

Registered pharmacy inspection report

Pharmacy Name: Evercare Pharmacy, 242 Yorkshire Street, Rochdale, Greater Manchester, OL16 2DP

Pharmacy reference: 9012100

Type of pharmacy: Community

Date of inspection: 30/10/2023

Pharmacy context

The pharmacy is situated in a parade of shops on a main road. The pharmacy changed ownership in August 2023. The pharmacy dispenses medicines and supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines.

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	2.2	Good practice	Team members are supported with and get time set aside for ongoing training and the pharmacy monitors it. This helps team members keep their knowledge and skills up to date.
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 adequately manages risks, and it takes steps to improve patient safety. It completes the records that it needs to by law and asks people for their views and feedback. Members of the pharmacy team work to professional standards, and they are clear about their roles and responsibilities. They keep people's private information safe, and they understand how to protect the welfare of vulnerable people.

Inspector's evidence

Standard operating procedures (SOPs) were available and review dates were recorded on a tracker which also had an audit trail of SOPs that team members had read. But there was no record to show who had reviewed the SOPs. The responsible pharmacist (RP), who was also the superintendent pharmacist (SI), confirmed that he had reviewed the SOPs. The SI had developed a professional standards audit for the pharmacy manager to complete; this included various clinical governance checks and included checks to see if near misses were being recorded. However, no audit had yet been completed as the SI had only recently taken over the business and a number of staff had left since the change of ownership.

Dispensing mistakes which were identified before a medicine was supplied to people (near misses) were highlighted to the team member involved in the dispensing process. They were asked to identify their mistake and rectify it, and the incident was discussed with the team. However, there were no records of near misses available, and the SI admitted the team had not recorded some mistakes that occurred. This could make it difficult for the team to learn from mistakes or spot trends and patterns. As a result of previous near misses the team had been asked to mark split packs and write the brand names of the controlled drugs (CD) to be dispensed on the prescription form.

A team member described when they had first started, they made many mistakes when preparing backing sheets for the multi-compartment compliance packs. But as they became more confident, they had not made any mistakes in the last two months. The RP said there had not been any instances since the pharmacy had been taken over where a dispensing mistake had happened, and the medicine had been supplied to a person (dispensing errors). But they confirmed that any dispensing errors that did occur would be investigated and recorded electronically.

The correct RP notice was displayed. When questioned, the team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure. The RP had printed several notices including details on how people could raise concerns but was waiting for a display board to be fitted so these could be displayed.

Private prescription records, emergency supply of medicines, RP records and CD registers were generally well maintained. However, some private prescription records did not have accurate details of the prescriber. Running balances of CDs were recorded and checked weekly against physical stock. A random balance was checked against the physical stock held and found to be correct. No unlicensed medicines had yet been dispensed, but the RP was able to describe the records that needed to be kept

when unlicensed medicines were supplied.

Assembled prescriptions which were ready to collect were stored in the dispensary and not visible to people using the pharmacy. The pharmacy had an information governance policy on which the RP had completed training. And the pharmacy manager had started the training. Other team members had completed some training on data protection and patient confidentiality as part of their mandatory training courses. The pharmacy stored confidential information securely and separated confidential waste which was then shredded. The RP had access to summary care records (SCR) and obtained verbal consent from people before accessing. The RP and pharmacy manager had individual smartcards.

The RP had completed level three safeguarding training. Some team members including the driver had completed safeguarding training at their previous place of work. Members of the team explained that if they had any concerns, they would refer to the RP and they were aware of the next steps to follow. The RP had briefed the pharmacy student on safeguarding.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough trained staff to provide its services effectively. Team members are appropriately trained or are in the process of completing the appropriate training for their roles. The pharmacy helps staff to keep their knowledge and skills up to date. Team members get regular feedback, and they are supported when completing accredited courses. And the pharmacy team can provide feedback and concerns relating to the pharmacy's services.

Inspector's evidence

At the time of the inspection the team comprised of the RP, who was the regular pharmacist and a trained dispenser, who was also the pharmacy manager and had been enrolled on a pharmacy technician training course. A pharmacy student worked a few days each week and had been enrolled on the combined course (which covered the medicines counter assistant and dispenser training). The pharmacy also had a delivery driver and a trained dispenser who were not present. The RP felt that there were enough staff to manage the workload. The team were observed to be able to be working effectively and were up to date with the dispensing. Team members booked their leave using an electronic application and were asked to do this in advance to allow the RP enough time to plan and arrange cover.

The team worked closely together and discussed matters as they arose. Weekly team meetings were held, and all team members were asked if they had questions or feedback. Team members said they felt comfortable raising concerns and providing feedback.

Team members asked appropriate questions and counselled people before recommending over-the-counter treatments. They would refer to the RP if they were not sure or if they identified red flag symptoms. They were aware of the maximum quantities of medicines that could be sold over the counter. The RP held reviews with new team members when they first started after one week, and then at six or twelve weeks. All team members had an annual 'how am I doing' discussion with the RP which was recorded. Team members were also provided with feedback at the weekly team meetings.

Team members on formal training courses were well supported by the RP and other members of the team. The pharmacy student worked part time at the pharmacy and was given training time when it was not busy. The RP had a list of training modules all team members were required to complete in order to keep up to date. In addition to this a different clinical topic was covered each month. The slides for the training were produced by the RP and another pharmacist. The trainee pharmacist who worked at the sister branch delivered the training. The topics selected were aligned with the areas the trainee pharmacist was studying. There was a mini test at the end of the training to test understanding and key learning was discussed at the team meeting. Team members said the last topic covered was haemorrhoids. Certificates were retained by the pharmacy for formal training completed or for any mandatory training. Targets were set for services provided, but pharmacists provided the services because they wanted to help people. Targets did not affect the professional judgement of the pharmacists.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are clean, secure and provides a safe environment to deliver its services. People using the pharmacy can have conversations with its team members in a private area.

Inspector's evidence

The pharmacy was bright, clean and organised. There was a waiting area and the RP had moved the medicines counter further back to create a space where people could talk to team members quietly.

The dispensary was large, tidy and had been structured so that the workflow was organised and flowed through the dispensary. More workstations had been built after the pharmacy had been taken over. A clean sink was available for the preparation of medicines and medicines were arranged on shelves in a tidy and organised manner. A separate dedicated workbench was used for the preparation of multi-compartment compliance packs. Cleaning was done by the team. The room temperature and lighting were appropriate.

The premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for private conversations. There were some folders containing confidential information in the room, the RP said these would be moved into the dispensary as more storage space had been created.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers a range of service which are accessible and generally well managed. But in some instances, it does not follow the written procedures that are in place to make sure people receive their medicines safely. The pharmacy obtains its medicines from licensed sources and largely manages them properly. And it takes the correct action in response to safety alerts so that it supplies people with medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy had a small step at the entrance which may make it harder for people with a wheelchair or push chair to enter. The RP said he had spoken to the previous owners and builders about having a ramp built either externally or internally, but this had not been possible. People who had difficulty entering the pharmacy were helped by team members at the door or signposted to other local services. The pharmacy also provided a prescription delivery service. Most team members were bi-lingual which helped to meet the needs of the local area. When necessary, the team used the internet to find out details of local services so that they could signpost people who needed services that the pharmacy did not provide.

The RP was an independent prescriber but had no plans to launch any prescribing services. The pharmacy had recently launched a travel vaccination service.

There was an established workflow within the dispensary and prescriptions were usually assembled by the dispensers. The dispensary had separate allocated areas to complete different parts of the dispensing and checking process. 'Dispensed by' and 'checked by' boxes were available on dispensing labels, and these were routinely used to create an audit trail showing who had carried out each of these tasks. Baskets were used to separate prescriptions, to prevent them being mixed up. Baskets were also colour-coded to help manage the workflow.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). Sodium valproate was only dispensed in original packs. The computer system highlighted people that had not previously received sodium valproate from the pharmacy. The RP described how people had been supplied with warning cards in the past, but these were now included on the packs. Additional checks were carried out when people collected medicines which required ongoing monitoring. People collecting warfarin had their INR monitored at a local warfarin clinic and verbally confirmed monitoring information with the RP.

Some people's medicines were supplied in multi-compartment compliance packs. Packs were prepared by the dispenser. Each person had an individual backing sheet which was used to collect medicines from the shelves. The dispenser made a record of the medicines ordered from the surgery and the corresponding prescriptions received. Care records were also kept in people's folders and any changes were confirmed with either the prescriber or using SCR. A record was made on the care record with the date it was confirmed and by who. Packs were prepared in advance of receiving prescriptions. And prepared packs for one person were seen to have been left unsealed over the weekend. Team members agreed that there were risks associated with both preparing packs in advance of receiving the

prescriptions and leaving packs unsealed. The RP and dispenser agreed that they would review the service. The RP was due to have a meeting with the practice manager at the local surgery to discuss ordering prescription in advance. The dispenser felt that there was little risk of packs being handed out before being checked against the prescription as all team members were aware and locum pharmacists were briefed on the process when they started working. Following the inspection team members confirmed that the service had been reviewed alongside the SOPs and packs were only being prepared once prescriptions were received .

Assembled packs were labelled with the product descriptions and empty original packs were also given to people. There were no mandatory warnings included on the labels, but the dispenser agreed she would speak to the system provider to change the settings. There was an audit trail to show who had prepared and checked the packs. Patient information leaflets were issued monthly.

The pharmacy offered a prescription delivery service and had a designated driver. The driver had a delivery log sheet and marked when they had delivered medicines to people. Team members confirmed signatures were obtained for CDs that were delivered. If someone was not available to receive a delivery, the medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and stored appropriately. This included medicines requiring special consideration such as CDs. Fridge temperatures were monitored daily and recorded; these were within the required range for storing temperature-sensitive medicines. Team members were able to describe the steps they would follow if the temperature was not within range. The RP had reported issues with the fridge to the manufacturer. A few medicines were seen to be stored in brown bottles without any records of expiry dates or batch numbers. An original pack was seen which had mixed batches and the date of opening was not recorded on all liquids with limited stability. These were removed from the shelves during the visit and the RP provided an assurance that he would speak to the team members. Team members explained that date checking was done monthly, and a full check had been done when the pharmacy had been taken over. A random sample of stock was checked, and no date-expired medicines were found. Short-dated stock was marked with labels. Out-of-date and other waste medicines were separated and then collected by licensed waste collectors. Drug recalls were received electronically. The team would check the stock and take the action as required; the system had to be updated with details of the steps taken.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. Equipment is kept clean and is ready to use.

Inspector's evidence

The pharmacy had calibrated glass measures and some plastic measures. The SI said these had been left by the previous owners and provided an assurance that they would stop using the plastic measures. Separate measures were available for liquid CD preparations to avoid cross contamination. Tablet counting equipment was available. Equipment was clean and ready for use. A medical fridge was available, but the RP mentioned there had been issues with it and he had spoken to the manufacturer who had sent a new seal for the door.

A blood pressure monitor was available but had not been used. The RP was unaware of the calibration arrangements or how old this was as it had been inherited from the previous owners. The RP planned to replace this with a new monitor. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected and screens faced away from people using the pharmacy.

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.