General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Malcolm's Pharmacy, 28 Flixton Road, Urmston, MANCHESTER, M41 5AA

Pharmacy reference: 1110146

Type of pharmacy: Community

Date of inspection: 21/11/2023

Pharmacy context

This pharmacy is located on a busy main road in the Urmston area of Manchester. Its main activity is dispensing NHS prescriptions, but it also provides some people with medicines in multi-compartment compliance packs. The pharmacy provides a range of NHS and private services which include seasonal flu vaccinations, COVID-19 vaccinations, and travel vaccinations. It also offers services provided by other healthcare professionals such as podiatry, chiropractic, and audiology services.

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 members of the pharmacy team have not completed appropriate training. So, the pharmacy cannot provide assurance that they have the skills and knowledge they need for their roles.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	Medicines are sometimes re-packaged and stored without batch numbers or expiry dates. So, the pharmacy cannot provide assurance that they are in good condition and suitable to supply
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures to help make sure its team members know how to complete tasks safely. Members of the team keep records of their mistakes so that they can learn from them. But they do not review the records and they do not record all their mistakes. So, they may miss some opportunities to prevent mistakes from being repeated. Members of the team protect people's private information and know how to protect vulnerable people. The pharmacy generally keeps the records it needs to by law.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs), and some team members had signed training records to confirm they had read and understood them. The superintendent pharmacist (SI) stated that all team members had read the SOPs but that some hadn't signed the training records. Members of the team were able to describe the processes that were in place to help manage the workload in a safe and effective manner. They were aware of the tasks that could not be completed when the responsible pharmacist (RP) was absent. The pharmacy did not have an SOP about protecting people's information, but members of the team took appropriate steps to maintain confidentiality. They kept information secure from unauthorised access and separated confidential waste before appropriately disposing of it. And team members' private conversations could not be overheard by people waiting in the pharmacy.

The pharmacy kept some records of mistakes that were identified during the dispensing process, also known as near misses. The person who completed the accuracy check informed the team member who had made the error and asked them to identify the mistake and correct it. The team member was then supposed to make a record of their mistake in a near miss log with an explanation of what the probable cause may have been. The SI admitted that mistakes were often not recorded and that the records hadn't been reviewed. This means the pharmacy team may miss opportunities to learn and may not always take appropriate action to help prevent mistakes from being repeated. The pharmacy had a process to manage dispensing errors. This is when a mistake is made during the dispensing process and not identified before the medicine is supplied to people. The SI explained that errors were investigated, and a record was made. They shared the details of dispensing errors with members of the team to make them all aware.

The pharmacy kept electronic records for controlled drugs (CDs) on the pharmacy computer. Team members recorded running balances of CDs and regularly checked them against the physical stock. And they kept a separate record of patient-returned CDs. A random sample of three recorded balances were checked against the physical CD stock, and two were found to be correct but one was incorrect. The SI agreed to investigate the discrepancy and inform the CD accountable officer if it could not be resolved. Private prescription records were generally in order, but the details of the prescriber were often inaccurate. A responsible pharmacist (RP) record was maintained and completed in full. The pharmacy kept appropriate records when unlicensed medicines were supplied to people.

The pharmacy had an SOP about safeguarding vulnerable people which most team members had read. When questioned, they were able to explain the signs to look out for which may indicate a safeguarding concern. And they would refer any concerns to the pharmacist. Details of local safeguarding contacts

were available in case a concern needed to be reported.

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

Summary findings

The pharmacy has enough team members to manage the workload. But some team members have not completed appropriate training. So, the pharmacy cannot provide assurance that they have the skills and knowledge they need for their roles. And some team members have not read the pharmacy's procedures for services they provide. So, they may not fully understand what is expected of them.

Inspector's evidence

The pharmacy team consisted of two regular pharmacists, one of whom was the SI, two pharmacy technicians, one of whom worked as an accuracy checker (ACT), four dispensers, a medicines counter assistant, two students and two delivery drivers. Other members of the team who were not present during the inspection included, eight students, two delivery drivers, two medicines counter assistants, and a pharmacy student who worked as an accuracy checker (ACD).

The pharmacy employed a number of students to help dispense prescriptions, to manage the workload. Only two of the students were studying pharmacy and most of them did not hold suitable qualifications for their roles or the tasks they were completing. And they had not been enrolled on to any pharmacy training courses. Two students provided flu and COVID-19 vaccinations to people. They had certificates available showing they had completed appropriate training courses for injection technique, and online training about the vaccines. One of the students admitted they hadn't read some of the SOPs about needle stick injuries or the administration of adrenaline and hadn't read the national protocols which provided the legal authority to administer the vaccines. This meant they may not have been fully aware of the pharmacy's processes and what they were expected to do if something went wrong.

A pharmacy technician was undertaking additional training to become an ACT and a dispenser was completing an apprenticeship to obtain a level three technician qualification and become an ACT. Those on training courses said they felt supported. There was no formal programme of ongoing training in place for team members to complete.

The pharmacy team were seen working well together to manage the workload. And they communicated with each other when a query arose. A medicines counter assistant explained how they recognised over-the-counter medicines that were liable to abuse or misuse. They knew the correct questions to ask when selling these medicines. And they asked the pharmacist for advice when they felt the sale was inappropriate or when repeated requests were made.

The pharmacy didn't complete appraisals with its team members, instead it carried out informal conversations when needed. The SI explained they had a team huddle each morning when they discussed the priorities for the day, shared any important messages, and raised awareness of any errors that's had happened. The pharmacy team did not have any targets or incentives relating to professional services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's environment is suitable for the services that it provides. It is generally clean and tidy, but some areas are cluttered which detract from its professional appearance. A consultation room is available for the confidential provision of pharmacy services.

Inspector's evidence

The pharmacy was clean and well-lit. It had climate control to help maintain the room temperature at a suitable level. Its team members cleaned the pharmacy daily. The pharmacy had adequate bench space to safely assemble prescriptions and a designated area to assemble and store multi-compartment compliance packs. But some work surfaces were cluttered which made it more difficult to team members to work effectively. A clean sink with hot and cold running water was available and was suitable for preparing medicines that required mixing before being supplied to people.

The pharmacy had a consultation room available for people to have private conversations or receive pharmacy services. There was also another room used as a treatment room for other healthcare professionals to provide services to people. Both rooms were clean and tidy. The consultation room was large enough for the services that the pharmacy offered. It was located behind the front counter of the retail area. So, a member of the team always accompanied people to the room to prevent unauthorised access to medicines. The dispensary area was situated behind the front counter and unauthorised access was restricted. Suitable staff facilities were available which included a small kitchen area, washroom and rest area. The pharmacy was secured when closed.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy obtains its medicines and devices from licensed suppliers. And it stores them securely and at the required temperatures. But the team does not regularly check stock medicines to make sure they are in good condition. And some medicines are re-packaged and not properly labelled. So, the pharmacy cannot provide assurance that all its medicines are suitable to supply. Members of the team provide advice to people who are supplied high-risk medicines, to help make sure they use them safely.

Inspector's evidence

The pharmacy had a step free entrance which led into the retail area. Seating was available which people used when they waited for their medicines or a pharmacy service. Health information leaflets were available if people needed to access additional health related information. The opening hours and services offered were advertised in the pharmacy window.

The pharmacy provided seasonal flu vaccinations and COVID-19 vaccinations to people who were eligible. The vaccinations were administered in accordance with a current patient group directive (PGD) or national protocol. The SI explained the PGDs were used by pharmacist vaccinators and the national protocols were used by the non-pharmacist vaccinators. The SI was the clinical supervisor, and they helped make sure vaccines were administered safely by the non-pharmacist vaccinators.

The pharmacy advertised services provided by other healthcare professionals. And they used one of the consultation rooms which was signposted as a 'treatment room.' People accessed podiatry, audiology, and chiropractic services. The pharmacy had not completed any checks to confirm that the healthcare professionals had been registered with their respective regulatory bodies or if adequate personal professional indemnity was in place.

The pharmacy obtained its medicines and medical devices from multiple licensed sources and stored them appropriately to prevent unauthorised access. The SOPs stated that regular expiry date checks should be carried out for stock medicines. But there were no records to show when these checks had been completed. And the SI admitted stock checks didn't happen often but said team members checked the expiry dates of medicines when they completed accuracy checks. A random selection of stock was checked, and no expired medicines were found. A few medicines had been de-blistered from their original packaging and were being stored in brown tablet bottles after they had been removed from multi-compartment compliance packs that hadn't been supplied. The bottles were labelled with the name, strength, and form of the medication but not the expiry dates or batch numbers. This meant the pharmacy could not provide assurance that the medicines were in good condition and suitable to be supplied to people.

Medicines that required cold storage were stored in three fridges. The fridges were equipped with thermometers and the temperatures were seen to be within the required range. Members of the team made daily records of the temperatures on the pharmacy computer. And they were able to explain the actions they had taken when the temperatures had gone outside of the 2-8 degrees Celsius range. Controlled drugs that required safe storage were kept in two secure CD cabinets. Obsolete CDs and patient-returned CDs were clearly marked and separated from that CD stock that was used to fulfil

prescriptions. The pharmacy received MHRA drug alerts by email. The team described how they checked them against the stock on the shelves, but no records of the actions they had taken were made. So, the pharmacy could not show that all alerts had been dealt with appropriately.

The pharmacy dispensed both NHS and private prescriptions. And it supplied medicines to people residing in nursing homes. Team members used baskets to separate prescriptions intended for different people to help reduce the risk of any mistakes happening. They also signed dispensing labels to indicate who was involved in the prescription assembly process. Once the assembly was complete the pharmacist carried out a clinical and accuracy check. They then signed the dispensing label to show this had been done. This helped the team identify who had been involved in the if a query arose. Medicines waiting to be collected were stored securely from unauthorised access. Members of the team used a range of stickers to highlight if a prescription had a cold-chain item or a CD that needed to be added before the medicines were supplied. The use of CD stickers prompted team members to check schedule 2 and 3 controlled drugs were not handed out beyond their legal limit of 28 days. The pharmacy offered a delivery service. The delivery driver used an APP on their phone which helped to maintain a record of the completed deliveries. A signature was captured for controlled drugs that were delivered.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide the services that it offers. And its facilities help its team members provide a safe and effective service.

Inspector's evidence

The pharmacy had a selection of clean calibrated glass measures to help its team members measure liquid medicines. And it clearly marked measures that were used for higher risk medicines to prevent cross-contamination. Clean counting equipment was also available for tablets and capsules. Electrical equipment was in good working order and had been PAT tested in April 2023. The pharmacist explained they used the internet to access resources such as the British National Formulary (BNF). The pharmacy had four computer systems installed which held people's medication records. The screens were not visible to members of the public and the computers were password protected to prevent unauthorised access. Members of the team used cordless phones so they could have conversations without being overheard by people.

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.