General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Manor Pharmacy, 157-159 Ainsworth Road, Radcliffe, Manchester, Greater Manchester, M26 4FD

Pharmacy reference: 9012178

Type of pharmacy: Community

Date of inspection: 16/04/2024

Pharmacy context

This pharmacy is situated in a small parade of shops within a residential area. The pharmacy dispenses NHS prescriptions and supplies some people with medicines in multi- compartment compliance packs to help them manage their medicines. It also provides a seasonal flu vaccination service, the NHS Pharmacy First service and a blood pressure check 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 manages the risks associated with its services to make sure people receive appropriate care. Members of the pharmacy team follow written procedures to make sure they work safely, and they complete tasks in the right way. They discuss their mistakes so that they can learn from them. And the team members understand their role in protecting vulnerable people and they keep people's personal information safe.

Inspector's evidence

Standard operating procedures (SOPs) were available and had been read and signed by the team. SOPs were issued and reviewed by the head office team.

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 and recorded in a near miss log. If the responsible pharmacist (RP) noticed that similar mistakes were happening she would discuss them with the team. Warning labels had been stuck on shelf edges near where medicines that looked or sounded alike were kept. The RP reviewed near misses each month or more frequently if needed. Any instances where a dispensing mistake had happened, and the medicine had been supplied, (dispensing errors) it was investigated, and a record was made. A copy of the completed form was sent to head office. The RP described that she had been notified of an incorrect strength of phenytoin being dispensed. She was due to have a discussion with the team and review where the items were stored on the shelves to make changes if needed. Any major errors that had occurred in one of the company's other branches was shared via the managers group communications channel.

A correct RP notice was displayed. When questioned, 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. A complaints procedure was in place and team members tried to resolve complaints in the pharmacy where possible. Any matters which could not be resolved were escalated to head office. A poster with details about how people could raise concerns was displayed in the pharmacy.

Private prescription records, emergency supply records and RP records were well maintained. Controlled drug (CD) registers were generally well maintained but there were a few missed headers in some of the registers seen. This could make it difficult to identify what register the pages belonged to if they became loose. Running balances for CDs were recorded and regularly checked against physical stock held in the pharmacy. A random balance was checked and found to be correct. CDs that people had returned to the pharmacy were recorded in a register and appropriately destroyed.

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 available, which was renewed by head office annually. And its team members had read through it. The pharmacy stored confidential information securely and separated confidential waste which was then collected and taken to head office. Pharmacists had access to National Care Records and obtained verbal consent from people before accessing it.

All team members had completed safeguarding training relevant to their roles. The RP had completed level three safeguarding training. The delivery driver had not completed any training courses and the RP provided an assurance that she would speak to the superintendent pharmacist (SI) about this. However, she described that the driver had faced instances where he had been concerned about someone's welfare and had contacted the pharmacy. Details for local safeguarding contacts were available.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload safely. And they are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team comprised of the RP, a pharmacy technician and three trained dispensers. One of the dispensers was also the supervisor. A relief dispenser was also working on the day of the inspection and completing merchandising activity in the retail area. The pharmacy also had a delivery driver. A trainee dispenser was on long term leave. The RP felt that there were enough staff to manage the workload. The team were observed working effectively together and were up to date with the workload.

Team members had annual appraisals with the RP and were also provided with ongoing feedback. The RP explained that the team was relatively new and there was an opportunity for them to complete additional training if they wanted or if they wanted to train on new services being provided. However, at the time of the inspection they were settling in. Team members were able to raise concerns and give feedback.

Team members asked appropriate questions and counselled people before recommending over-the-counter medicines. They were aware of the maximum quantities of medicines that could be sold over the counter and would refer any requests for multiple quantities to the RP. Team members were asked by head office to complete training modules on the eLearning for healthcare (elfh) portal, in line with contractual requirements. The RP briefed the team if there were any patient safety alerts and pharmacy magazines were given to team members that they could read. The team were also given literature which was received from manufacture. The dispenser described how they had recently been briefed about melatonin. And completed some training on dementia. Team members were provided with training time at work which also allowed them to discuss what they had learnt with colleagues. Certificates for training completed were retained by the RP.

Meetings with members of the team were held occasionally, however as the team was small and worked closely together, any new information, issues or concerns were discussed as they arose. Team members felt able to provide feedback and said it was easy to speak to the head office team and share suggestions and ideas. Targets were set for services provided, but the RP confirmed that they did not allow the targets to compromise their professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and tidy, and it provides a suitable environment for the delivery of healthcare services. It has a consultation room, so that people can speak to the pharmacy team members in private when needed.

Inspector's evidence

The pharmacy had recently relocated to a new premises. It was clean, tidy, and organised. The dispensary was large and had ample workspace which was allocated for specific tasks. Separate shelves were used to store baskets containing dispensed prescriptions waiting to be checked and those that were incomplete.

A clean sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by members of the team. The room temperature and lighting were appropriate, and the premises were secured from unauthorised access. The pharmacy had two consultation rooms. One of the rooms was being used for storage and the other was clean and suitable for private conversations.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy largely provides its services safely. It obtains its medicines from licensed sources and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy was easily accessible from the street. There was a ramp at the entrance, the shop floor was clear of any trip hazards and the retail area was easily accessible. Team members assisted people who needed help entering the pharmacy and the pharmacy provided a medicine delivery service. When it was necessary, the pharmacy team used the internet to find out the details of local services so that they could signpost people who needed services that the pharmacy did not provide. Team members used translation applications when needed.

The RP explained that the NHS Pharmacy First service and NHS 111 service had both been popular as people struggled to get appointments with their GP. Some people were referred to the pharmacy by their GP surgery and the there was a procedure to refer people back to the doctor if needed. The pharmacy had identified some people with high blood pressure as part of the hypertension service, people were referred back to their GP and in some instances had been prescribed medicines for high blood pressure.

The pharmacy had an established workflow. Prescriptions were processed and any repeat prescriptions were marked off against records to make sure the GP had prescribed the medicines that people required. The prescriptions were then separated for either delivery or collection. A dispenser was assigned to label all the prescriptions and then assembled them leaving them for the RP to check. 'Dispensed by' and 'checked by' boxes were routinely signed on dispensing labels, to create an audit trail showing who had carried out each of these tasks. Baskets were used to separate prescriptions, preventing the transfer of medicines between different people and were colour coded to help manage the workload.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP) and had a consultation with people who fell in the at-risk group and were supplied with this medicine. A poster about sodium valproate was displayed in the dispensary. Team members were aware that the original pack should not be split and made sure warnings were not covered when attaching the dispensing label. Some people were supplied with sodium valproate in multi-compartment compliance packs. The RP had not been aware of the need to have completed risk assessments for them. Subsequently, the RP confirmed that she had completed risk assessments for all the people who were not supplied sodium valproate in its original pack. And the review resulted in some people switched to having their medicines supplied in the original pack. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring. Stickers were attached to the prescription so that team members could check at handout. The RP described that people who had their medicines delivered did not always have these checks carried out and provided an assurance that a check would be done when they called in to order their prescription.

Some people's medicines were supplied in multi-compartment compliance packs to help them take

their medicines at the right time. The service was managed by one of the dispenser and other team members had also been trained to cover holidays and absence. Individual records were kept for each person and detailed all their current medicines and any notes regarding changes. The pharmacy received discharge summaries when people were admitted into hospital. The discharge summary was reviewed, and changes were confirmed with the person's GP. Prescriptions were ordered by the pharmacy. Any changes were checked and confirmed with the surgery. Prescriptions were labelled and packs were prepared by the dispensers and checked by the RP. Assembled packs seen were labelled with mandatory warning and product descriptions. Patient information leaflets were not routinely supplied, and the dispenser provided an assurance that these would be issued each month.

Prior to the launch of the NHS Pharmacy First service the RP had completed both face to face and online training. A printed copy of the PGD was kept in the dispensary which had been signed by the pharmacists who provided the service.

Deliveries were carried out by the delivery driver. Signatures were obtained when CDs were delivered, and the driver annotated the record for all other medicines. In the event that someone was not home, medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and were stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of cold chain medicines. Some higher risk medicines were not always stored appropriately. Expiry dates were checked routinely, the dispensary had been split into sections which were checked each week. An updated date checking matrix was seen. No date expired medicines were found on the shelves. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. Drug recalls were received via email. They were printed, shared with the team, and actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had calibrated glass measures. Tablet counting equipment was available. Separate measures were available for liquid CD preparations to avoid cross-contamination. Equipment was clean and ready for use. A large medical fridge was available. A blood pressure monitor was used for some of the services provided and was replaced annually. The pharmacy had recently obtained an otoscope, thermometer and pulse oximeter for the Pharmacy First service.

Up-to-date reference sources were available. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. A cordless telephone was also available to ensure conversations could not be overheard.

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.