General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medichem Pharmacy, Units 34-35 Woodley Precinct, Woodley, STOCKPORT, Cheshire, SK6 1RJ

Pharmacy reference: 1107409

Type of pharmacy: Community

Date of inspection: 20/11/2019

Pharmacy context

This community pharmacy is open extended hours. It is situated in a pedestrianised shopping area in a semi-rural location serving the local population. It orders NHS prescriptions on behalf of people and supplies medication to them, and it prepares some of these medicines in weekly multi-compartment compliance packs to help make sure people take them safely. The pharmacy also has a home delivery service.

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 met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	Some team members are not qualified for their role and the pharmacy delays providing training for new team members. So, they may not have the skills needed to provide all services safely.
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 suitably manages its risks. Team members have a basic understanding about protecting people's information and supporting vulnerable people. The pharmacy has some written procedures to help make sure the team provides safe services. But these are not regularly updated, and they do not cover all the key areas, so the team might not always work effectively. And the team does not always review and record any mistakes that happen, so it may miss learning opportunities.

Inspector's evidence

The pharmacy had written procedures that covered safe dispensing of medicines, the responsible pharmacist (RP) regulations and controlled drugs (CDs). However, many of these procedures were last reviewed in 2012 or 2015, and records indicated that not all the staff had read them, which they confirmed to be correct. The pharmacy did not have any written procedures for handling complaints, near misses or dispensing errors. So, there was a risk that some team members may not fully understand how they should provide the pharmacy's core services or manage any identified risks.

The senior dispenser explained that she recorded dispensing errors on the pharmacy's PMR incident reporting system and informed one of the resident pharmacists. The rest of the staff said that historically the pharmacy had a book in which it recorded dispensing errors, but they could not locate it and did not know about any current arrangements or procedures for handling dispensing errors.

The pharmacy team discussed mistakes it identified when dispensing medicines and it addressed each of them separately. However, team members had limited discussions about why they thought each mistake had happened, and the pharmacy did not have any system for recording or reviewing these mistakes to identify any patterns. So, staff could miss additional opportunities to learn and mitigate risks in the dispensing process.

The team had received positive feedback on providing an efficient service and advice on a current health problem or a longer-term health condition, in its most recent patient survey. However, these results were issued in April 2018, so may no longer be representative of people's views. There was no publicly displayed information about how to make a complaint.

The superintendent pharmacist, who was one of the regular pharmacists, said that the pharmacy had professional indemnity insurance for its services. The pharmacy maintained the records required by law for the RP log and any urgent requests for medication without a prescription. The pharmacy kept records of private prescription transactions, which did not always include the date each medication was supplied as required by law. The pharmacy kept records of medicines manufactured under a specials licence that it had ordered and supplied. However, these records did not always have the details of the people to who it had supplied them, which could make it more difficult for the pharmacy to explain what has happened in the event of a query.

Staff understood the basic principles of protecting people's information and they securely stored confidential material, but they had not received any formal training about this, including on the General Data Protection Regulation. They used passwords to protect access to people's electronic information and had their own security cards to access people's NHS electronic data. But, they did not always use

their own card, which meant it could be difficult confirming who had accessed the information. The pharmacy had a system for securely disposing of confidential material, but there had been one isolated case where staff had disposed of a dispensing label in the general waste. Staff also could not recall signing any confidentiality agreement. The pharmacy did not have any official policies on data protection, and it did not display a privacy notice.

The team had reported safeguarding concerns to the GP when people exhibited signs of confusion. It also informally assessed whether any of these people needed their medication limited to seven days' supply, which could help them to avoid becoming confused, but it did not keep any corresponding record that supported this. The pharmacy also did not keep any records of the next of kin or care arrangements for these people, which could be helpful when supporting them and resolving issues. The superintendent said that they and the main resident pharmacist had level two safeguarding accreditation, but they had obtained it several years ago and had not completed any refresher training since that time. They said that the other resident pharmacist, who was a locum, also had level two accreditation. Some staff had historically completed safeguarding training when they worked elsewhere and knew where to access the local safeguarding board's contact details and procedures. But, most staff had not completed any safeguarding training and the pharmacy did not have its own safeguarding procedures.

Principle 2 - Staffing **Standards not all met**

Summary findings

Some team members are not qualified for their roles and training is sometimes delayed. So, they may not have the skills and competence needed to provide all services safely. And team members do not have regular performance reviews and qualified staff do not complete any additional training. This could mean that there are gaps in their skills and knowledge. But the pharmacy has enough staff to provide an efficient service and team members work well together.

Inspector's evidence

The staff present included the RP, who was a locum pharmacist providing temporary cover, the senior dispenser who was NVQ level three accredited, a trainee dispenser, and an experienced medicines counter assistant (MCA). The other staff included three resident pharmacists, one of who was the superintendent pharmacist, two experienced dispensers, and a pharmacy undergraduate who had recently started working.

The pharmacy also employed an unqualified member of staff, who said they had worked in the dispensary for the last six years and had been dispensing most people's compliance packs for the last five years as well as managing the service. They had been unsuccessful at completing a dispenser training course on several occasions. Their last attempt ended a few years ago and there was no plan for them to re-enrol. Staff had raised concerns about this with the superintendent and one of the resident pharmacists, but there had been no effective response.

The trainee dispenser, who commenced employment in August 2018, had completed around half of their qualification course, but they did not start it until January 2019. The trainee felt well supported by the resident pharmacists, and they had a one-hour tutorial with the course provider and other trainees once a week. However, they did not have any protected study time. And the pharmacy did not have a staff appraisal process or on-going training programme for qualified members of the team.

The pharmacy had enough staff to manage its workload and the dispensary team members worked well both independently and collectively while providing services. Staff said that they usually had repeat prescription medicines, including those dispensed in compliance packs ready in good time for when people needed them. The pharmacy received most of its prescriptions via the prescription ordering and electronic prescription services, which helped to make dispensing more efficient. The pharmacy had a constant but steady footfall of one or two people, so the team avoided sustained periods of increased workload and it could promptly serve people. The pharmacy did not have any formal targets for the volume of services it provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are clean, secure and spacious enough for the pharmacy’s services. It has a private consultation room, so members of the public can have confidential conversations and maintain their privacy.

Inspector's evidence

The pharmacy was situated in a retail unit, which had shop and dispensary fittings that were suitably maintained. It was spacious and professional in appearance. The retail area and counter design could accommodate the number of people who usually presented at any one time. The open-plan dispensary and rear compliance pack dispensing area provided enough space for the volume and nature of the pharmacy's services. The consultation room, accessible from the retail area, could accommodate two people, but its availability was not prominently advertised, so people may not know about this facility. The level of cleanliness was appropriate for the services provided. And staff could secure the premises to prevent unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally sources and supplies medicines safely. But some of its working procedures are unclear, which could mean services are not always provided efficiently. Stock medicines are not always stored in an orderly manner, and the team is not able to fully demonstrate that it manages them effectively.

Inspector's evidence

The pharmacy was open from early morning to late night six nights a week as well as Sunday. It had step-free access and the team could see and assist people who needed help entering the premises.

The pharmacy did not have any written procedures that covered the safe dispensing of higher-risk medicines. Staff said that the resident pharmacists had checked all the people on valproate and gave appropriate advice to those in the at-risk group. However, staff did not know if the pharmacy had given these people the advice cards, as stated under MHRA guidance, and they could not locate the valproate advice booklets or cards. The resident pharmacists checked if people on other higher risk medicines were experiencing any side effects or interaction at the time of their Medicines Use Review (MUR). However, the team did not regularly check if people on other higher-risk medicines had a recent blood test.

The pharmacy team prompted people to confirm the repeat medications they required around five to seven days before they were due, which helped it limit medication wastage. However, staff did not always make records of these requests. Staff said that the pharmacy kept records of the reasons why prescription requests that the local surgery had frequently not fulfilled. However, several randomly selected records did not have any note to indicate that these requests were not fulfilled or the reason why. So, the pharmacy could find it difficult to effectively resolve queries if needed. Staff said the reasons why these prescriptions were not issued were usually either the local surgery's administrative oversight or people needed a medication review, which they communicated to them.

Staff last used the pharmacy's schedule to order prescriptions for people who used multi-compartment compliance packs several months ago, which meant there was a chance that they could unnecessarily delay supplying their medication. The team did not keep a record of these people's current medication that clarified the time of day they were to take them, so it may not be able to effectively identify and query any medication changes with the GP surgery, and risked these being overlooked. The pharmacy also did not keep any records of communications about medication queries or changes for people using compliance packs, which could increase the risk of errors. The team labelled each compliance pack with a description of each medicine inside them. However, it sometimes did not include enough detail in each description, which could make it more difficult for people to identify each medicine.

The team used baskets during the dispensing process to separate people's medicines and organise its workload. However, the team usually only left a protruding flap on medication stock cartons to signify they were part-used, which could increase the risk of people receiving the incorrect medication quantity. The team prepared methadone instalments in advance of people attending to collect them, but it did not always dispense them in divided daily doses, which could help people take their dose accurately.

The pharmacy obtained its medicines from a range of MHRA licensed pharmaceutical wholesalers. It did not have a system required to follow the Falsified Medicines Directive (FMD), as required by law, and staff said the pharmacy owner had not suggested when it would be installed.

The pharmacy suitably secured its CDs and CD destruction kits were available. However, the CD storage space was full, which meant the cabinet had become untidy and disorganised. The team suitably monitored the medication refrigerator storage temperatures. Records indicated that the pharmacy had monitored its medicine stock expiry dates between May 2019 and June 2019. Staff could not locate any other records and they were unsure when stock had been previously checked. Several randomly selected stock medicines had long-shelf lives, but two had expired in September 2019 and November 2019. Staff said that they took appropriate action when they received alerts for medicines suspected of not being fit for purpose but could not locate any corresponding records that supported this. The superintendent subsequently confirmed that the pharmacy did have these records. The pharmacy disposed of obsolete medicines in waste bins kept away from medicines stock, which reduced the risk of these becoming mixed with stock or supplying medicines that might be unsuitable. The team used an alpha-numeric system to store patient's bags of dispensed medication, which meant it could efficiently retrieve people's medicines when needed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment that it needs to provide its services effectively. It properly maintains its equipment and it has the facilities to secure people's information.

Inspector's evidence

The pharmacy team kept the dispensary sink relatively clean, but it had a limescale film. The team had access to hot and cold running water and an antibacterial hand-sanitiser. It also had a range of clean measures, including separate ones for methadone. So, the team had facilities to make sure it did not contaminate the medicines it handled and could accurately measure and give people their prescribed volume of medicine. Staff had access to the latest version of the BNF and a recent cBNF, which meant they could refer to pharmaceutical information if needed.

The pharmacy team had facilities that protected peoples' confidentiality. It viewed their electronic information on screens not visible from public areas and regularly backed up people's data on its PMR system. So, it secured people's electronic information and could retrieve their data if the PMR system failed. And it had facilities to store people's medicines and their prescriptions away from public view.

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.