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: 30/11/2023

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 not all met	1.1	Standard not met	The pharmacy fails to identify and manage all of the risks associated with the services provided. Including the risks with the supply of medicines in compliance packs and the storage of medicines.
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	4.2	Standard not met	The pharmacy does not have adequate checking procedures in place to check that medicines supplied in compliance packs are always appropriate for the people taking them.
		4.3	Standard not met	The pharmacy does not always store all of its medicines in accordance with legal requirements.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy fails to identify and manage all of the risks associated with the services provided. Including the risks with the supply of medicines in compliance packs and the storage of medicines. Its team members have defined roles and accountabilities. The pharmacy manages people's electronic personal information safely, and its team members know how to protect vulnerable people. And the pharmacy has some procedures to learn from its mistakes. But because it does not always record who is involved in dispensing a medicine, it might be more difficult to discuss a mistake with the person who made it. And it might miss opportunities to improve its ways of working.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which had been due a review in December 2022. This could mean that some of the SOPs do not reflect current best practice. The pharmacy team members had signed the SOPs to show they had read and understood them. Team members were seen dispensing medicines in an organised way. However, they did not always initial dispensing labels to show when they had undertaken parts of the dispensing process. And clinical checks were not always being done in accordance with SOPs. 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. The pharmacy highlighted Schedule 2, 3 and 4 CDs to remind the person handing out of the shorter validity of prescriptions.

The pharmacy had some 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). The pharmacist said that the number of near misses made was small, so it was difficult to see trends and patterns. When they occurred the pharmacist said near misses were discussed with the member of staff at the time they were spotted and would be recorded in a near miss log. But because the pharmacy did not always have a clear audit trail showing who had dispensed or checked a medicine, it could be harder for team members to learn from all their mistakes.

The responsible pharmacist (RP) record was mainly accurate, but the pharmacist did not usually sign out when they stopped being the RP. The pharmacy stayed open into the evening; some evenings a different pharmacist became RP. This meant the record might not always clearly show the time that the RP changed. There were two RP notices on display to the public. When this was pointed out the pharmacist removed the incorrect notice. The CD register complied with legal requirements. The entries checked at random during the inspection agreed with the physical stock held. Balance checks were completed regularly. Patient-returned CDs were recorded in a designated register.

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 largely stored securely. A member of the team took confidential waste away for destruction, but the pharmacist was not sure how it was destroyed. The pharmacist said that he would review the process. Professional indemnity insurance was in place. The pharmacy's team members understood safeguarding requirements and a team member explained the actions she had taken to safeguard a vulnerable person when they could not deliver his medicines to him.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s team members work together to manage the day-to-day workload within the pharmacy. They know how to raise a concern if they have one. They are suitably trained for the roles they undertake. But they don't receive ongoing structured training which could mean their learning and development needs are not always being addressed.

Inspector's evidence

The RP at the time of the inspection was the regular, full-time pharmacist. The rest of the team consisted of one accuracy checking dispenser, one trained dispenser, two trainee dispensers and one trained counter assistant. The trainee dispensers were 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 including training in any new services that the pharmacy was going to provide. But staff did not have any other ongoing training to keep their skills and knowledge up to date.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises safe, secure, and appropriately maintained. And people visiting the pharmacy can have a conversation with a team member in private.

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. However, 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 had air conditioning which provided a reasonable temperature for storing medicines; lighting was suitable and hot and cold water was available. There were two good sized consultation rooms 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 does not have adequate procedures in place to check that medicines supplied in compliance packs are always appropriate for the people taking them. And it does not store all its medicines requiring special storage arrangements properly. But the pharmacy gets its medicines and medical devices from reputable sources. And it knows the right actions to take if medicines or devices are not safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacist was easily accessible and engaged with people visiting the pharmacy during the inspection. The pharmacy team understood the signposting process and used local knowledge to direct people to other local health services when needed. The pharmacy delivered medicines 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 warfarin or methotrexate, to check their INR levels were appropriate or that they had regular blood tests. This could make it harder for the pharmacy to know if people were receiving the right follow-up care and monitoring at appropriate intervals.

The pharmacy had a pharmacist independent prescriber (PIP) who occasionally worked at the pharmacy. The PIP was not present at the pharmacy during the inspection and this service was not reviewed in this inspection. The PIP agreed to suspend the service until a review had been completed in the New Year.

Baskets were used to keep medicines and prescriptions for different people separate to reduce the risk of error. The pharmacy aimed to use 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. But, when checked, some of the dispensed medicines which had been bagged and placed on the shelf waiting collection did not have both boxes signed. In addition, when a CD was dispensed and checked by the pharmacist, the 'dispensed by' and 'checked by' boxes on the medicine label were not routinely signed. This meant it might be more difficult to be sure that a dispensed medicine had been checked properly, and if a mistake had occurred to be able to discuss the mistake with the person who had made it. This had been raised at the previous inspection. The pharmacist said that he would remind the team of the need to sign the 'dispensed by' and 'checked by' boxes to create an audit trail.

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 to make sure packs were prepared and supplied on time. Compliance packs seen included medicine descriptions on the packs to make it easier for people to identify individual medicines in their packs. The pharmacy did not routinely send a patient information leaflet (PIL) every month but did send a PIL when a new medicine was prescribed. The dispenser said that she would start supplying PILs every month.

The compliance packs were accuracy checked by the accuracy checking dispenser (ACD). The

ACD explained that she checked the prescription against the patient's medicine record and if there was a new medicine or if there was a change in dose then she asked the pharmacist to complete a clinical check. But if the medicines remained the same, a clinical check was not carried out. The pharmacy did not carry out a regular review of medicines in compliance packs by a pharmacist if no changes had been made. In addition, the pharmacy had not considered that different medicines had different risks which might mean some medicines needed more frequent reviews. For example, whether some medicines required a review even if a change had not been made. This increased the risk of a medicine being supplied to a person which might not be clinically appropriate, or which might need some other intervention such as a dose change. The pharmacy had an SOP for compliance pack dispensing and an SOP for accuracy checks (final checks) not carried out by the pharmacist. The SOP for compliance packs was being followed but the SOP for accuracy checks said that all prescriptions should receive a clinical check. So, this SOP was not being followed.

Not all CDs were stored properly. This had been raised at the previous inspection. Other stock medicines were stored on shelves, mainly in original containers. The pharmacy team explained the process for date checking medicines. There were some records of date checking, but not all date checking was being recorded. Most date-expired CDs were separated to prevent dispensing errors. But one obsolete CD was still stored with stock medicines which increased the risk it might be supplied by mistake. The pharmacist moved it. A check of a small number of medicines did not find any others that were 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. The pharmacy maintains the equipment and facilities adequately.

Inspector's evidence

The pharmacy had suitable measures for measuring liquids and it had up-to-date reference sources. Records showed that the regular fridge was in working order and stored medicines within the required range of 2 and 8 degrees Celsius. The pharmacy had two additional fridges that had recently been received back from a care home. Although the fridges felt cold inside, they did not have working thermometers to measure the temperature. The pharmacist said that they had received some additional medicines that required cold storage the previous day and because they had been short of space to store medicines in their usual fridge the medicines had been put in the other fridges. The pharmacist said he had ordered thermometers, but they had not yet arrived. The pharmacist arranged for the medicines to be put back into the original fridge which now had sufficient space. 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.