General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: iConnect Pharmacy, First Floor, Unit 23, The Meridian Business Centre, Wainwright Street, Oldham, Greater Manchester, OL8 1EZ

Pharmacy reference: 9012115

Type of pharmacy: Closed

Date of inspection: 31/10/2023

Pharmacy context

This pharmacy is located in a closed unit in a business centre. People cannot visit the pharmacy in person unless they are attending a pre-arranged appointment, such as a blood pressure check. The pharmacy dispenses NHS prescriptions. It supplies medicines to care homes and some of the people receive their medicines in multi-compartment compliance aid packs to help them take their medicines at the right time. The pharmacy has a website (www.iconnectpharmacy.co.uk) which provides information about the pharmacy.

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 generally manages risks to make sure its services are safe. It reviews any errors and makes changes to improve patient safety, and it completes the records that it needs to by law. The pharmacy has written procedures on keeping people's private information safe. And team members understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had started operating around five months ago. It had up-to-date standard operating procedures (SOPs) for the services it provided, with signatures showing that members of the pharmacy team had read and accepted them. The pharmacist superintendent (SI) said he had explained the delivery procedure to the delivery driver. But he had not read any of the SOPs, so there was a risk that he might not fully understand his responsibilities. The SI agreed to ensure that the driver read the relevant SOPs. Roles and responsibilities were set out in SOPs. The SI was working as the responsible pharmacist (RP) and his name was displayed as required by the RP regulations.

The pharmacy team recorded near misses on a log. Some near misses had been logged for during the previous month. The SI said he would review them and discuss them with the rest of the pharmacy team. The team had placed stickers in front of look-alike and sound-alike drugs (LASAs) such as Zolpidem and zopiclone, and promazine and promethazine, so extra care would be taken when selecting these. The SI said there had not been any dispensing errors, but he would follow the 'Dealing with an incident' SOP and investigate and report any incident that occurred.

The pharmacy's complaint procedure and the details of how to give feedback was available on the pharmacy's website. A current certificate of professional indemnity insurance was on display in the pharmacy. The SI confirmed that the insurance covered all of the services provided by the pharmacy.

Private prescription and emergency supply records were recorded electronically. The RP record and the controlled drug (CD) registers were appropriately maintained. Records of CD running balances were kept and these were regularly audited. The pharmacy only had a single CD, which required recording in the CD register. Its running balance was correct. The pharmacy did not have a record of any patient returned CDs. The SI confirmed that none had been returned yet but he would order a book to record the return and destruction, so the team would be prepared if anyone returned CDs.

The pharmacy had Information Governance (IG) policies which included information on data protection and protecting people's private information. The pharmacy's privacy and cookie policies were on the website. Confidential waste was collected in a designated place and shredded.

The pharmacists had completed level 2 training on safeguarding children and vulnerable adults. There was a safeguarding SOP. The pharmacy had a chaperone policy, and the SI said he asked people if they wanted to bring someone with them to the pharmacy when they came for a consultation.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team, and the workload is manageable. Team members have opportunities to discuss issues informally together. But training is not well organised, and the delivery driver is carrying out duties which he has not been properly trained to do, which increases the chances of mistakes happening.

Inspector's evidence

The pharmacy team consisted of the SI, a delivery driver and a second pharmacist who worked half days in the pharmacy to provide support to the SI. The second pharmacist could work additional hours when necessary. On some occasions the SI was based in a local GP practice carrying out blood pressure testing. On those days, the second pharmacist worked as RP in the pharmacy. The SI generally checked the prescriptions which the second pharmacist had dispensed. He said if he was required to self-check prescriptions, he would take a mental break between dispensing and checking. The SI said he would recruit additional members of staff as the workload increased.

The SI confirmed that he was trained and competent to carry out the services he was providing. The delivery driver had not completed any training on delivering medicines, but the SI would look into enrolling him onto a suitable course. Team members discussed issues informally as they arose, and the pharmacy had a whistleblowing policy. The pharmacists were empowered to exercise their professional judgement and could comply with their own professional and legal obligations. For example, refusing to supply a medicine if they felt it was inappropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally provides a suitable environment for the provision of healthcare services. It has a consultation room so people can receive services in private. The pharmacy's website has useful information about the pharmacy and its services.

Inspector's evidence

The pharmacy consisted of the main dispensary, a room for care home assembly and the consultation room. The premises were in an adequate state of repair, but the area between the entrance and the consultation room was untidy which compromised the professional appearance of the pharmacy. The lighting was adequately controlled. There were portable radiators to heat the pharmacy. Team members could use the business centre's communal facilities which included WCs and wash hand basins with hot and cold running water. There was a kettle in the pharmacy. The pharmacy did not have its own sink but used the water from the nearby communal facilities when cleaning and re-constituting antibiotics. The consultation room was clean and professional in appearance. The pharmacy's website provided useful information about the pharmacy such as its contact details, practice leaflet, and the services provided.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a small range of healthcare services, which are generally well managed. It gets its medicines from licensed suppliers and the team carries out some checks to ensure medicines are in suitable condition to supply.

Inspector's evidence

The pharmacy was on the first floor of the building. People with appointments for services were required to phone the pharmacy when they arrived at reception, so they could be allowed access. There was a sign at reception explaining this. The building did not have a lift, so the pharmacy was not accessible to everyone. People could communicate with the pharmacy team via the telephone or by email.

Services provided by the pharmacy were advertised on the pharmacy's website. And there was a link to the NHS.uk website where people could access general information on medicines and healthcare conditions. As well as supplying NHS prescriptions, the pharmacy provided other NHS services including a blood pressure testing service, a repeat oral contraceptive service, and the Community Pharmacy Consultation Service (CPCS). The blood pressure testing service had been successful at identifying people with unknown hypertension. On one occasion a person had been sent to the A and E department at the local hospital because their blood pressure was so high it was classed as a hypertensive crisis.

All prescriptions were delivered. There was a robust audit trail for deliveries made to the care homes, and the pharmacy obtained signatures from them to confirm the safe receipt. The delivery process for people in the community was not as robust, as neither the name or the signature of the person receiving the delivery was obtained, which limited the information available in the event or a problem or query. This was not in line with the delivery SOP. The SI confirmed that he would review the delivery process. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. The procedure for any prescriptions received from outside the delivery area was that they would be posted using a Royal Mail tracked service.

Space was quite limited in the dispensary, but the workflow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat, and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

The SI was aware of the requirements for a Pregnancy Prevention Programme to be in place for people in the at-risk group who were prescribed valproate, and that people were required to have annual reviews with a specialist. The SI said that the pharmacy did not currently have any patients in the at-risk group. He confirmed that original packs would always be supplied to ensure people in the at-risk group were given the appropriate information.

The pharmacy supplied medicines to two care homes. The patients in one of the care homes received

their medicines in original packs and patients in the other care home received their medicines in multi-compartment compliance aid packs. There was a partial audit trail for changes to medication in the compliance aid 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. A dispensing audit trail was completed, and medicine descriptions were usually included on the packaging to enable identification of the individual medicines. Packaging leaflets were included so people were able to easily access additional information about their medicines, but some of the cautionary and advisory labels were missing from the labelling sheets. The SI said he would contact the software provider to resolve this labelling issue. Disposable equipment was used. An assessment was made by the SI as to the appropriateness of a pack or if other adjustments might be more appropriate to their needs.

The pharmacy stocked a small range of over-the-counter (OTC) medicines mostly for use in the CPCS. The SI explained that he had supplied a few OTC medicines following phone calls with people as part of this service. He said a pharmacist would always talk to the patient and ask the relevant WWHAM questions. The pharmacy did not sell any medicines which could be misused such as codeine containing products.

CDs were stored in a CD cabinet which was securely fixed to the floor. The keys were under the control of the RP during the day, and they were stored securely overnight. Denaturing kits were available to destroy any patient returned CDs. Recognised licensed wholesalers were used to obtain stock medicines and appropriate records were maintained for medicines ordered from 'Specials.' Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and documented. Short-dated stock was noted down in a book, so it could be taken off the shelves before it expired. Dates had been added to opened liquids with limited stability. Expired and unwanted medicines were segregated and placed in designated bins.

Alerts and recalls were received via email messages from the Medicines & Healthcare products Regulatory Agency (MHRA). These were read and acted on by the SI. A copy was retained in the pharmacy, if relevant to the pharmacy, with a record of the action taken so the team were able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date information. For example, the electronic British National Formulary (BNF), BNF for children and Summaries of Product Characteristics (SPCs). There was a clean medical fridge for storing medicines. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. There was a new blood pressure testing machine, which the SI confirmed was reliably accurate. He said it would be calibrated or replaced in a couple of years. All electrical equipment appeared to be in working order. There was a small selection of clean liquid measures. One was glass with accuracy markings, but the other one was plastic without any accuracy stamps. The SI explained that this was a temporary measure as the other glass measures which he had ordered had broken in transit. The pharmacy had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Patient medication records (PMRs) were password protected. Individual electronic prescriptions service (EPS) smart cards were used 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.