General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Moin's Chemist, 11-15 Coventry Road, MARKET HARBOROUGH, Leicestershire, LE16 9BX

Pharmacy reference: 1107722

Type of pharmacy: Community

Date of inspection: 04/04/2023

Pharmacy context

This is a community pharmacy situated in a row of shops in the town centre. 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 also provides the seasonal flu vaccination service, and the hypertension case finding service. The pharmacy delivers medicines to people's homes.

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 met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy is unable to show that it has robust governance processes to ensure that medicines supplied to people are safe to use. It has not considered all the risks around storing medicines outside of their original containers before using them to assemble compliance packs. Or the risks in storing mixed batches in single stock containers which do not contain all the information required to be able to date check and respond to alerts effectively.
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. Its team members work safely but because the pharmacy's written procedures are not regularly reviewed there is a risk that they might not always work as effectively as they could. The pharmacy manages people's electronic personal information safely. People who work in the pharmacy talk to each other about their mistakes to try and stop the same sort of mistakes happening again. But because the pharmacy does not record all its mistakes it might miss opportunities to improve its ways of working.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which required review. The pharmacist said that he had started the process. The SOPs had been signed by the pharmacy team members to show they had read and understood them. The staff member present understood how to sell medicines safely and knew when to seek the pharmacist's advice. Staff knew that prescriptions were valid for six months apart from some controlled drugs (CDs) which were valid for 28 days. But not all prescriptions containing CDs were highlighted to remind staff of their shorter validity. This increased the risk that a CD might be supplied when the prescription was no longer valid. The pharmacist said that he would start highlighting all CDs with a 28-day validity.

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. The pharmacist showed the inspector a new way of recording near misses electronically though no records had been made using this approach yet. The pharmacist said that the previously used paper records had been shredded.

The pharmacy maintained the necessary legal records to support the safe delivery of pharmacy services. These included the responsible pharmacist (RP) record, the private prescription book, and the CD register. The entries checked at random during the inspection agreed with the physical stock held. Balance checks were completed regularly apart from a liquid CD which had not been checked for some time. Patient-returned CDs were recorded in a designated register. Date-expired CDs were separated 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 stored and destroyed securely. Professional indemnity insurance was in place. The pharmacy's team members understood safeguarding requirements and could explain the actions they would take to safeguard a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s team members work well together to manage the day-to-day workload within the pharmacy. And they have the appropriate range of experience and skills. Team members can raise concerns if needed.

Inspector's evidence

The responsible pharmacist at time of the inspection was the regular, full-time pharmacist. The rest of the team consisted of another pharmacist, one accuracy checking dispenser, two dispensers, one trainee dispenser and one counter assistant. The trainee dispenser was on an appropriate training course. The pharmacy was busy throughout the visit, but the team was able to manage the workload, serving people promptly and working in an organised way. When asked team members said that they discussed any issues informally on a daily basis and felt able to raise concerns if necessary. The team received informal training from the pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. It is designed so that people visiting the pharmacy can receive services in private when they need to.

Inspector's evidence

The pharmacy had several large steps which meant that access for people with a disability or a pushchair to get into the pharmacy was difficult. The pharmacy team said that they provided accessibility in different ways such as through the delivery service. The public area of the pharmacy was a good size. The dispensary was a reasonable size for the services provided. The pharmacy was a reasonable temperature; lighting was suitable and hot and cold water was available. A consultation room was available for people to have a private conversation with pharmacy staff. There was hand sanitiser available. Unauthorised access to the pharmacy was prevented during working hours and when closed.

Principle 4 - Services Standards not all met

Summary findings

The pharmacy is unable to show that it has robust governance processes to ensure that medicines supplied to people are safe to use, to protect people’s health and wellbeing. It has not considered all the risks around storing medicines outside of their original containers before using them to assemble compliance packs. Or the risks in storing mixed batches in single stock containers which do not contain all the information required to be able to date check and respond to alerts effectively. However, the pharmacy gets its medicines and medical devices from reputable sources.

Inspector's evidence

The pharmacy team understood the signposting process and used local knowledge to direct people to local health services. The pharmacy delivered medications to some people. The pharmacy team 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 included advice when they had a new medicine or if their dose changed. But he did not routinely speak to people who took medicines that required ongoing monitoring such as people who took warfarin to check their INR levels were appropriate or people taking methotrexate had regular blood tests. This could make it harder for the pharmacy to know if people were having relevant blood tests at appropriate intervals.

The pharmacy mainly 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 multi-compartment compliance packs to some people to help them take their medicines at the right time. The pharmacy spread the workload of assembling compliance packs across the month, using a tracker to make sure packs were prepared and supplied on time. Each person had an individual record sheet and team members recorded any changes on this sheet. Packs were labelled with doses and warnings and included descriptions of the medicines on the packs to make it easier for people to identify individual medicines in their packs.

Medicines were mainly stored on shelves in original containers. However, the pharmacy had recently started using a deblistering machine to save time when assembling compliance packs. The medicines were then put in a container which included the name of the medicine, the batch number, and the expiry date. However it did not record the date the medicine had been deblistered. The pharmacy had not considered how long a medicine would be safe to use after it had been removed from its original pack. The pharmacist said he would review this process. Some of the original containers had cut blisters inside which had a different batch number or expiry date . Other blisters did not have the batch number or expiry date. Some were batches from a different manufacturer. This would make it difficult for the person checking the medicine to know if they were suitable to be supplied and meant that medicines might be missed if part of a medicine recall. The pharmacist said he would make sure that medicines were stored in containers which recorded their batch number and expiry date. Most 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 pharmacist explained the process for date checking medicines. There were no recent records of date checking. A check of a small number of medicines found one that was out of date. 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

Members of the pharmacy team mainly have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacy had some suitable measures for measuring liquids. However, some measures did not show that they had been calibrated to ensure the volume measured was accurate. The pharmacist said he would stop using these and replace them. The pharmacy had up-to-date reference sources. The record showed that the fridge was 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 recently to make sure they were safe.

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.