General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Medichem Pharmacy, KOS Clinic, 4 Roydlands Street, Hipperholme, Halifax, West Yorkshire, HX3 8AF

Pharmacy reference: 9012186

Type of pharmacy: Community

Date of inspection: 23/04/2024

Pharmacy context

The pharmacy is located in a medical practice based in Halifax, West Yorkshire. The pharmacy dispenses NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines. It also provides a COVID-19 vaccination booster service, the NHS Pharmacy First service and a blood pressure check service.

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's working practices are safe and effective. It keeps the records it needs to keep by law, and these are kept accurate and up to date. And it protects people's personal information appropriately. The pharmacy team knows how to help protect the welfare of vulnerable people.

Inspector's evidence

Standard operating procedures (SOPs) were available and had recently been reviewed and updated by the branch manager, who was also the responsible pharmacist (RP) and superintendent pharmacist (SI). Not all of the team members had read and signed the most recent SOPs. The RP provided an assurance that this would be done by the end of the month.

Dispensing mistakes which were identified before the medicine was supplied to people (near misses) were usually picked up by the pharmacy computer 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. Any near misses identified when medicines were manually checked by either the pharmacist or accuracy checker, were recorded on a near miss log. However, the RP said there had not been any mistakes identified. The RP explained there had not been any instances 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. This included completing an investigation, making a record and taking steps to avoid a similar mistake from happening. Records of near misses made automatically by the system could only be accessed by the SI. There was no evidence of the near misses being reviewed. This could mean that the team members are missing out on opportunities to learn from the mistakes and make the pharmacy's services safer.

The pharmacy had current professional indemnity insurance. There was a complaints procedure and laminated sheets were available which advised people how they could raise concerns or provide feedback. The team explained that they tried to accommodate requests where possible and tried to resolve matters in store before escalating. 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.

Private prescription, emergency supply records of unlicensed medicines supplied, RP records and controlled drug (CD) registers were well maintained. 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.

Assembled prescriptions that were ready to collect were not visible to people using the pharmacy. The pharmacy had an information governance policy available, and its team members had been briefed about it. Team members had read and signed the confidentiality agreements and described how they made sure there was no personal data was in view of people using the pharmacy. And they used the consultation room to have private conversations with people. The pharmacy separated confidential waste which was sent to another branch for destruction. The RP and technician had access to summary care records (SCR) and obtained verbal consent from people before accessing it.

All team members had completed safeguarding training on the eLearning for health (elfh) platform. The RP was unsure if delivery drivers had completed any formal safeguarding training. The RP provided an assurance that he would speak to the SI and request for drivers to complete the relevant 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. And they work effectively together and support each other. 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 comprised of the RP, three trained dispensers, an apprentice, and an accuracy checking technician (ACT). The pharmacy also had three delivery drivers and a trainee medicines counter assistant (MCA). The team felt there were enough staff manage the workload safely. They felt that they worked well together and were observed to be up to date with the workload.

The performance of the pharmacy team members was managed by the RP who held check-ins with each individual annually in the summer. The RP checked with the team member if they were happy in their role and with any upcoming changes, their goals, any courses they wanted to complete as well as suggestions to changing the workflow. Team members were also 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, and group discussions were held if the team needed to be updated. Team members felt able to feedback concerns and offer suggestions to both the RP and SI.

Team members asked appropriate questions and provided advice to people before recommending over-the-counter medicines. They confirmed the diagnosis with the RP before selling medicines. They were aware of the maximum quantities of medicines that could be sold over the counter and always referred to the RP for multiple sales requests.

Team members completing formal training courses were provided with adequate time and were supported by colleagues. Both the pharmacist and technician completed their own continuing professional development (CPD) and used resources from the Centre for Pharmacy Postgraduate Education (CPPE) or other material that was received. The pharmacist was provided with time to complete training related to the services provided. There were no targets set for services provided. To keep up to date team members were provided with time to complete training modules in line with requirements for the Quality Payment Scheme. There were no targets set for services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are clean, secure and provide an appropriate environment to deliver its services safely. People can have a conversation with a team member in a private consultation room.

Inspector's evidence

The premises were clean, tidy, and organised. The dispensary was large, well laid out and a separate area was used to manage and prepare the multi-compartment compliance packs. The retail area was small, but it was tidy and clear of clutter. A clean sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by members of the team. The room temperature and lighting were appropriate. The premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for private conversations.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. It obtains its medicines from licensed sources and generally manages them appropriately so that they are safe for people to use. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

Inspector's evidence

The pharmacy was accessible from the street, the access into the premises was wide with a ramp at the entrance. The shop floor was clear of any trip hazards and the retail area was accessed easily. Team members assisted people who needed help entering the pharmacy. Services were advertised using posters and leaflets displayed within the pharmacy. The pharmacy team were familiar with other services provided locally but also used the NHS directory of services available online to signpost people who needed services that the pharmacy did not provide. The RP spoke a few languages and team members used electronic translation applications.

The RP felt that hypertension case-finding services had the most impact on people using the pharmacy. He explained that it was accessed on more occasions than the other services on offer. The service helped identify people who had high blood pressure and they were then referred on to the GP surgery. The local GP surgery also referred people to the pharmacy if they needed to have the ambulatory blood pressure monitor fitted. The RP was an independent prescriber and trained in hypertension. However no prescribing services were provided from the pharmacy
Prescriptions were received electronically and were clinically checked by the pharmacist and then moved to a workflow list. The RP made the team aware of any notes or queries. Team members used the workflow list to process the prescriptions so they could be dispensed. Prescriptions for people who were waiting were marked by the team and prioritised. 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 part of the dispensing process. And it made a record when the dispensed medicines were placed on the shelf to be delivered or collected by 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 and CDs were accuracy checked by the pharmacist or accuracy checker. Baskets were used to separate prescriptions, preventing transfer of medicines between different people. The system alerted the team to complete an audit of the computer system's accuracy checking from time to time. When the message was displayed, the RP physically checked the list of items that were highlighted and recorded on the system when this was done. The RP had not picked up any errors as part of this check. The system had a mechanism to report issues and issues would also be reported to the SI.

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 labels. The computer system also made team members aware of any additional messages when prescriptions for sodium valproate were processed. And the RP added additional notes when clinically checking prescriptions for these medicines. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring.

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 checked against the backing sheet for any changes or missing items. The prescription was clinically checked by the pharmacist who stamped and initialled the backing sheet once it had been checked and passed to the dispensers. Before preparing the packs, medicines were selected and checked using the inbuilt accuracy checking system. Any items which did not scan were left in a basket to be checked by the RP. The RP or accuracy checker also completed a final accuracy check was also completed after the pack had been prepared. A token was sent prior to this date to the pharmacy for the pack to be prepared. In the event that someone was admitted into hospital any changes to medicines were received electronically. Team members said they had a good relationship with the surgery next door who also communicated any changes. Assembled packs were labelled with mandatory warnings. Product descriptions were not included on everyone's packs, this could make it difficult for people to identify what each medication was. Team members provided an assurance that they would speak to the SI and have this set up on the system. There was an audit trail to show who had prepared and checked the packs. Patient information leaflets were issued monthly. Pivotal packs were prepared in the same way. Backing sheets placed within plastic packs.

In advance of starting the NHS Pharmacy First service the RP had completed training on the eLearning for health (Elfh) portal and the relevant modules on the CPPE site. As part of his prescribing course the RP had covered acute prescribing which had covered some of the training including using an otoscope. Signed PGDs were available.

Deliveries were carried out by the delivery driver. Delivery sheets were prepared by the team which had a list of the people whose medicines were due to be delivered. There was a separate delivery form for CDs and all CD prescriptions needed to be checked by the RP before they were handed out. Signatures were obtained for CDs delivered but for other medicines the driver annotated the delivery sheets. If people were not available to accept the delivery the medicines were returned to the pharmacy.

The pharmacy provided the COVID-19booster vaccination service. This was provided under the national protocol on an appointment basis. One of the dispensers was trained to vaccinate people, the technician was due to complete some eLearning which needed renewal.

Medicines were obtained from licensed wholesalers and were stored appropriately. Medicines were stored on the shelves, in a tidy and organised manner. Fridge temperatures were monitored daily and recorded; they were within the required range for the storage of cold chain medicines. And CDs were kept securely. Expiry date checks were completed by the team every three months. Short-dated stock was highlighted. A date checking matrix was available. No date expired medicines were found on the shelves checked. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. MHRA drug recalls were received via email and on the electronic system, these were discussed with the team and actioned. The system was updated once the alert had been actioned.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment. Equipment was clean and ready for use. Two medical fridges were available. A blood pressure monitor, pulse oximeter, weighing scales, thermometer and an otoscope were available and used for some of the services provided; the RP said these were fairly new and he would check calibration requirements and discuss this with the SI. Up-to-date reference sources were available. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. Team members had individual log in details which created an audit for any completed task. A cordless telephone was also available to ensure conversations could not be overheard.

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.