General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: HMI Pharmacy, 14 Moor Street, Kirkham, PRESTON, PR4 2AU

Pharmacy reference: 1033836

Type of pharmacy: Community

Date of inspection: 25/01/2023

Pharmacy context

This is a community pharmacy situated in the centre of Kirkham, a market town west of Preston. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a seasonal flu vaccination service. The pharmacy supplies medicines in multi-compartment compliance aids for some people to help them take the medicines at the right time. The superintendent pharmacist regularly works at the pharmacy as the responsible pharmacist.

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	1.1	Standard not met	The pharmacy cannot provide assurance that its SOPs are fit for purpose. Members of the team have not read the SOPs and do not properly understand their responsibilities.
		1.3	Standard not met	Members of the team cannot demonstrate they fully understand their responsibilities, such as what they can or cannot do in the absence of a pharmacist.
		1.6	Standard not met	The pharmacy's responsible pharmacist record is inaccurate and unreliable.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.5	Standard not met	The pharmacy is cluttered and untidy, which impedes the safe and effective provision of services.
4. Services, including medicines management	Standards met	N/A	N/A	N/A
5. Equipment and facilities	Standards not all met	5.2	Standard not met	A fridge is in use which is significantly damaged and not fit for purpose.

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy has written procedures to underpin its services. But they have not been updated for several years and they have not been read by the team. As a consequence, team members do not properly understand their responsibilities, such as what they can or cannot do in the absence of a pharmacist. This means the control measures intended to manage risk are not applied in the team's day-to-day practice. So the team may not always work safely and effectively. The pharmacy keeps a responsible pharmacist record, but it is automatically generated when the pharmacy computer is switched on. This means the record is inaccurate and unreliable. Members of the team discuss when things go wrong, but they do not make a record. So they may miss some learning opportunities.

Inspector's evidence

There was a set of standard operating procedures (SOPs) with an original date of issue that was several years old. The SOPs had been annotated periodically to show that they had been reviewed by the superintendent pharmacist but there was no evidence of any amendments being made when they were reviewed. Training records attached to the SOPs had been signed by staff around the time of first issue. But these had not been updated and none of the current team had signed them. On the day of the inspection the pharmacist was late for work and did not arrive until about 9.30am. The pharmacy had opened at its normal time of 9am and so operated for about half an hour in the absence of a responsible pharmacist. During this time a trainee dispenser was seen assembling medicines against prescriptions, ready for the pharmacist to check when he arrived. When questioned, she was unaware that she was not supposed to do this and admitted she had not read the SOPs. The rest of the team admitted that they had not read the SOPs either.

The responsible pharmacist (RP) had their notice on display. The RP record was held electronically on the pharmacy computer. It was noted that the record showed that the RP had assumed responsibilities at 9am, which was before he had actually arrived. The RP explained that the pharmacy computer automatically recorded him as RP when it was switched on. This meant the record was inaccurate and unreliable.

The pharmacy had systems in place to record and investigate dispensing errors. A paper log was available to record any near miss incidents, but none had been recorded since June 2022. The pharmacist admitted some incidents had occurred during this time but had not been recorded. He explained that if he found an error, he would ask members of the team to identify their mistake before asking why the error may have occurred. He gave an example of action being taken to help prevent mistakes being repeated by moving prochlorperazine away from prednisolone.

The trainee dispenser had a general understanding of what her role involved and said she had been given instruction about her responsibilities when she started her employment. The pharmacy had a complaints procedure. A notice in the retail area advised people they could discuss any concerns or feedback with the pharmacy team. Any complaints would be recorded and followed up by the superintendent (SI). A current certificate of professional indemnity insurance was available.

Records for private prescriptions and emergency supplies appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and these were usually checked each

month. But these checks had not been completed since November 2022. Three random balances were checked, two of which were found to be accurate. A third balance was incorrect. After the inspection the pharmacist provided confirmation that CD balances had been checked and corrected. Patient returned CDs were recorded in a separate register.

An information governance (IG) policy was available, but this had not been read by members of the team. The trainee dispenser had signed a confidentiality agreement and understood the need to protect people's information. Confidential material was disposed of in a separate bin and collected by a specialist waste contractor. But there was an overflowing pile of confidential information waiting to be put in the confidential waste bin. So there was a risk that it could fall into the wrong hands. The pharmacist could not find a copy of the safeguarding procedures or local contact details of the safeguarding board. He said he had completed level 2 safeguarding training. The team said if they were concerned about a person's safety, they would refer to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are generally enough staff to manage the pharmacy's workload, and they complete appropriate training for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date. But ongoing learning and development is not structured, so some learning opportunities may be missed.

Inspector's evidence

The pharmacy team included a pharmacist, a pharmacy technician, two trainee dispensers and a medicine counter assistant (MCA). All members of the pharmacy team had appropriate qualifications for their roles or were on accredited training programmes. Each member of the team worked full time, and there was a staggered holiday system to help manage absences. The volume of work appeared to be managed. But two members of the team were currently off sick. And the pharmacist said he did not have any means of getting additional cover. So there may be insufficient contingency arrangements in place in the event of multiple long-term absences.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about antimicrobial stewardship. Training records were kept showing what training had been completed. But further training was not provided in a structured or consistent manner.

A trainee dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines she felt were inappropriate, and refer people to the pharmacist if needed. She felt a good level of support from the pharmacist and was able to ask for help if she needed it. But there was no formal appraisal programme. Team members said they would be comfortable reporting any concerns to the pharmacist. There were no targets in place for professional services.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy premises is cluttered and untidy. This does not create suitable environment for safe and effective working or a professional appearance appropriate for a healthcare provider.

Inspector's evidence

The pharmacy was located inside a retail unit amongst terraced housing. It had been registered as a pharmacy for many years. The retail area was cluttered with boxes of stock. And the carpet had not been hoovered for some time. The dispensary was small, and the space was further limited due to dispensing benches being taken up by excess stock. There were also piles of historic post and litter from dispensing activities. The dispensary floor was cluttered with boxes of stock and dispensing baskets. The temperature was controlled using air conditioning units and electric heaters. Lighting was sufficient. The pharmacy team had access to a kitchenette area and WC facilities.

Part of the retail area had been de-registered to enable an automated collection point to be installed, which was accessible at all times by people outside of the pharmacy.

A consultation room was available. The space was cluttered with boxes of information leaflets and paper materials. There was a desk and seating. The patient entrance to the consultation room was clearly signposted and indicated if the room was engaged or available.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are generally easy to access. But the pharmacy entrance is via steps so patients with limited mobility may not be able to enter. Members of the pharmacy team carry out some checks to help make sure stock medicines are kept in good condition. But they do not always know when they are handing out higher-risk medicines. So they might not always be able to check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

Access to the pharmacy was via steps to a single door and there was no wheelchair access to the consultation room. The pharmacy could deliver medicines and speak to wheelchair users by telephone. But they may not be able to access all of the services provided by the pharmacy, such as flu vaccinations. Posters and digital screens gave information about the services offered and information was also available on the website. The pharmacy opening hours were displayed and a range of leaflets provided information about various healthcare topics.

The pharmacy had a delivery service. A delivery record sheet was used as an audit trial following successful delivery. Any unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing. Owing slips were used to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were kept on a shelf using an alphabetical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out. But schedule 3 and 4 CDs were not highlighted to remind team members to check the validity of the prescription. The pharmacist said he would counsel people who had been commenced on any high-risk medicines (such as warfarin, lithium, and methotrexate). But prescriptions containing these medicines were not routinely highlighted. So team members may not always know when they are being handed out. Which means they won't be able to give people advice or check that they are taking the medicines correctly. The pharmacist was aware of the risks associated with taking valproate during pregnancy. He confirmed that he had spoken to patients who were at risk to make sure they were aware of the pregnancy prevention programme. Educational material was available to provide when dispensing valproate medicines.

The pharmacy had adequate processes in place for people collecting their medicines from the external collection point. If the person did not collect their medicines after 4 days, the collection point would create a list of dispensed medicines to be removed from the machine. When the person came to collect their medicines, the pharmacy team would ask questions to help identify any potential counselling points or concerns.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started

on a compliance aid the pharmacist would ask questions to assess suitability. But details of the conversation were not recorded, so the pharmacy was not able to demonstrate whether assessments had been appropriate. An electronic record was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. But the pharmacy did not ask to see the discharge sheet when a person had been discharged from hospital. So it was not able to check whether the correct medication had been prescribed. Patient information leaflets (PILs) were not routinely supplied. So people may not always have important information about how to take their medicines safely.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. Stock was date checked but only on a yearly basis. This meant there was a risk that short-dated stock may not be noticed until after it had expired. Short-dated stock that was identified was highlighted using a sticker and recorded in a diary for it to be removed at the start of the month of expiry. A spot check of medicines did not find any stock which had expired. Liquid medication did not have the date of opening written on. So team members would not be able to check whether medicines remained fit for purpose if they needed to be used within a limited time after opening. Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use.

A large volume of patient returned medication was waiting to be sorted and disposed of in designated bins. This was located away from the dispensary but may present a risk to members of the team. Drug alerts were received by email from the MHRA. But the pharmacy team did not keep records of alerts they had dealt with. So it could not demonstrate that the alerts had been handled appropriately.

Principle 5 - Equipment and facilities **Standards not all met**

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. But a fridge is in use which is significantly damaged and not fit for purpose.

Inspector's evidence

The staff had access to the internet for general information. This included access to the BNF, BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures, most of which had British Standard and Crown marks. But a plastic measure was also in use which may not provide the required degree of accuracy. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment appeared clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy.

There were clean medicines fridges, each equipped with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had remained in the required range for the last 3 months. But one of the fridges was damaged, and the door of the fridge was no longer held on by its hinges.

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.