General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medihome Pharmacy, Remmets House, Unit 1, Lord Street, Bury, Greater Manchester, BL9 0RE

Pharmacy reference: 9011587

Type of pharmacy: Internet / distance selling

Date of inspection: 08/02/2022

Pharmacy context

The pharmacy is in a business estate on the outskirts of Bury town centre. It has an NHS distance selling contract, so people do not access the pharmacy premises directly. They assess pharmacy services via its website, email, and telephone. The pharmacy dispenses NHS prescriptions, mainly for care homes. And some people receive their medicines in multi-compartment compliance packs. The pharmacy delivers medicines to the care homes and to people at home. The inspection was completed during the COVID-19 pandemic.

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	1.2	Standard not met	The pharmacy does not have a robust process implemented to identify, manage and learn from near miss errors and dispensing incidents.
		1.8	Standard not met	The pharmacist and team members do not have up-to-date safeguarding training to identify and help vulnerable people that access pharmacy services. They do not have the necessary details or knowledge of who to contact to report a concern.
2. Staff	Standards met	N/A	N/A	N/A
3. Premises	Standards not all met	3.3	Standard not met	The pharmacy doesn’t have adequate facilities to complete personal and professional tasks requiring hot and cold water.
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy doesn’t adequately store or manage all of its medicines appropriately. It doesn't have robust stock control processes. It has expired medicines on its shelves. And it doesn’t have effective arrangements to identify and remove these medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy identifies and manages some of the risks to its services. But it doesn't have a robust process to identify, manage and learn from dispensing mistakes. The pharmacy team doesn't have suitable up-to-date training to help protect vulnerable people that access its services. The pharmacy mostly protects people's confidential information as it should. And it makes the records it must by law. People have the opportunity to feedback about the pharmacy's services and team members listen and act appropriately to this feedback.

Inspector's evidence

The pharmacy had identified risks associated with the COVID-19 pandemic and had made changes to reduce the risk of spreading infection. People requiring pharmacy services did not access the pharmacy premises directly, so infection control measures mainly protected team members. The pharmacy had hand sanitiser available at various places throughout the premises and notices reminded team members of the importance of regularly sanitising their hands. The pharmacy had separate workstations to help with social distancing and one trainee dispenser worked in a separate room. The team members had personal protective equipment (PPE) and team members donned face masks when the inspector entered the pharmacy. The delivery drivers had made changes to their processes during the pandemic to reduce contact with the people they delivered to.

The pharmacy kept its standard operating procedures (SOPs) online and these were relevant to a distance selling pharmacy. The procedures reminded team members that people could not access services directly from the premises. The SOPs included those for controlled drug (CD) management, Responsible Pharmacist (RP) regulations and dispensing. Each team member had a separate sheet to sign to confirm SOPs had been read, but these had not been completed. The trainee dispenser had no signature sheet and had not read the SOPs. The SOPs had some important details missing. They had no dates of when they had been written and when they were due for review. They did not have a version control, or the premises address they related to. The superintendent had authorised the SOPs, but it was unclear when this was. Some details in the SOPs were not relevant to the way the pharmacy provided its services, for example sale of medicines. The pharmacy had not reviewed its way of working against the SOPs since the relocation.

The pharmacy had a paper near miss log, with one entry from 2020, which related to the old premises and one entry had been made by a locum pharmacist to indicate some aspirin had been omitted from a multi-compartment compliance pack. There was little evidence of learning from near miss errors. The pharmacy had a near miss and dispensing incident SOP, but this had not been implemented into ways of working. The pharmacy team didn't evidence any learning or changes made when similar packaging had been identified. The pharmacy had untidy and overstocked dispensary shelves. This increased the risk of selection errors. The pharmacist and dispenser had not completed any learning relating to near misses, such as the CPPE module for look-alike and sound-alike medicines (LASAs). There was no clear culture of understanding and learning from errors. The team didn't have regular meetings to discuss errors and didn't complete patient safety reviews.

The pharmacy displayed the correct RP notice. Team members were observed working within their roles and responsibilities, with the dispenser making referrals to the pharmacist when necessary. The

pharmacy advertised how people could provide feedback and raise concerns on its website. It had a written procedure to manage customer complaints. The dispenser and pharmacist described how they resolved concerns people raised. This included from care home staff who had queries about deliveries and people's medication. The pharmacy had a procedure relating to information governance and confidentially. Some team members had signed a confidentiality clause form. There was no completed form for the trainee dispenser. The pharmacy had a privacy policy displayed on its website. Team members were aware of the importance of keeping people's private information safe although some information was sometimes securely stored away from the pharmacy overnight. The team treated all dispensing paper waste as confidential and stored it in confidential waste sacks. A third-party company removed these for shredding.

The pharmacy had up-to-date professional indemnity insurance. It kept a CD register that mostly met requirements. There were instances where different brands of CDs had been entered in the same register with only one running balance. The pharmacy completed checks of the physical quantity of stock against the register approximately monthly. For the CD item checked, the physical balance matched the CD register balance. The pharmacy had a record of the destruction of patient-returned CDs, but the last entry was from some time ago. The dispenser reported no private prescriptions being received and private prescription records were not seen. The pharmacy had an RP record, and the entries were complete.

The pharmacy didn't have a safeguarding policy or SOP. The pharmacist hadn't completed the CPPE level 2 training since 2012 and the team members had not received training. The team didn't have the NHS safeguarding leads contact information available and hadn't assessed any safeguarding risks associated with supplying medicines to care homes. The team didn't evidence any learning or examples of how the pharmacy safeguarded vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team is suitably skilled and experienced to safely provide its services. Team members complete some reading to keep their knowledge up to date. They feel comfortable discussing ideas together. And they appropriately resolve any concerns.

Inspector's evidence

The RP was the pharmacist manager, and the main full-time dispenser was also a director of the pharmacy. A trainee dispenser was working at the time the inspector arrived, but he left the premises soon after. The director confirmed the trainee dispenser was enrolled on the Buttercups dispensing course but couldn't locate any paperwork to confirm this. The pharmacist and dispenser worked well together. Due to the non-urgent nature of the workload the team didn't appear under undue pressure, although there was a degree of clutter on the dispensing benches. The pharmacy employed two part-time delivery drivers. They delivered in the late afternoons and would continue delivering after the pharmacy closed. This meant people receiving their medicines and also the delivery driver didn't have access to the pharmacist to resolve any queries. The director confirmed the hours of working would be reviewed.

Apart from qualification training the pharmacy didn't have any ongoing formal training support for team members. Training from the Pharmacy Quality Scheme (PQS) was not embedded. The pharmacy received emails from organisations such as the local pharmaceutical committee (LPC) and Pharmaceutical Services Negotiating Committee (PSNC) to help team members keep their knowledge up to date. The pharmacy didn't have a whistleblowing policy. The pharmacist worked closely with the director and felt they could discuss and resolve any concerns. They didn't have any formal, regular team meetings with other team members and the pharmacy didn't have a formal appraisal system. The superintendent was accessible to escalate any issues.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy premises are of a suitable size for the pharmacy's services, but many areas are cluttered. The pharmacy doesn't have adequate facilities to complete personal and professional tasks requiring hot and cold water. The pharmacy has adequate lighting, and it is secure.

Inspector's evidence

The pharmacy premises consisted of several rooms on one level. As part of the relocation, one room close to the entrance had been designated as a potential consultation room. This room was full of compliance pack blisters and racks returned from the care homes. The pharmacist confirmed he currently didn't provide any services involving people attending the premises and he had none planned. Team members dispensed in two adjacent rooms. They had enough room to work, including enough bench space. However, these areas were cluttered with stock and dispensed medicines in baskets. The pharmacy had an excess of medicine stock and it stored these medicines untidily on the dispensary shelves. The pharmacy had a corridor leading to room with a toilet and a sink for handwashing. It had cold running water only and it had no paper towels available. The team had hand sanitiser to use in this area. The pharmacy had no hot running water on the premises. A sink designated for professional use in a back room had not been completed on relocation. This back room was full of totes containing more excess stock stored on the shelves. The pharmacy stored medicines, returned by people, on the floor in this room. It was not possible to access the far corner of the room where the sink was to be, due to all the medicines stored in there. The pharmacy had no separate facilities to reconstitute medicines, for cleaning equipment or for washing pots and cups.

The pharmacy had carpet throughout. There was a small trip hazard as part of the carpet between the two dispensing rooms had lifted. The carpet was dark in colour and adequately clean at the time of the inspection. There was a degree of paper and rubbish on the floor making it appear untidy. The pharmacy had adequate lighting. The temperature during the inspection felt cold and the pharmacist reported one of the heaters was not working. The main entrance was signposted as the fire exit.

The pharmacy had a website, where it advertised its NHS services. It advertised over-the-counter medicines for sale including Pharmacy (P) only medicines. A third-party pharmacy managed the sale of medicines and this was detailed on the website. The website advertised that the pharmacy provided flu vaccinations, which it didn't. It incorrectly mentioned another pharmacy on the website home page, which may be confusing for people. The pharmacy superintendent's details, and the pharmacy's address were advertised on the website.

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

Summary findings

The pharmacy doesn't adequately store or manage all of its medicines appropriately. It has expired medicines on its shelves. And it doesn't have effective arrangements to identify and remove these medicines. Team members follow a robust process to act appropriately when medicines are subject to a recall. The pharmacy has sufficient safeguards in place to help deliver its services safely.

Inspector's evidence

People accessed the pharmacy's services via the telephone, email, and its website as there was no direct access to the premises. Delivery drivers delivered people's medicines to their home and they also delivered medicines to care homes. The pharmacy didn't have a written record that the drivers had read the delivery SOP. The dispenser described how he helped train the drivers to ensure they were competent in their role. The driver's delivery list was the only record of the deliveries being made at a particular time. The team didn't keep a copy of this list in the pharmacy in case of queries. The drivers had started asking for signatures from people as government COVID-19 restrictions lifted.

The pharmacy used baskets to keep people's medicines separate and to help prevent errors. It had separate areas for labelling prescriptions, dispensing, and checking. Some of these areas were cluttered. The team dispensed some of its medicines in multi-compartment compliance packs for people living in care homes and in their own homes. It dispensed some medicines in blisters and on racks for care homes. The pharmacy spilt dispensing up into four separate weeks to help manage the workload. The dispenser clearly described when and how medicines were ordered to make sure the team received them in time to have adequate time to dispense them. Once the pharmacy received the prescriptions, the team checked them for accuracy and contacted the care home or surgery staff to resolve any queries. All records of administration times and of any changes were recorded on the patient medication records (PMR). The dispenser organised and managed the compliance pack workload and ensured people received their medicines in plenty of time before they were needed. But the pharmacy did not keep a written record. This meant there was an over-reliance on one person to ensure the service ran smoothly. The pharmacy supplied patient information leaflets (PILs) for people, and it supplied PILs in a file for care home staff. The pharmacy SOPs had information on dispensing higher-risk medicines, including the requirements when dispensing valproate. The pharmacist was aware of the requirements of the pregnancy prevention programme for people prescribed valproate and recognised the importance of the patient alert card embedded in the manufacturer's packs.

The pharmacy obtained medicines from licenced wholesalers and it kept invoices, including from AAH, Alliance and Ethigen. The pharmacy kept a lot of excess stock of medicines stored throughout the premises in various rooms, including on the shelves in the dispensary. It stored some excess medicine stock in totes that it mostly kept clearly labelled. Some of the totes the pharmacy stored in the back room contained medicines with short expiry dates such as levetiracetam which expired at the end of February 2022. A tote with over 30 packets of nebivolol were due to expire in June 2022. Due to the volume of prescriptions dispensed the pharmacy was highly unlikely to dispense these medicines before they expired. The pharmacist and director reported excess stock had been purchased due to ongoing stock shortages and was only used for prescriptions received by the pharmacy. The pharmacy didn't have a wholesale dealers' licence (WDL). From a sample checked, the pharmacy also had short-dated and expired medicines stored on the dispensary shelves. Expired stock was removed during the

inspection. The team transferred some fast-moving lines from original containers into amber bottles to help dispense for people in care homes efficiently. This helped reduce pressure when the pharmacy was busy. The team labelled most of these with the medicine name, strength and form and included the batch number and expiry. The team didn't print the quantity transferred on the label and there was no evidence that the transfer of medicine had been checked by the pharmacist. Most of these bottles contained approximately 100 or more tablets. Many of the medicines stored in these amber bottles were short-dated and eight or more bottles were removed from the dispensary shelves as the medicines had expired. The pharmacy had not reviewed whether this process was needed and whether these medicines were still fast-moving lines. The team had transferred in excess of 200 thiamine tablets into amber bottles from the original containers due to the insecurity of the lid on the original packs. On examination the thiamine tablets in stock were classed as a food supplement and did not have a medicine product licence number. The pharmacy team members had not annotated the date of opening on any of the liquid medicines seen on the shelves. An opened bottle of morphine liquid, with a three-month expiry once opened, was removed as it was unknown when it had been opened. The team stored some loose blisters of medicines on the dispensary shelves and those with no batch numbers were removed. This included some for antibiotics. The pharmacy didn't have a date checking schedule and team members hadn't checked the expiry dates of medicines recently. This meant there was a risk of expired medicines being stored throughout the premises. The director confirmed that the pharmacy didn't sell over-the-counter medicines from the premises and described a recent scenario when someone requested to buy Phenergan liquid during a telephone conversation. The pharmacy did have some OTC packs in stock, including for example Dulcolax tablets. The pharmacist explained that these had been purchased when the dispensary packs were unavailable. These had a short-dated expiry date of March 2022. The team had not highlighted the packs of the short-dated medicines in any way to help reduce the risk of these being used in dispensing.

The pharmacy had three medical fridges and the temperatures were in range during the inspection. The pharmacist recorded whether temperatures were between 2-8 degrees Celsius in the RP log on a daily basis but didn't record the actual maximum and minimum temperatures. He didn't record the individual temperature of each of the three fridges separately. This meant the pharmacy didn't have a robust audit trail in case of problems. The pharmacy had medicinal waste bins available for returned medication. It had appropriate processes to action medicine recalls and safety alerts. A team member printed these off and annotated what action had been taken. They had actioned the recent medicine recalls from January 2022.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities to adequately provide its services. It mostly ensures its equipment is working appropriately.

Inspector's evidence

The pharmacy had reference resources and access to the internet for up-to-date information. It had password-protected computers, with individual log-in. It had maintenance support for the patient medication record (PMR) system.

The pharmacy team had only one glass measure to help with accurate measuring. It had a range of consumables to dispense medicines in compliance packs and used large baskets to keep people's medicines and compliance packs separate. The pharmacy had electric heaters, but one was reported broken, and the temperature felt cold during the inspection. Team members wore coats.

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.