General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Manchester Chemist, Unit 11, 20-22 Mary Street, Strangeways, Manchester, Greater Manchester, M3 1DZ

Pharmacy reference: 9010683

Type of pharmacy: Community

Date of inspection: 22/03/2024

Pharmacy context

This pharmacy supplies most of its services at a distance, and it is located in an industrial estate in Manchester. The pharmacy dispenses NHS prescriptions which are delivered to people. It offers the New Medicine Service (NMS) and provides the NHS Pharmacy First service, a phlebotomy service and seasonal flu vaccinations.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 identifies and manages the risks associated with its services to help provide them safely. And people can provide feedback about its services. It keeps the records it needs to keep by law, and these are largely kept accurate and up to date. And it protects people's personal information appropriately.

Inspector's evidence

Standard operating procedures (SOPs) were available and had been read by team members. The SOPs for dispensing and accuracy checking prescriptions were not in line with the process being followed by the pharmacy. This meant team members may not be familiar with the pharmacy's processes and procedures and may not always work effectively. The pharmacy used several features that were part of the pharmacy computer system during the dispensing and accuracy checking process. Team members explained that this had streamlined the dispensing process and reduced the number of mistakes. However, this was not reflected in the SOPs which stated that the pharmacist should complete the final accuracy check rather than the pharmacy computer system. The superintendent pharmacist (SI) had subsequently provided the SOPs which directly related to the pharmacy's activities and confirmed that the new SOPs had been read and signed by the team.

Risk assessments were not available at the pharmacy. They were subsequently provided and there was a risk assessment for the service as a whole. The SI had used a template risk assessment for pharmacies providing services at a distance which looked at areas such as staff training, medicines management and provision of services at a distance. A separate risk register was also in place. This covered the potential for the online sales of medicines that may be subject to abuse and detailed steps to limit this as well as aspects of the delivery service.

Dispensing mistakes which were identified before the medicine was supplied to people (near misses) were usually picked up by the electronic system and automatically recorded. All medicine packs were scanned into the pharmacy computer system before the dispensing labels were generated. Team members said the number of near misses had decreased since they had started using the new system. Evidence of automatically generated near miss entries were seen. The system also produced a report based on the near misses recorded. However, there was no evidence of the near misses being reviewed. This could mean that the team are missing out on opportunities to learn and make the pharmacy's services safer. The SI explained there had not been any instances since the pharmacy had started using the new system where a dispensing mistake had happened, and the medicine had been supplied (dispensing errors). The pharmacy had a procedure to follow in the event that a dispensing error was to occur.

The pharmacy had current professional indemnity insurance. The pharmacy had a complaints procedure and there was information on the website advising people how they could raise concerns or provide feedback. The correct RP notice was displayed. When questioned, team members were aware of the activities that could not be carried out in the absence of the RP.

Emergency supply records, RP records and controlled drug (CD) registers were well maintained. Private

prescription records were generally well maintained but the prescriber's address was not recorded on the system. The SI provided an assurance that he would speak to the system provider and have the setting changed to include this. Records of unlicensed medicines supplied had not been kept for some time. This could make it difficult to identify who had received a particular batch of an unlicensed medicine in the event that there was an issue or a recall. The SI provided an assurance that they would restart keeping these. Running balances were recorded. A random balance was checked and found to be correct. A register was available to record CDs that people had returned.

The pharmacy had an information governance policy which team members had completed training about. The pharmacy stored confidential information securely and separated confidential waste which was then shredded. The pharmacists had access to summary care records (SCR) and obtained verbal consent from people before accessing.

Team members including the delivery driver had all completed safeguarding training. Both pharmacists had completed level three safeguarding training. If the team had concerns, they would refer to the RP and were aware of the next steps to follow.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload appropriately. Its team members are able to discuss pharmacy related issues as they arise. Team members are supported with their training courses.

Inspector's evidence

The pharmacy team consisted of a regular pharmacist, the superintendent pharmacist, a trained dispenser, an apprentice and a delivery driver. The RP felt that the team were able to manage the workload and the team were up to date with their dispensing and usually worked so that they were two days ahead.

The performance of the pharmacy team members was managed by the SI who held monthly appraisals. Team members were provided with feedback on an ongoing basis by the RP. The team was small and worked closely together. Issues and concerns were discussed as they arose or during team meetings that were occasionally held. Team members felt able to feedback concerns and offer suggestions to both the RP and SI.

Team members completing formal training courses were provided with time to complete their training and were supported by the pharmacists. Both pharmacists completed their own continuing professional development (CPD) and passed on any information to the team. The pharmacist was provided with time to complete training related to the services provided. There were no targets set for services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are suitable for the pharmacy's services. But some areas of the pharmacy need to be organised and tided up to present a more professional image for people using the pharmacy's face to face services. The pharmacy's website gives people information about who is providing its services so people can access the information if needed.

Inspector's evidence

The pharmacy was situated in an industrial property. The pharmacy was untidy and disorganised and did not present a professional image to people accessing its services. The SI provided an assurance that he would declutter and tidy up. The dispensary had ample workspace, which was organised, a separate area was used for the management of the compliance pack service. There was a clinic room, which was used to provide face to face services. This room was clean and suitable for the services provided from it. Cleaning was done by the team. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of healthcare services.

The pharmacy had its own online website (https://manchesterchemist.com/). The website gave clear information how people could make a complaint, how people can contact the pharmacy and the GPhC registration information for the pharmacy and its owner. There were a limited number of over-the-counter medicines which could be purchased via the website. Over the counter medicines were also sold via eBay and Amazon. The SI explained that the website was being updated to allow for people to book in for services.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. Team members take the right action in response to drug alerts and recalls. The pharmacy gets its medicines from licensed sources and generally stores them properly. But it stores a few medicines in inappropriately labelled containers. So, this may increase the chance that people receive a medicine which is not suitable to use.

Inspector's evidence

The pharmacy was a distance selling pharmacy, so medicines were not supplied directly to people using the pharmacy. The pharmacy was open to people who were accessing services that it provided on site and services were provided on an appointment basis. The pharmacy website listed the services it provided and displayed the pharmacy's opening times.

Prescriptions were received electronically and were clinically checked by the pharmacist and then moved to a workflow list. Team members then used this list to process the prescriptions so they could be dispensed. Prescriptions for antibiotics were prioritised due to its urgent nature. Team members picked stock and then released the prescription which allowed for the dispensing labels to be printed. The computer system recorded which team member had completed each section of the dispensing process. And it made a record when the dispensed medicines were placed on the shelf to be delivered and supplied to people. The pharmacy computer completed some accuracy checks of the medicines that were dispensed by scanning a barcode found on its original pack. Any split packs, CDs and higher-risk medicines were accuracy checked by the pharmacist. Baskets were used to separate prescriptions, preventing transfer of medicines between different people. The pharmacy used a text messaging application to send people messages if they needed to pay or if there were any messages to pass on.

The pharmacy also used the text messaging application to counsel people on their medicines. For services like the NHS Pharmacy First service, a video link was sent by text. The SI had developed a leaflet with safety netting information which was messaged to people. Team members also counselled people over the telephone. Team members spoke different languages and people would generally ask to speak to a named team member.

The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). Team members were aware of the need to dispense sodium valproate in its original pack and ensure any warnings were not covered with dispensing labels. One person was supplied with sodium valproate in a compliance pack, but the pharmacy had not completed a written risk assessment to help make sure the risk of this was considered. The SI provided an assurance that this would be completed. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring. A template for checking INR levels for people taking warfarin was given to the delivery driver who obtained the details and passed these on to the pharmacist.

The pharmacy dispensed private prescriptions for an ADHD clinic. The SI had completed checks before agreeing to provide this service. Medicines were either delivered by the driver or a signed for courier service was used.

Some people's medicines were supplied in multi-compartment compliance packs to help them take their medicines at the right time. Once the prescription was received, it was clinically checked by the pharmacist and then passed to the dispensers. Before preparing the packs, medicines were selected and checked using the inbuilt accuracy checking system. And it was double checked for accuracy by the RP who also completed the final check after the pack had been prepared. The pharmacy received information about hospital admissions, including discharge information. Assembled packs were labelled with the product descriptions and mandatory warnings. There was an audit trail to show who had prepared and checked the packs. Patient information leaflets were issued monthly. Some packs for a few people were prepared in advance of the prescription being received by the pharmacy to help manage the workload better. These were stored in a separate area and only moved for a check once the prescription had been received. The SI agreed that there were some risks associated with this and provided an assurance that he would speak to the surgeries and ask if prescriptions could be sent earlier.

The pharmacy provided a phlebotomy service, people booked online and came in to have their blood test done. Both pharmacists had completed the training. Once the blood test was done the lab arranged for a courier to come and collect the sample. Results were sent to people directly by the lab.

Online orders from eBay and Amazon for general sale products were processed and prepared by the apprentice. These were checked by a pharmacist before they were packaged. The pharmacy had some Pharmacy only items available for sale on their website. People needed to complete a questionnaire for these medicines. The pharmacy had not sold any medicines via this route.

Deliveries were carried out by the delivery driver. A handheld device was used to track and audit deliveries. As medicines bags were scanned in by the driver a text message was sent to the person to notify them that the driver was on the way. If people were not available to accept the delivery the medicines were returned to the pharmacy. A tracked delivery service was also used.

Medicines were obtained from licensed wholesalers and were stored appropriately. Fridge temperatures were said to be monitored daily and recorded; however, there had been no records made since 6 March 2024. Fridges were all checked and the actual temperature for all was within the required range for the storage of medicines. CDs were kept securely. The dispensary had been split into sections and the expiry dates of medicines in each section were checked routinely., No date expired medicines were found on the shelves. There was no date checking matrix available. So, the pharmacy may not be able to show when the last date check was completed or what medicine stock had been checked. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. A few medicines were seen to be stored in mixed batches in original packs and others like Laxido sachets were all stored in a basket outside of the packaging. This would make it hard to carry an expiry date check or check the batch in the event that there was a drug recall. The SI provided an assurance that medicines would be stored in their original packaging or in appropriately labelled boxes. Drug recalls were received electronically. The team would check the stock and take the action as required; an audit was kept on the system.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses its equipment in a way which helps protect people’s personal information.

Inspector's evidence

The pharmacy had calibrated glass measures, plastic measures and tablet counting equipment. The SI said the plastic measures were not usually used. Equipment was clean and ready for use. Three fridges were available. Blood pressure monitors were available and used for some services provided. These were fairly new the SI was aware of the need to make arrangements for calibration. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected, team members all had individual log in details and screens were not visible to people using the pharmacy.

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.