General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hinckley Pharmacy Delivery, Dodwells Bridge Industrial Estate, Unit 3, Jacknell Road, HINCKLEY, Leicestershire, LE10 3BS

Pharmacy reference: 1098148

Type of pharmacy: Community

Date of inspection: 29/02/2024

Pharmacy context

This is a distance-selling pharmacy that is situated on an industrial estate in Hinckley. Most of its activity is dispensing NHS prescriptions and selling medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own homes. It provides other NHS services including the New Medicine Service and Pharmacy First. It also delivers medicines to people's homes.

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

Overall, the pharmacy identifies and manages the risks associated with the provision of its services. And the pharmacy keeps the records it needs to by law. The pharmacy manages people's electronic personal information safely. Team members record things that go wrong so that they can learn from them.

Inspector's evidence

The pharmacy was a distance-selling pharmacy, but it had a set of standard operating procedures (SOPs) which did not always fully reflect how the pharmacy operated. This could mean that some of the SOPs available in the pharmacy did not provide information to help new staff or locum pharmacists follow current best practice. The pharmacist said that she would review the SOPs. Not all the pharmacy team members had signed the SOPs to show they had read and understood them. The team members said that they would read and sign them. However, staff were seen dispensing medicines safely.

The pharmacy had processes for learning from dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes where they had reached the person (errors). Near misses were discussed with the member of staff at the time and were then recorded in the near miss log. Entries seen in the near miss log had limited information which might limit their usefulness. The pharmacist reviewed the logs for trends and patterns and shared the outcomes at the team meeting.

The pharmacy displayed a notice showing the name of the responsible pharmacist (RP). The pharmacy maintained the necessary records to support the safe delivery of pharmacy services. These included the RP log, the private prescription book, and the controlled drug (CD) register. The entries checked at random in the CD register during the inspection agreed with the physical stock held. The pharmacist said that she balance checked CDs on supply but that she did not always record in the CD register. The register recorded some full balance checks with the last full recorded check in October 2023. The pharmacist said she would make sure all CDs were balance checked weekly to comply with the SOP. Patient-returned CDs were recorded promptly on receipt in a designated register. Patient-returned CDs and date-expired CDs were clearly marked and separated from stock CDs to prevent dispensing errors.

The pharmacy had a complaints procedure and an information governance policy. Access to the electronic patient medication record (PMR) was password protected. Confidential information was destroyed securely. Professional indemnity insurance was in place. The pharmacy team members understood safeguarding requirements and could explain the actions they would take to safeguard a vulnerable person. A team member explained how a pharmacy driver had raised concerns about a vulnerable adult which had led to them receiving care support at home.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to manage the pharmacy's workload. They are suitably trained for the roles they undertake. Team members can raise concerns if needed.

Inspector's evidence

During the inspection, the pharmacy team managed the day-to-day workload of the pharmacy effectively. There was one pharmacist, who was the superintendent pharmacist, one pharmacy technician, who was an accuracy checking technician, and an accuracy checking dispenser. The pharmacist had completed training to provide the new 'Pharmacy First' NHS commissioned service. The team had received recent training about the 'Pharmacy First' service and the team also had ad-hoc training by the pharmacist. The drivers had completed a training course to help them provide an effective service. A team member said they had an annual review with the pharmacist and felt able to raise any concerns or issues if necessary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises provides a suitable environment for people to receive its services. And they are sufficiently clean, appropriately maintained, and secure.

Inspector's evidence

The pharmacy was based in a warehouse unit on an industrial estate. It had a large dispensary with a public area and a separate waiting area available for when the pharmacy provided a vaccination service. The dispensary was a good size for the services available. The pharmacy had air conditioning which provided a reasonable temperature for storing medicines; lighting was suitable and hot and cold water was available. One reasonable sized consultation room was available for people to have a private conversation with pharmacy staff. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's healthcare services are suitably managed and are accessible to people. The pharmacy gets its medicines and medical devices from reputable sources. It stores them safely and team members know the right actions to take if medicines or devices are not safe to use to protect people's health and wellbeing. But the way the pharmacy currently provides information to people about their medicines may mean some people do not get all the support and advice they need to take their medicines safely and effectively.

Inspector's evidence

Although the pharmacy was a distance-selling pharmacy, people had accessed the pharmacy in-person for Covid-19 and flu vaccinations. The pharmacy had flat access with a push-pull door which provided suitable access for people with a disability or a pushchair to get into the pharmacy. The pharmacy team understood the signposting process and used local knowledge to direct people to local health services. The pharmacy knew the advice about pregnancy prevention that should be given to people in the at-risk group who took sodium valproate. The pharmacist gave a range of advice to people using the pharmacy's services. This was usually through written information rather than speaking to the person. This might mean that some people missed out on useful information about their medicine and the pharmacist said she would review whether she should phone people to give them advice.

The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label to help identify who had done each task. Baskets were used to keep medicines and prescriptions for different people separate to reduce the risk of error. The pharmacy supplied medicines in multi-compartment compliance packs to people living in the community to help them take their medicines at the right time. The pharmacy spread the workload for preparing these packs across the month. Compliance packs seen included medicine descriptions on the packs to make it easier for people to identify individual medicines in their packs. The pharmacy supplied patient information leaflets to people when they received a new medicine but did not routinely provide them to people every month. The pharmacist said she would start doing so.

The main service that the pharmacy provided was the supply of multi-compartment compliance packs to people living in their own home to help them take their medicines at the right time. There was sufficient lead time to prepare packs and the pharmacy spread the workload across the month, using a tracker to make sure packs were prepared and supplied on time. Packs were labelled with doses and warnings and included medicine descriptions on the packs to make it easier for people to identify individual medicines in their packs. Patient information leaflets (PILs) were supplied to people when they started a medicine for the first time; the pharmacist said she would make sure that PILs were provided to people each month. Each person had an individual record sheet and team members recorded any changes on this sheet. The pharmacy also had good access to information about hospital admissions and discharges and changes to people's medicines when this happened. The pharmacist said that they were still supplying sodium valproate in compliance packs. She said that they had assessed the risks and made sure that appropriate advice and warning labels were provided. She had not recorded her risk assessments and said that she would do so. She said that some medicines with stability issues were still supplied in compliance packs because some carers would not administer medicines from original packs.

The pharmacy used a number of delivery drivers to deliver dispensed medicines to people in the local area. Deliveries were logged onto an electronic delivery device, which recorded the patient's signature on delivery. A record of deliveries was kept as an audit trail. The pharmacy could deliver across the UK but had not received a request for the service.

Medicines were stored on shelves or in cupboards in their original containers. Opened bottles of liquid medications were marked with the date of opening so that the team would know if they were still suitable for use. The pharmacy team had a process for date checking medicines. A check of a small number of medicines did not find any that were out of date. CDs were stored appropriately. A record of invoices showed that medication was obtained from licensed wholesalers. The pharmacist explained the process for managing drug alerts which included a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment so that it is safe to use.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. The pharmacy had up-to-date reference sources. Records showed that the fridges were in working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacy's portable electronic appliances had been tested in May 2021 to make sure they were safe. The pharmacist said she would arrange testing.

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.