temperature

check. Neither record included the maximum and minimum temperatures since the last check. So it may make it difficult for the pharmacy to demonstrate that these medicines were being stored within the correct temperature range. The RP stated that these refrigerators alerted courier staff if the temperature exceeded the recommended limit for medicines.

The RP stated that courier staff minimised the time that refrigerated medicines were transferred between the vehicle and storage facility refrigerators to help keep them cool. However, this requirement was not included in the courier's procedures. And refrigerated products were not packed in cooling or insulating material to help maintain the cold chain.

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.