

Registered pharmacy inspection report

Pharmacy Name: Trustcare Pharmacy, Suit 11, Prospect House,
Featherstall Road South, Oldham, Greater Manchester, OL9 6HT

Pharmacy reference: 9012220

Type of pharmacy: Internet / distance selling

Date of inspection: 03/04/2024

Pharmacy context

This pharmacy is located in a closed unit in a business centre and offers its services to people through its website (www.trustcarepharmacy.co.uk). It delivers medicines to people in the local area. Members of the public do not usually visit the pharmacy in person, unless they have an appointment booked for a consultation with the pharmacist. The pharmacy dispenses NHS prescriptions, and it provides some other NHS funded services including the Pharmacy First Service. It supplies some medicines in multi-compartment compliance packs to help people take their medicines at the right time. The pharmacy started operating around six months ago.

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	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 completes the records that it needs to by law. But some details are missing, which could make it harder to understand what has happened if queries arise. And some team members have not read and confirmed their understanding of the pharmacy's written procedures, so they may not always work effectively or fully understand their roles and responsibilities. Team members have completed training and have a basic understanding of how to keep people's private information safe and how to help protect children and vulnerable adults.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided, but there was nothing to indicate the date of preparation, who had prepared them, or which members of the pharmacy team had read and accepted them. The pharmacy manager explained that the pharmacy had obtained the SOPs from a third party, and he had read and tailored them to the pharmacy before it started operating around six months ago. The pharmacist superintendent (SI) was working as the RP. She said she had read the main dispensing SOPs but admitted that she hadn't read all of the SOPs. Roles and responsibilities were set out in the SOPs and the pharmacy team members were generally performing duties which were in line with their roles. The name of the responsible pharmacist (RP) was displayed as required by the RP regulations.

There were dispensing error and near miss SOPs. The pharmacy team were not currently recording or formally reviewing near miss errors, so the pharmacy team might be missing out on some learning opportunities. The pharmacy manager explained that errors were minimal because of the low volume of dispensing and the patient medication record (PMR) system had a facility which checked the accuracy of the selected medicine against the prescribed and labelled medicine. The SI admitted that some medicines, such as parallel imports did not scan, and the PMR system didn't check quantities, so there was still a risk of errors. There was an SOP for dealing with complaints. The complaint procedure and the details of who to complain to was advertised on the pharmacy's website and in the practice leaflet which was available via the website. Professional indemnity insurance arrangements were in place.

There were some missing entries in the RP record during the previous month, so the pharmacy was not able to provide a reliable record of who had been the RP on those dates, or the times that they were present. The pharmacy manager stated that he would ensure that the missing entries were completed, and the record would be completed accurately going forward. Following the inspection, the SI confirmed that these actions had been completed. Controlled drug (CD) registers were generally in order, but one or two headers were missing from the tops of pages, which might lead to incorrect entries. A couple of entries had been made in pencil, and one register was on a sheet of paper rather than in a bound book which compromised the accuracy of the record and was not in keeping with CD regulations. The pharmacy manager explained that the pharmacy had run out of CD inserts, but some new ones had arrived the previous day, and he said he would ensure the register was fully completed using the new inserts. Records of CD running balances were kept and audited. Two CD balances were checked and found to be correct. The pharmacy did not have a system to record patient returned CDs or any denaturing kits for their destruction. The pharmacy manager confirmed that the pharmacy had

not received any patient returned CDs yet but said he would order a book and some CD denaturing kits, so that they would be prepared. The details of patients receiving medicines obtained from 'Specials' were not always recorded, which might cause a delay if there was a problem or query about a medicine. The pharmacy manager said the pharmacy team had got behind with recording these details but said he would ensure that all 'Special' records were up to date going forward.

There was an information governance (IG) SOP which included details about patient confidentiality. Confidential waste was collected in a designated place and shredded in the pharmacy. The apprentice dispenser carried out some shredding during the inspection. He understood the difference between confidential and general waste and knew what it meant to maintain patient confidentiality. He said this had been explained to him when he started working at the pharmacy a couple of weeks ago. A privacy policy and a cookie policy were available on the pharmacy's website.

The pharmacy manager and SI had both completed level three training on safeguarding. The pharmacy manager said the pharmacy did not have a chaperone policy, but he said he would consider this and would make sure people were given the option of having a consultation with a chaperone, or a female pharmacist.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has a small team. The workload is manageable, and the pharmacy team has increased in line with workload. 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 SI and an apprentice dispenser were on duty at the start of the inspection. The staffing level was adequate for the volume of work during the inspection. The SI explained that she usually worked one morning a week and there were two other regular pharmacists who covered the rest of the week. The pharmacy team was small and close-knit. If necessary two of the regular pharmacists worked together, or they would contact a locum agency to request a locum pharmacist or a locum dispenser to support the team. The pharmacy manager, who was one of the regular pharmacists arrived during the inspection. He said that the apprentice dispenser had been recruited a few weeks ago because the workload had increased. He confirmed that he would soon be enrolling the apprentice onto a suitable dispensing assistant course, and he would be given training time to complete the course. The pharmacy manager said he had a clinical role in local GP practices and was confident in carrying out a wide range of consultations. He said that he carried out consultations for the NHS Pharmacy First service in the pharmacy. He confirmed that he had signed a declaration of competence, but the details were not on the pharmacy premises. The SI said she was not confident on the NHS Pharmacy First service and did not carry out any consultations. There was a part time delivery driver on the pharmacy team. He was not present during the inspection. The pharmacy manager said the delivery driver had not completed any formal training and was not on a course, but he would ensure that he read the delivery SOPs.

Pharmacy related issues were discussed informally within the team as they arose, and the team used an electronic messenger system to communicate with each other if face-to-face communication was not possible. Both pharmacists stated they would raise concerns of a professional nature with the GPhC. The pharmacists were empowered to exercise their professional judgement. They were not given incentives and they were not under any pressure to achieve targets.

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 some useful information about the pharmacy and its services, but some information is misleading and could cause confusion.

Inspector's evidence

The pharmacy premises were clean and in a good state of repair. The temperature and lighting were adequately controlled. The pharmacy was fitted out to a reasonable standard. The pharmacy team used the communal facilities of the business centre which included a kitchen area, WCs, and wash hand basins with hand wash. The pharmacy did not have its own sink but used the water from the nearby communal facilities when cleaning and used bottled water when re-constituting antibiotics. The consultation room was small, but it was uncluttered, clean and professional in appearance. The pharmacy's website provided useful information about the pharmacy such as its contact details and practice leaflet. But it advertised a weight loss clinic which the pharmacy did not currently provide and indicated the pharmacy team included nutritionists and GPs which was misleading and could cause confusion. The pharmacy manager removed some of this information from the website during the inspection and confirmed that he would review the website and ensure it was up-to-date and accurate.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy offers a small range of healthcare services which are reasonably well managed and easy for people to access. It generally manages its compliance aid packs service well, but doesn't always make sure people receive all the information they need to take their medicines safely. The pharmacy gets its medicines from licensed suppliers and the team carries out some checks to ensure medicines are in suitable condition to supply. But the pharmacy could improve the way it stores and manage some of its medicines.

Inspector's evidence

Services were advertised on the pharmacy's website, along with the opening hours. Health information was available on the website, via a link to the NHS.UK website. The SI and pharmacy manager gave examples of when they had signposted people to services they didn't provide and had given healthy living advice, but this was not generally recorded. Some members of the pharmacy team were multilingual which assisted some of the non-English speaking people in the local community. The pharmacy had carried out a large number of NHS Pharmacy First consultations in the previous month. Many were for chest infections following minor illness referrals from local GP practices. Notes of the consultations had been made electronically and were available. The minor illness consultations generally consisted of face-to-face consultations and when necessary, recommending the patient's GP issued a suitable prescription. Video consultations were used for certain conditions which the service treated. Blood pressure testing was offered, and smoking cessation consultations following referrals from hospitals. The pharmacy manager explained the demand for these two services had been very low.

The pharmacy delivered medicines to people in the local area. There was a home delivery service with a basic audit trail. The delivery driver had not read the delivery SOPs, and the delivery SOPs were not being closely followed. Each delivery was recorded, but a signature was not obtained from the recipient, and the name of the person receiving the delivery was not recorded. The two regular pharmacists and the delivery driver carried out deliveries, but there was no record of who had made each delivery, even when CDs were delivered. This might cause delays if there were any problems or queries and was not in line with the CD delivery SOP.

Space was quite limited in the dispensary, but the workflow was organised into separate areas with a designated checking area. The dispensary shelves were generally well organised, neat and tidy. The PMR system recorded the details of the person who had labelled, assembled, and checked each medication. For this reason, the pharmacy manager felt it wasn't necessary to capture this information on the medication labels. Different coloured 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. Some baskets were stored on the floor which compromised hygiene and were a tripping hazard. The pharmacy manager explained that a contractor was soon to carry out some work at the pharmacy to add some extra benches and shelving.

The team were aware of the requirements for a Pregnancy Prevention Programme to be in place and

that people who were prescribed valproate containing medicines should have annual reviews with a specialist. The pharmacy manager said the pharmacy did not currently have any patients in the at-risk group. He pointed out that the valproate information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling and the SI knew that original packs should always be supplied for valproate containing medicines.

The pharmacy supplied some medicines to people in multi-compartment compliance packs and disposable equipment was used. The packs were not always labelled at the time of assembly, which could increase the risk of errors. Medicine descriptions were not added to the compliance packs labels and packaging leaflets were not usually included. So, people might not be able to identify the individual medicines and may not be able to access all of the information they need. An assessment was not carried out by the pharmacist as to the appropriateness of a compliance pack, or if other adjustments might be more appropriate to the person's needs, prior to commencing this service. So, some people might be receiving their medicines in a compliance pack who don't necessarily require one, and this increased the risk to the individual. The pharmacy manager and SI agreed to review their procedure for managing compliance packs.

CDs were stored in a CD cabinet which was securely fixed to the wall. The keys were under the control of the RP during the day and stored securely overnight. Recognised licensed wholesalers were used to obtain stock medicines. Medicines were generally stored in their original containers at an appropriate temperature. The SI said she would set up a process to ensure all area of the dispensary was date checked on a rolling basis. Dates had been added to opened liquids with limited stability. A process was not in place for the collection of returned and obsolete medicines. The pharmacy manager confirmed that he would arrange this.

Medicine alerts and recalls were received via email messages from the central alerting system (NHS). These were read and acted on by a member of the pharmacy team, but they were not retained, so team members might not be able to respond to queries and provide assurance that the appropriate action had been taken. The SI said she would set up a folder to retain the alerts and recalls which were relevant to the pharmacy.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe, and they use it in a way that protects privacy.

Inspector's evidence

The pharmacist could access the internet for the most up-to-date reference sources. For example, the electronic British National Formulary (BNF), BNF for children and Clinical Knowledge Summaries (CKS). The pharmacists used the electronic medicines compendium (eMC) for patient information leaflets and the Greater Manchester Medicines Management Group (GMMMGM) for information on antibiotic prescribing and clinical management.

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. All electrical equipment appeared to be in good working order. A video facility was available to allow consultations to be carried out remotely. An Otoscope, a stethoscope and suitable blood pressure testing equipment were available. There was no record of when the blood pressure machine had last been calibrated. The pharmacy manager confirmed that it had been within the last year. There was no equipment to test ambulatory blood pressure. The pharmacy manager said it had not been necessary to obtain this equipment, as there was such low demand for the blood pressure testing service.

There were plastic liquid measures. These did not have accuracy markings, compromising the accuracy of measurement and were more difficult to keep clean. The SI provided an assurance that she would order some glass measures. She confirmed that there was equipment for counting loose tablets and capsules and explained that she would use tweezers to count cytotoxic drugs out. The pharmacy manager pointed out that methotrexate tablets were usually obtained in foil strips which avoided the need for handling.

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.