General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Moir Pharmacy, The Moir Medical Centre, Regent Street, Long Eaton, NOTTINGHAM, NG10 1QQ

Pharmacy reference: 1109863

Type of pharmacy: Community

Date of inspection: 09/11/2022

Pharmacy context

This busy pharmacy is located in a medical centre. Most people who use the pharmacy are from the local area and a home delivery service is available. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines. It supplies some medicines in multi-compartment compliance aid packs to help people take their medicines at the right time.

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 adequately manages risks to make sure its services are safe, and it takes some action to improve patient safety. It generally keeps the records required by law. Pharmacy team members work to professional standards although the pharmacy's written procedures are not regularly reviewed, so there is a risk that team members may not always work effectively. Team members have a basic understanding about protecting the welfare of vulnerable people, but they do not all receive formal training, so there is a risk that some team members might not always notice issues and take the appropriate action.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services it provided. The SOPs had not been reviewed since 2018, so they might not be up-to-date or reflect current practice. Some members of the pharmacy team had not signed the SOPs to show they had read and accepted them, so there was a risk that they might not fully understand the pharmacy's procedures. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their roles. Team members did not generally wear uniforms or anything to indicate their role, so this might not be clear to visitors to the pharmacy. The incorrect name of responsible pharmacist (RP) was on display at the start of the inspection, which might cause confusion in the event of a problem or query. The correct notice was printed off and displayed when this was pointed out.

The pharmacy team recorded dispensing incidents electronically and near misses were recorded on a log and discussed within the team. Actions were taken to prevent reoccurrences, such as separating the different strengths of bendroflumethiazide and omeprazole. Clear plastic bags were used for assembled CDs to allow an additional check at hand out. Team members were aware of the common look-alike and sound-alike drugs (LASAs) so extra care would be taken when selecting these. Formal reviews of near misses were not carried out or documented, so the team might be missing out on additional learning opportunities.

There was nothing on display to show people how they could leave feedback or raise a concern about the pharmacy services, so people might not know how to do this. A dispenser described how she would deal with a customer complaint which was to refer it to the pharmacy manager. She said complaints were very rare and most feedback was positive. Insurance arrangements were in place. A current certificate of professional indemnity insurance was on display in the pharmacy.

Private prescriptions and emergency supplies were recorded in a book. The date of supply and the prescriber's address were missing from the samples checked, so they did not provide a reliable audit trail. The patient medication record (PMR) system included a facility to record private prescriptions automatically, so the details were available electronically. The RP record and the controlled drug (CD) registers were appropriately maintained. Records of CD running balances were kept and these were regularly audited. A CD balance was checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately.

Confidential waste was collected in a designated place and then stored in locked containers in the

medical centre until collected by an appropriate waste disposal company. A dispenser correctly described the difference between confidential and general waste. A privacy statement was on display, in line with the General Data Protection Regulation (GDPR). 'Your data matters' leaflets were on display which gave information about data protection in the NHS and outlined the role of the Information Commissioner's Office (ICO). Consent was received when Summary Care Records (SCR) were accessed, for example when checking when a patient's medication had changed.

The pharmacist had completed level three training on safeguarding. Other staff had not received any formal training, but they were aware that concerns regarding children and vulnerable adults should be reported. There was a safeguarding notice on display containing the contact numbers of who to report concerns to in the local area. There was nothing on display highlighting that the pharmacy had a chaperone policy, so people might not realise this was an option. The pharmacy team were aware of the initiatives where pharmacies were providing a safe space for victims of domestic abuse. They said the consultation room was always available for anyone requiring a confidential conversation.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team work well together in a busy environment and team members have the right qualifications for the jobs they do. Team members are comfortable providing feedback to their manager and they receive feedback about their own performance. Some members of the team get structured training. But other members of the team do not receive regular ongoing training, so there may be gaps in their knowledge and skills.

Inspector's evidence

There was a locum pharmacist, two NVQ2 qualified dispensers (or equivalent) and an apprentice dispenser on duty at the time of the inspection. There were another dispenser and two delivery drivers on the pharmacy team who were not present. Staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and people who visited the pharmacy. Planned absences were organised so that not more than one person was away at a time. Absences were covered by re-arranging the staff rota and team members could work additional hours when necessary to match the workload.

Members of the pharmacy team carrying out the services had completed appropriate training and their qualification certificates were on display. One of the dispensers was on an NVQ3 dispensing course and she received some training time each week, and the apprentice dispenser received a set amount of protected training time. But there wasn't a structured programme of ongoing training for other member of the team, so there was a risk their knowledge might not be up-to-date. There was a formal appraisal process for the apprentice to review their performance and development. Other members of the team received feedback informally from the pharmacy manager. The pharmacy team was small and team members discussed issues as they arose. Team members confirmed there was an open and honest culture in the pharmacy and they felt comfortable admitting errors and sharing their learning from mistakes. They did not know if there was a whistleblowing policy but said they would feel comfortable talking to the pharmacy manager about any concerns they might have.

The pharmacist said he could comply with his own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because he felt it was inappropriate. He said he had not been set any targets when working at the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable environment for people to receive healthcare services. It has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations.

Inspector's evidence

The pharmacy premises was within a medical centre. It was accessible from the medical centre but it also had its own separate entrance. The pharmacy, including shop front and facia, were clean and in a good state of repair. The retail area was professional in appearance. It did not have a waiting area, but people could use the chairs in the adjoining waiting room of the medical centre if necessary. The temperature and lighting were adequately controlled. The pharmacy was fitted out to a good standard, and the fixtures and fittings were in good order. The pharmacy was small and staff facilities were limited. The staff used the WC in the medical centre which had a wash hand basin and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. The consultation room was used as an office and for storage of prescriptions and paperwork. It was cluttered, which detracted from its professional appearance. The availability of the room was highlighted by a sign on the door. This room was available when customers needed a private area to talk, but team members said it wasn’t ideal because it was used for so many other things, due to the lack of space in the pharmacy.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are generally well managed and easy for people to access. The pharmacy gets its medicines from licensed suppliers, and it carries out some checks to ensure medicines are in good condition and suitable to supply. But the pharmacy could improve the way it stores and manage some of its medicines.

Inspector's evidence

The pharmacy was accessible to everyone, including people with mobility difficulties and wheelchair users. A list of the services provided by the pharmacy was displayed, although it wasn't fully up-to-date which might cause confusion. The pharmacy team were clear what services were offered and where to signpost people to if a service was not offered. For example, people requiring emergency hormone contraception (EHC) if the pharmacist on duty that day couldn't provide it. There was a small range of healthcare leaflets.

The pharmacy had a home delivery service with associated audit trail. The service had been adapted to minimise contact with recipients, during the pandemic. The delivery driver confirmed the safe receipt in their records. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was limited in the dispensary, but the workflow was organised into separate areas. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. 'Speak to Pharmacist' stickers were used to highlight when counselling was required, or the prescription placed in a designated part of the dispensary to be handed out by the pharmacist. High-risk medicines such as warfarin and valproate were targeted for extra checks and counselling. The team were aware of the valproate pregnancy prevention programme. The pharmacist knew to highlight the care card attached to the original packs and a dispenser explained that valproate care cards were printed off if it wasn't possible to supply the medicine in the original pack. This was to ensure people in the at-risk group were given the appropriate information and counselling.

Multi-compartment compliance aid packs were reasonably well managed. There was a partial audit trail for changes to medication in the packs, but it was not always clear who had confirmed these and the date the changes had been made, which could cause confusion in the event of a query. A dispensing audit trail was completed, and medicine descriptions were usually included on the packaging to enable identification of the individual medicines. Staff confirmed packaging leaflets were usually included so people were able to easily access additional information about their medicines. Disposable equipment was used. An assessment was made by the pharmacist as to the appropriateness of a pack or if other adjustments might be more appropriate to the patient's needs, and this usually included liaising with the patient's GP practice.

The apprentice dispenser explained what questions she asked when making a medicine sale and knew when to refer the person to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

CDs were stored in a CD cabinet which was securely fixed to the floor. The keys were under the control of the responsible pharmacist during the day and stored securely overnight. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain stock medicines. Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out, but it was not always recorded, and some date expired medicines were found on the dispensary shelves. These were removed for destruction when pointed out. Following the inspection, the pharmacist superintendent (SI) confirmed that the pharmacy had a date checking matrix which the team would use going forward, to ensure that the date checking was better managed. Dates were added to opened liquids with limited stability. Expired and unwanted medicines were segregated and placed in designated bins.

Alerts and recalls were received via email messages to the pharmacy. Team members explained that only the pharmacy manager had access to these, but he forwarded them if he was absent from the pharmacy, so that they could be acted on. Team members did not know if the pharmacy manager recorded what action had been taken. This meant they would not easily be able to respond to queries and provide assurance that the appropriate action had been taken in the pharmacy manager’s absence.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to 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 pharmacist could access the internet for the most up-to-date reference sources. He said he used his mobile phone to access the electronic British National Formulary (BNF) as the most recent BNF was not available in the pharmacy in printed form.

There was a clean medical fridge. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order. There was a clean glass 100ml liquid measure with British standard and crown marks. A team member explained that they had recently broken the small measure but said they would reorder one to ensure smaller doses could be measured accurately. The pharmacy had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs.

Computer screens were positioned so that they weren’t visible from the public areas of the pharmacy. PMRs were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.