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: 03/07/2024

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 provides the Pharmacy First and the hypertension case-finding service. It supplies medicines in multi-compartment compliance packs to people who live in their own homes. The pharmacy 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

The pharmacy identifies and manages most of 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. The pharmacy has some procedures to learn from its mistakes. But because it does not record all of its mistakes it might miss opportunities to improve its ways of working.

Inspector's evidence

The pharmacy had a set of electronic up-to-date standard operating procedures (SOPs) which had been read and understood by the pharmacy team members. Staff were seen following the SOPs which included dispensing medicines and handing medicines out to people safely. Staff understood how to sell medicines safely. Staff knew that prescriptions were valid for six months apart from some controlled drugs (CDs) which were valid for 28 days. The pharmacy highlighted prescriptions containing CDs to remind the person handing out the medicines of the shorter validity of prescription.

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 dispenser said that people were not recording all of their near misses, and she would remind the team to record them. But she reviewed the near miss logs monthly and had given good advice to the team to reduce the risk of making a mistake.

The Responsible Pharmacist (RP) notice was visible in the dispensary but was for the previous pharmacist on duty. The RP changed the notice to display the correct RP. The responsible pharmacist (RP) record was mainly accurate, record keeping had improved since the previous inspection. But occasionally the pharmacist did not 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. 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 stored and 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.

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 do not receive ongoing structured training which could mean their learning and development needs are not always being addressed.

Inspector's evidence

During the inspection, the pharmacy team managed the day-to-day workload of the pharmacy effectively. There was one pharmacist, two accuracy checking dispensers, one trained dispenser, one trainee dispenser and one trained counter assistant. The trainee dispenser was on an approved apprenticeship. 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. And the member of staff asked said that she had personally signed up to receive training emails. But staff as a whole did not have any other ongoing training to keep their skills and knowledge up to date. This had been highlighted at a previous inspection and the dispenser said that she would raise this.

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 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 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.

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 members said that they provided accessibility in different ways such as through the delivery service. 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 pharmacy put one person's sodium valproate tablets in their compliance pack. The dispenser said that she had considered the risks and had decided it was the appropriate action to take. She had not recorded her risk assessment but said that she would do so. 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.

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 was also offering the NHS 'Pharmacy First' service. This allowed the pharmacy to treat seven common conditions including supplying prescription-only medicines. The pharmacist had spoken to the local surgery to make sure that referrals met the clinical criteria. The pharmacist said that this service was regularly used by people and had been positively received.

The pharmacy supplied medicines in 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. Patient information leaflets (PILs) were sent to people every

month. The compliance packs were accuracy checked by the accuracy checking dispenser (ACD). The processes had improved since the last inspection and a pharmacist now clinically checked all prescriptions before they were dispensed. An audit trail was created by the pharmacist initialling the prescription. However, the SOP for accuracy checks by an ACD had not been fully updated to reflect the changes introduced. The dispenser said she would speak to the pharmacist and arrange for it to be updated.

CDs were now being stored properly. Other stock medicines were stored on shelves in original containers. The pharmacy team explained the process for date checking medicines. A check of a small number of medicines did not find any 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

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 had suitable measures for measuring liquids, and it 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 April 2024 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.