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: 27/02/2024

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 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

Overall, the pharmacy adequately manages the risks with delivering its services. It keeps the records it needs to keep by law, and these are accurate and up to date. It keeps people's private information secure and listens to people's feedback about its services. Team members record and learn from mistakes that happen to help make services safer. And they understand their role in helping to protect vulnerable people's welfare.

Inspector's evidence

Standard operating procedures (SOPs) were available and had been read and signed by team members. SOPs had been reviewed within the last six months of the inspection.

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 then recorded. QR codes were displayed around the dispensary which team members could scan on their mobile phones and complete a near miss report. Near misses were seen to be recorded consistently. Team members described that they were familiar with their weak points and were mindful of this when dispensing. The responsible pharmacist (RP) explained where the wrong medicine was supplied to a person (dispensing errors), it would be investigated and recorded on the electronic system. Near misses were reviewed by the RP informally from time to time and any trends were discussed with the team. The RP explained that there had not been many trends identified. The pharmacy shelves had been arranged in a way to reduce picking errors, team members were asked to review certain SOPs periodically and were mindful when dispensing medicines which looked or sounded-alike. More formal reviews were completed by the RP bi-annually.

A correct Responsible Pharmacist (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. Although one of the team members was unsure as to whether dispensed medicines could be handed out to the driver. This was discussed and the RP provided an assurance that posters were displayed in the dispensary showing team members what activities could be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and review cards were kept in the consultation room and waiting area. People could also feedback via the pharmacy's website and the pharmacy had an electronic device to obtain feedback which was not in use. The RP described how feedback received via online review websites was usually positive.

Private prescription records, emergency supply records, records for unlicensed medicines supplied, RP records and controlled drug (CD) registers were well maintained. Running balances for CDs were recorded. 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 which had been reviewed by the pharmacists, and its team members had been verbally briefed on it. The pharmacy stored confidential information securely and separated confidential waste which was then shredded. Pharmacists had access to summary care records (SCR) and obtained verbal consent from people before

accessing it.

Pharmacists had completed level three safeguarding training; pharmacy technicians had completed level two training and all other team members had completed level one training. The RP was unsure of what training the delivery driver had completed, he provided an assurance that he would speak to the superintendent pharmacist (SI) to check and arrange for the driver to complete some training if needed. The RP was aware of where to find the details for the local safeguarding boards and said a poster had previously been displayed which had been removed due to the renovation.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members have the appropriate knowledge and skills to provide services safely. Team members work well together to manage the workload safely and they complete some ongoing learning to keep their knowledge up to date.

Inspector's evidence

The pharmacy team comprised of three pharmacists, including the SI, two trainee pharmacists, two pharmacy technicians, two trained dispensers, a trained medicines counter assistant (MCA), an apprentice and a delivery driver. One of the pharmacy technicians was working as an accuracy checker (ACT). The RP felt that there were enough staff to manage the workload and usually there would be two pharmacists working together. The team were observed working effectively together and were up to date with the workload.

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 to the pharmacist if unsure.

Team members had annual reviews to manage performance. The pharmacists held regular meetings with individuals in between reviews to discuss what team members were doing well and what they could improve on. The pharmacists also looked at patient safety reviews and incorporated this into the performance review. The pharmacy team held huddles on a regular basis to discuss tasks. Team members felt able to make suggestions and give feedback. The SI was open to receiving feedback and had made changes to way in which medicines were stored and having a second consultation room based on suggestions from team members. There were no targets or incentives in place for any of the services provided.

Team members completed ongoing training to keep their knowledge up to date and were supported by the pharmacists when doing so. Certificates of completion for training were seen, relating to antibiotic stewardship. The SI was an independent prescriber but was not currently using the qualification to prescribe medicines to people. Team members were briefed on new services by the pharmacists. The apprentice had one day a week allocated to training and felt able to ask colleagues for help and support.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises clean, secure, and suitable for the services provided. It has designated rooms 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. The pharmacy had enough space to store medicines and plenty of clear bench space to complete dispensing tasks. The pharmacy premises were over two floors and services for care homes were provided from a room upstairs. A clean sink was available in the dispensary for the preparation of medicines before they were supplied to people. Cleaning was done by a designated cleaner and team members. The room temperature and lighting were appropriate, and the premises were kept secure from unauthorised access.

The pharmacy had two good-sized consultation rooms, where people could sit down to access services and private conversations. One of the consultation rooms had recently been built following the launch of the Pharmacy First service. A secrecy film was to be added to the glass window on the consultation room door and there was still some work remaining from the refit of the premises.

Principle 4 - Services ✔ Standards met

Summary findings

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. It gets its medicines from licensed sources, stores them appropriately and carries out regular checks to help make sure that they are safe to supply to people.

Inspector's evidence

There was a small ramp from the wide pavement outside to support access into the pharmacy. 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. Services offered by the pharmacy were listed on their website, and leaflets were placed into people's medicine bags from time to time with information about the services. There was an information screen in the window and inside the pharmacy to provide health information for people using pharmacy services and list the services offered by the pharmacy. An automated message on the telephone lines also provided people with this information. 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.

The RP said the travel vaccination service and the ear wax removal service were both fairly busy. The pharmacist and ACT had completed training for the ear wax removal service from the company providing the equipment. The RP felt this service complemented the Pharmacy First service.

The pharmacists had completed both online and face-to-face training before the launch of the Pharmacy First service. And they had signed the patient group directions (PGDs). The pharmacy had a dedicated pharmacist who provided services and so there had not been any impact on the other services that were being provided. The ACT also helped with checking prescriptions which freed up the pharmacist's time to provide services.

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. Following feedback from the last inspection information was documented on the administration form about 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. Prescriptions were clinically checked by pharmacists before they were dispensed. Prescriptions which were clinically checked and suitable for the ACT to accuracy check were signed by the pharmacist. 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. Assembled packs seen were labelled with product descriptions and mandatory warnings. However, the backing sheets were placed loosely inside the packs. This meant that the backing sheets could be misplaced and people may not know what medicines are included within the pack. Patient information leaflets (PILs) were not routinely supplied with the packs which means people many not have access to all the information they may need about their medicines. The dispenser and RP provided an assurance that the backing sheets would be securely affixed, and information leaflets would be supplied monthly. 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 RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). The team were aware of the labelling requirements and requirement for sodium valproate to be dispensed in its original packaging. One person was supplied with sodium valproate in a compliance pack. A written risk assessment had not been completed and the RP provided an assurance that he would speak to the SI and complete one together. The pharmacy carried out some checks on medicines that required ongoing monitoring. Details about INR readings and checks were carried out verbally on some occasions. Details of any checks carried out were not routinely recorded. This could mean that any information collected is not available for future checks. Warning cards and books were kept on the shelves with some medicines, and these were handed out for the first time.

Deliveries were carried out by the delivery driver. The pharmacy used a handheld device to book in all deliveries. Prescription bags were marked if they contained fridge lines or if the medicines needed to be urgently delivered. Acute prescriptions were delivered to the care homes through the course of the day. Signatures were obtained when CDs were delivered on the back of the prescription form. The RP agreed that there was a risk that the prescription form could be lost during the process and agreed to review with the SI how signatures could be obtained. 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. CDs were kept securely. Expiry dates were checked routinely. Short-dated stock was said to be marked in way so that it could be easily identified. However, this was not evident, and a few short-dated medicines were seen on the shelves that were checked without any markings. 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 on an electronic system. These were shared with the team, actioned and marked as complete on the system.

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 calibrated glass measures and tablet counting equipment was available. Equipment was clean and ready for use. Up-to-date reference sources were available electronically. A blood pressure monitor, otoscope and thermometer were available and were used as part of the services provided. The RP said the blood pressure monitor was fairly new, but he was unsure of the calibration arrangements and would discuss this with the SI. The pharmacy also had equipment for the ear syringing service, this was calibrated by the service provider. The pharmacy had two fridges and two CD cabinets.

The pharmacy's computers were password protected and screens faced away from people using the pharmacy; team members all had individual log in details. A cordless phone was available which helped members of the team have a private conversation with people.

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.