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: 18/09/2023

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 their medicines at the right time. The superintendent pharmacist regularly works at the pharmacy as the responsible pharmacist.

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 team follows written procedures to help maintain the safety and effectiveness of the pharmacy's services. Members of the team record things that go wrong, but they do not review the records, so they may miss some learning opportunities. The pharmacy keeps the records it needs to by law. And members of the team are given training so that they know how to keep private information safe.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which had recently been updated by the superintendent (SI). An electronic record was kept showing pharmacy team members had read and accepted the SOPs.

The pharmacy had a process in place to record and investigate dispensing errors. A paper log was available to record any near miss incidents. The pharmacist reviewed the incidents, and they discussed learning opportunities with the pharmacy team. But there was no review of the records to help identify potential underlying factors. To help prevent common picking errors of 'look alike, sound alike' (LASA) medicines, the team had moved atenolol and allopurinol away from one another.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A trainee dispenser was able to explain what their responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The responsible pharmacist (RP) notice was on display. 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 the RP, 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. Two random balances were checked, and both were found to be accurate. Patient returned CDs were recorded in a separate register.

Information governance (IG) procedures formed part of the SOPs. Each member of the team had signed a confidentiality agreement. When questioned, the trainee dispenser understood the need to protect people's information. Confidential material was disposed of in a separate bin and collected by a specialist waste contractor. Safeguarding procedures were in place, and members of the team had completed safeguarding training. The pharmacist had completed level 2 safeguarding training. Contact details for the local safeguarding board were available. If members of the team identified a concern, they would initially report it to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload 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. But this is not structured so learning needs may not always be identified or addressed.

Inspector's evidence

The pharmacy team included a pharmacist, three dispensers, two of whom were in training 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.

Members of the pharmacy team completed some additional training as required by the NHS Pharmacy Quality Scheme. For example, they had recently completed a training pack about the early signs and diagnosis of cancer. 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 explained how she uses the WWHAM questioning technique when selling a pharmacy only medicine. And how she would refuse sales of medicines that were inappropriate or refer 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. Members of the team were seen working well together. Each morning they discussed the work required to be completed that day. 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 met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was located inside a retail unit amongst terraced housing. It had been registered as a pharmacy for many years. It was generally clean and tidy, and appeared adequately maintained. 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. 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 has steps leading to the entrance so people 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 people by telephone. But people with limited mobility 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 annotated following successful delivery to provide an audit trail. 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 and show who was involved in the dispensing process. 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 a record if the full quantity could not be immediately supplied. This served as a reminder to people to collect their remaining medicines.

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. Members of the team were seen to confirm the patient's name and address when medicines were handed out. They would also ask questions to help identify any potential counselling points or concerns.

But schedule 3 and 4 CDs were not highlighted so team members may not always check to make sure the prescriptions are still valid. 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. This means people may not always receive advice or confirm that they are taking their 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 being provided when dispensing valproate medicines.

The pharmacy had an external collection point which enabled people to collect their medicines at a time convenient for them. Only certain medicines would be stored in the collection point, and this did not include medicines which required CD safe storage or refrigeration. A PIN code was sent to the patient when their medicines were available for collection, and this helped to ensure the medicines

were going to the correct person. The pharmacy had a process in place for when people did not collect their medicines after 4 days. The collection point would create a list of dispensed medicines to be removed from the machine, and the team would store the medicines inside the pharmacy in order to provide counselling.

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 once a year. 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. There was a clean medicines fridge with a thermometer. The minimum and maximum temperature was being recorded daily and records showed they had remained in the required range for the last 3 months.

Patient returned medication was disposed of in designated bins located away from the dispensary. 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 met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

Team members 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. 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.

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.