General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Foreman's Chemist, 12 Park Hill, Bury Old Road, Prestwich, MANCHESTER, Lancashire, M25 0FX

Pharmacy reference: 1033636

Type of pharmacy: Community

Date of inspection: 02/08/2023

Pharmacy context

The pharmacy is on a parade of shops, in a residential area of Prestwich, close to Manchester city centre. It mainly dispenses NHS prescriptions, including for people living in care homes. It dispenses some medicines in multi-compartment compliance packs to help people take their medicines. It provides a range of both NHS and private services to support the health needs of the local community. This includes a private travel vaccination service and ear wax removal. The pharmacy delivers medicines to people's homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.6	Standard not met	The pharmacy does not keep accurate records as it should by law, including records for supplies of private prescriptions and responsible pharmacist records.
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 not all met	4.3	Standard not met	The pharmacy does not store and manage all its medicines properly. This includes for higher-risk medicines requiring safe custody storage and for medicines the pharmacy keeps in the fridge.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance Standards not all met

Summary findings

Overall, the pharmacy adequately manages the risks with delivering its services. But it does not accurately keep all the records as it should. It keeps people's private details secure and listens to people's feedback about its services. Team members record and learn from mistakes they make to help make services safer. And they understand their role in helping to protect vulnerable people's welfare.

Inspector's evidence

The pharmacy's standard operating procedures (SOPs) were dated May 2022 and relevant for the services provided, including SOPs for dispensing and housekeeping tasks such as date checking. Most of the team members had signed to say they had read and understood them. The SOP review was due for May 2023 and linked to the pharmacy changing the patient medication record (PMR) system to using barcode scanning in dispensing. This was imminent with training from the PMR supplier booked later that week. The pharmacy provided private services, using electronically held patient group directions (PGDs) from a third-party company. This included administering travel vaccines. The pharmacist completed consent forms and risk assessments as part of the consultation held for people using the service. Examples of these past consultations were seen filed in an orderly manner.

The pharmacy had a recently accredited accuracy checking technician (ACT) who was clear about her role and responsibilities. But there was no clear audit process to identify which prescriptions had been clinically checked by the pharmacist. The updated PMR system recorded the completion of the clinical check and so would provide an audit trail of the clinical check. The SI gave assurances that a signature on prescriptions would be used until the updated PMR system was introduced. Team members, including two trainee pharmacists who had been working in the pharmacy for two weeks, were seen completing tasks appropriate for their role. And the correct responsible pharmacist (RP) notice was displayed, so people were aware of the pharmacist working on the day.

The pharmacy recorded near miss errors electronically, using a QR code displayed on the wall in the dispensary. These near miss errors were mistakes identified before the person received their medicines. Regular entries were made each month with a clear indication of what had gone wrong, and the actions taken to reduce the risk of the same error occurring in the future. A couple of dispensing incidents, which were errors identified after the person received their medicine, had been recorded. The reason for the error was documented as was the learning. The SI described how the pharmacy obtained feedback using the pharmacy's website and mystery shopper telephone calls and visits to help improve services. If complaints could not be resolved in the pharmacy, the team escalated them to the SI for investigation.

The pharmacy had current professional indemnity insurance. The electronic CD registers appeared in order, with regular checks of physical stock against the register balance check recorded. However, the checks completed during the inspection were not all correct. Following the inspection, the SI confirmed these had been investigated and resolved. The pharmacy recorded the supply of private prescriptions within the PMR system, but the team could not demonstrate records within a date range during the inspection. A report was provided following the inspection, but the prescriber details on the records were either not recorded or recorded inaccurately. There was an entry that appeared incorrect and on investigation was a test entry on to the PMR but had been recorded as a supply in the private

prescription record. The pharmacy dispensed some private prescriptions from a clinic prescribing vitamin B12 injections, but no entries were seen in the private prescription register for these prescriptions. Four private prescriptions were matched with their PMR records. One had been recorded with the incorrect person's name and none had the correct prescribers' details recorded. The pharmacy had two RP records, both held electronically which was confusing and one record had three to four missing entries each week. The other record on the PMR was mostly complete, and the SI confirmed this was to be used going forward. This record showed that the RP had not signed out of the record on any of the entries seen. The pharmacy had three fridges, but there were only temperature records held for the fridge in the downstairs dispensary and these were not completed every day the pharmacy was open. The upstairs thermometer recorded a high reading, this had not been investigated and reset.

Team members understood their role in keeping people's confidential information secure. They separated confidential waste from general waste and shredded it in a very large industrial-looking shredder as part of the dispensing process. The pharmacy's website informed people how their personal data was managed. The SI confirmed they had completed level 2 safeguarding training and that the team completed safeguarding training in line with NHS Pharmacy Quality Scheme (PQS) requirements.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the appropriate knowledge and skills to provide services safely and effectively. Team members work well together to manage the workload and they complete some ongoing learning to keep their knowledge up to date. And they feel comfortable in raising any concerns should they need to.

Inspector's evidence

The RP was the superintendent pharmacist, and they were supported by a recently qualified accuracy checking technician (ACT), two trainee pharmacists, two dispensers and an apprentice. The apprentice was close to completing their course. The medicines counter assistant, who worked part time was not working on the day of the inspection and the dispensary team members covered this role. There was an employed driver, who delivered medicines to people’s homes. The team was observed to be working well together and managing the workload. The trainee pharmacists had started two weeks earlier and described how they were supervised in the tasks they completed. The ACT felt supported in completing their accuracy checking accreditation and had been given some protected learning time at work. A team member was observed counselling a person buying painkillers over the counter. And the team knew when to refer repeat sales of medicines liable for misuse to the pharmacist.

The SI had arranged a day’s training for the team before the new patient medication record (PMR) system was introduced. Team members completed ongoing training to keep their knowledge up to date. Certificates of completion for training were seen, relating to sepsis and errors involving medicines that looked alike and names sounded alike (LASA). The SI was an independent prescriber but was not currently using the qualification to prescribe. The pharmacy was signed up for the NHS prescribing pathfinder service. The pharmacist manager and the SI were described as approachable and team members felt comfortable raising any concerns and discussing ideas, they had to improve ways of working.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises clean, secure, and suitable for the services provided. It has a good-sized room where people can access services and have private conversations with team members.

Inspector's evidence

The pharmacy premises were clean, hygienic and of a professional appearance. The main dispensary was situated off the retail area, and there was a plastic screen up at the pharmacy counter to help with infection control. The pharmacy had enough space to store medicines and plenty of bench space to complete dispensing tasks. The pharmacy premises were over two floors and services for care homes were provided from a room upstairs. This room was slightly cluttered. There was a separate room upstairs for wholesaling activities. Staff facilities were available upstairs, including suitably hygienic toilet facilities, with hand sanitiser and hot and cold running water.

There was heating and the temperature was suitable for medicines storage and working conditions. The lighting was bright. The pharmacy had a good-sized sound-proof consultation room, where people could sit down to access services and private conversations. There was dual access from the retail area and behind the pharmacy counter and both doors were kept closed.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy does not store or manage all its medicines properly. And it doesn't regularly check the temperature in all the fridges it uses to store medicines. The pharmacy provides easy access to its services to help people with their healthcare needs. And the pharmacy manages and delivers its services safely and effectively.

Inspector's evidence

There was a small ramp from the wide pavement outside to support access into the pharmacy. There was a bright and professional facia outside and an information screen to provide health information for people using pharmacy services. The team displayed healthcare information for people to read and provided leaflets for people to take away. Team members were seen giving appropriate advice and helping people with their healthcare queries, referring to the pharmacist when they needed to. The pharmacy services included private travel vaccinations. Vaccine batch numbers and expiry dates were recorded on the person's consent form and these records were stored in a lockable cabinet in case of future queries. The pharmacy provided an ear wax removal service and the pharmacist and ACT had completed training from the company providing the equipment. People's consent was obtained, and notes were recorded on some of the forms, for example documenting a referral to a person's regular prescriber for antibiotics due to an ear infection. The pharmacy received some electronic private prescriptions from a clinic prescribing vitamin B12 injections. The prescriptions had a unique ID code to access the system and ensure prescriptions were only dispensed once. The pharmacy dispensed the prescriptions and administered the injection. Verbal consent was recorded on the administration form. Details of the batch number and expiry dates of the injection used was recorded. There was no information documented at the pharmacy as to the diagnosis or reason the person required the vitamin B12 injection.

There were separate areas for labelling, dispensing, and checking of prescriptions to manage the workflow. The pharmacy kept people's prescriptions and medicines in baskets during the dispensing process to reduce the risk of errors. And team members initialled dispensing labels to provide an audit trail of who had dispensed and checked prescriptions. The pharmacy provided services to care homes and dispensed medicines in multi-compartment compliance packs to help some people living in their own homes take their medicines at the right times. The team tracked the ordering, dispensing and supply of the compliance packs to help make sure people received their medicines when they needed them. The care home staff ordered the prescriptions for people living in the care homes. The pharmacy team provided some care home staff with printed medication administration records (MARs) and medicines in original packs and for other care homes electronic MARs were provided through the IT dispensing system. The pharmacist showed an understanding of the requirements of dispensing valproate for people who may become pregnant. The team understood the risks of becoming pregnant whilst taking valproate and showed some understandings of the requirements of dispensing and provision of the patient cards.

The pharmacy obtained medicines and medical devices from recognised wholesalers. Pharmacy-only (P) medicines were displayed behind the pharmacy counter, and this helped ensure the pharmacist supervised sales. The medicines on the dispensary shelves were overall kept neatly. The date checking matrix was up to date and medicines checked on the dispensary shelves were in date. The use of

stickers to highlight short-dated stock was seen on many medicines. There were various medicines that had been removed from their original containers and stored in amber bottles. The labels on these containers did not contain full details of the medicines inside, including no batch number and expiry date. These were removed from the shelves during the inspection. Some food supplements and vitamins without a product licence were on the dispensary shelves and used for dispensing. These were removed from the dispensary shelves to be assessed. The pharmacy stored medicines requiring cold storage in three large medical fridges. The fridge downstairs was full of stock and the fridge temperature records for this fridge were within the correct range. The fridge temperatures for the medical fridges upstairs were not recorded and one fridge thermometer recorded a high warning indicating at some point this had recorded a temperature above eight degrees Celsius. This had not been reset. The temperature of this fridge was in range during the inspection. But on examination there was milk stored next to insulin in this fridge. The insulin cardboard packaging was soggy, and it was removed for disposal during the inspection. Vaccines were stored in a basket in this fridge, the packaging appeared intact. The SI confirmed after the inspection that the food items and medicines had been moved to separate fridges. The pharmacy had a small CD cabinet and used a safe for some medicines requiring safe custody. The SI was not able to provide a police exemption certificate for this safe. The pharmacy received notification of medicine recalls and safety alerts electronically and the team annotated the system once the required action had been taken. The recalls and alerts from July were outstanding. After the inspection, the SI confirmed these had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services. And it uses the equipment and facilities in ways that protect people's private information.

Inspector's evidence

The pharmacy had reference sources and access to the internet for up-to-date information to help the team provide services. Suitable consumables were available for the compliance pack dispensing service and these were stored appropriately. The equipment for ear wax removal was maintained and repaired by the company who supplied it. The pharmacy had two relatively new blood pressure machines, but these had not been annotated with a date to show when calibration was required or show a date of renewal.

The pharmacy had password-protected computers and the team used NHS smart cards. But the MCA's smart card was in use in the computer on the pharmacy counter and she was not working on the day of the inspection. People's confidential information was stored in restricted areas of the pharmacy, reducing the risk of unauthorised access and information on the computer screens was only visible to the pharmacy team.

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.