General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Morrisons Pharmacy, Brunswick Road, PENRITH, Cumbria, CA11 7JU

Pharmacy reference: 1030227

Type of pharmacy: Community

Date of inspection: 06/12/2019

Pharmacy context

This is a community pharmacy inside a Morrisons supermarket in Penrith, Cumbria. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as the medicine use reviews, the New Medicines Service (NMS) and flu vaccinations. The pharmacy provides a substance misuse service. And it supplies medicines in multi-compartment compliance packs to some people living in their own homes.

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	1.2	Good practice	The pharmacy's team members openly discuss and record any mistakes that they make when dispensing. So, they can learn from each other. They are good at discussing how they can improve, and they make changes to minimise the risk of similar mistakes happening in the future.
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 identifies and manages the risks associated with the services it provides to people. And it has a set of written procedures for the team members to follow to help them deliver the services safely and effectively. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The team members openly discuss and record any mistakes that they make when dispensing. So, they can learn from each other. They are good at discussing how they can improve, and they make changes to minimise the risk of similar mistakes happening in the future. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy was situated close to the entrance of the supermarket and was easy to find. There was a small retail area which led to the dispensary at the rear. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The retail area and the dispensary were open plan which allowed the team members to easily see into the retail area from the dispensary. The dispensary was set back far enough from the pharmacy counter to allow the team members discuss confidential matters without being overheard by people in the retail area. The responsible pharmacist used a bench closest to the pharmacy counter to complete final checks on prescriptions. And this allowed her to easily oversee any sales of medicines and listen to any advice the team members were giving to people. The team members explained how the pharmacy's dispensing volume had increased significantly over the last few months.

The pharmacy had a set of standard operating instructions (SOPs) in place. The SOPs had an index, which made it easy to find a specific SOP. The pharmacy's superintendent pharmacist's team reviewed the SOPs every two years. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team. The team members had read and signed each SOP that was relevant to their role. The team members had been recently issued with a new SOP on the Community Pharmacist Consultation Service (CPCS).

The pharmacist highlighted near miss errors made by the team when dispensing. And the details of each near miss error were recorded onto a paper near miss log. The dispensers made the entries in the log. Which helped them analyse their own mistakes. And records were seen dating back to January 2019. The team members recorded the date, time and type of the error, for example, if the error involved a look-a-like, sound-a-like medicine (LASAs). They also consistently recorded the reason why the errors may have happened. The pharmacist spotted a near miss error during the inspection. A dispenser had incorrectly dispensed Symbicort 100 instead of Symbicort 200 dry powder inhalers. And the pharmacist and the dispenser discussed the error and how they could prevent a similar error happening again. Each month the pharmacist completed a near miss error improvement tool. The tool was divided into four sections. The first section was called 'What?' and was a summary of the number and types of near misses that had happened in that month. The second section was called 'Why?', which focused on the main reasons why the errors had happened. The third section documented the actions the team members took to improve their practice. And the fourth section was a review of the actions, once they had been put in place. The team explained there was a recent focus on reducing the number of errors involving LASAs. And there were several posters displayed in the dispensary which highlighted the LASAs which were at most risk of selection errors. For example, atenolol and allopurinol,

and quinine and quetiapine. The pharmacy had a process to record and report dispensing incidents that had reached the patient. It recorded the details of such incidents using an electronic reporting system and all incidents were also reported to the National Learning and Reporting System. No completed records for any incidents were available for inspection. But the team members were in the process of investigating an incident which involved a person receiving the incorrect quantity of Calcichew D3. The details to be recorded included why the incident might have happened, how did it happen and what actions were to be completed to reduce the risk of a similar incident happening again.

The pharmacy displayed the correct responsible pharmacist notice. So, people in the retail area could see the identity and registration number of the responsible pharmacist on duty. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn't do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist.

The pharmacy had a formal complaints procedure in place. And it was available for people to see via the pharmacy's practice leaflet which was available in the retail area for self-selection. The pharmacy collected feedback from people by using questionnaires. Pharmacy team members could not give any examples of any changes they had made in response to feedback to improve their services.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. A physical balance check of a randomly selected CD matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team members were aware of the need to keep people's personal information confidential. They explained the importance of offering the use of the consultation room to people as people often congregated close to the pharmacy counter and so any conversations that took place near the pharmacy counter could be overheard. They were seen moving to the back of the dispensary to take any telephone calls. The pharmacy had an information governance and a data security and protection policy which the team members could refer to. The information governance policy was due for review in March 2020. The pharmacy had written guidance on the General Data Protection Regulations (GDPR). And each team member had read it. Records containing personal identifiable information were held in areas of the pharmacy that only the team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a shredder.

The pharmacist and two pharmacy technicians had completed training on safeguarding vulnerable adults and children via the Centre for Pharmacy Postgraduate Education. The team members gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. A team member explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage and report a concern. And the contact details of the local support teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload and to ensure people receive a high-quality service. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns when necessary. The pharmacy provides access to ongoing training to help its team members keep their knowledge and skills refreshed and up to date.

Inspector's evidence

One of the regular pharmacists was the responsible pharmacist on duty during the inspection. The pharmacy employed another regular pharmacist who joined the team towards the end of the inspection. They were supported by two NVQ level three pharmacy technicians, two NVQ level two pharmacy assistants and two counter assistants. The pharmacy also employed two other NVQ level two pharmacy assistants, but they were not working on the day of the inspection. The two pharmacists covered most of the pharmacy’s opening hours between them and the remaining hours were covered by a pool of locum pharmacists. The pharmacy’s staffing rotas were organised in advance to ensure enough support was available during the its busiest periods. And they were reviewed every three months. The pharmacy’s dispensing volume had unexpectedly increased in the last few months. In response to this, the pharmacy was recruiting for an additional team member. The team members were observed managing the workload well and had a manageable workflow. The team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They mostly acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. They felt they could speak to senior management if they needed extra support and they often received additional support if they felt they were falling behind with their workload. This helped to make sure they provided the high quality of service they aimed to achieve. The team members often worked additional hours to cover absences and holidays. They did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various modules. The modules covered various topics, including mandatory compliance training covering health and safety and information governance. Other modules were based on various healthcare related topics and could be chosen voluntarily in response to an identified training need. The team members were given one mandatory module to complete each month and they had recently completed training on the over-the-counter medicine Solpadeine, sepsis and high-risk medicines. They were allocated protected training time during the working day to complete the modules. So, they could train without any distractions. But they were not always to take the time because of the dispensing workload. And so, they often completed training during their lunch hours or in their own personal time.

The pharmacy had an appraisal process in place for its team members. The appraisals took place every year. The appraisals were an opportunity for the team member to discuss which aspects of their roles they enjoyed and where they wanted to improve. They could also take the opportunity to give feedback to improve the services the pharmacy offered. The team members felt comfortable to raise professional

concerns with the regular pharmacist or the store manager. The pharmacy had a whistleblowing policy. And so, the team members could raise concerns anonymously. The team was set various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy’s team members.

Inspector's evidence

The pharmacy premises were spacious and suitable for the services provided. They were clean and professional in appearance. The pharmacy was easy to find from inside the supermarket. There was an open plan dispensing area which had plenty of bench space and storage for medicines. Floor spaces were kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member. And it was kept locked when it wasn't in use. The room was smart and professional in appearance and was signposted by a sign on the door. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. It engages with people using the pharmacy to help them improve their health. The pharmacy manages its services appropriately and delivers them safely. It provides medicines to some people in multi-compartment compliance packs to help them take them correctly. And it suitably manages the risks associated with this service. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had level access from the store car park through automatic doors. So, people with wheelchairs and prams could easily access the premises. There were several disabled car park spaces in the car park. The pharmacy was signposted, so it could be easily found from inside the supermarket. The pharmacy advertised its services and opening hours in the retail area and on the pharmacy's website. It stocked a small range of healthcare related leaflets in the retail area, which people could select and take away with them. And there were posters displayed in the retail area on various healthcare related topics. For example, flu. There was a small healthy living zone which was updated several times a year with a new topic. The team were currently raising awareness on the benefits of smoking cessation. A team member explained how she had spoken to several people who were either known to be smokers or had enquired about purchasing nicotine replacement products. The pharmacy could supply people with large print dispensing labels if needed. And a hearing loop was available for people who used hearing aids.

The team members regularly used various stickers during dispensing, and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people's prescriptions from getting mixed up. They used 'CD' stickers to keep with prescriptions. This system helped the team members check the date of issue of the prescription and helped prevent them from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team was responsible for ordering people's prescriptions. And this was done around two weeks in advance to give the team members the time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the packs on a bench at rear of the dispensary. This was to minimise distractions. The pharmacy managed the workload across four weeks. And it kept all documents together that related to each person on the service. This included any hospital discharge summaries and master sheets, that detailed a record of the person's current regime. Team members used these to check off prescriptions and confirm they were accurate. The pharmacy kept records of details of conversations they had with people's GPs. For example, if they were notified of a change in directions, or if a treatment was to be stopped. The packs were supplied with information which listed

the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. It also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin, lithium and methotrexate. The pharmacist explained she asked people prescribed high-risk medicines collecting various questions to make sure they were taking their medicines safely. For example, the pharmacist asked for the persons current and target INR, their daily dosage and the date of their next blood test. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely. They had completed a check to see if any of its regular patients were prescribed valproate. Those people who were, were given advice by the pharmacist. And, she checked if the person was aware of the risks of becoming pregnant while taking the valproate.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy stored its medicines in the dispensary tidily. The pharmacy had a process to check the expiry dates of its medicines to make sure none had expired. And records were seen which showed that the process was completed regularly. No out of date medicines were found following a random check of approximately ten medicines. The team members used alert stickers to highlight medicines that were expiring in the next twelve months. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received some training on how to follow the directive and had the correct type of scanners. The team members were unsure of when they were to start following the directive. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinets were secured and of an appropriate size. The medicines inside the fridge and CD cabinets were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. And there were some clearly marked cylinders which were only used for dispensing methadone. The team members used tweezers and rollers to help dispense multi-compartment compliance packs. The fridges used to store medicines were of an appropriate size. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private.

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.