General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Muirhead Avenue Pharmacy, 66 Muirhead Avenue East, LIVERPOOL, Merseyside, L11 1EL

Pharmacy reference: 1034536

Type of pharmacy: Community

Date of inspection: 04/09/2024

Pharmacy context

The pharmacy is located in a row of shops in a residential suburb of Liverpool. It changed ownership in February 2024. 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 seasonal flu vaccination 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 generally 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 updated by the superintendent pharmacist (SI) who was also the responsible pharmacist (RP). Team members were in the process of reading through the SOPs and the SI provided an assurance that this would be completed soon. SOPs were available electronically and all team members had individual log in details to access SOPs relevant to their roles. The SI was able to track which SOPs each individual had completed.

Dispensing mistakes which were identified before the medicine was supplied to people (near misses) were usually handed back to the dispenser who had made the mistake and they were asked to identify and rectify the mistake. Near misses were seen to be recorded on a log. As the team were settling into new ways of working following a change of ownership, reviews of near misses had been happening on an informal basis. The SI planned to ask team members to complete monthly reviews going forwards. Team members had been asked to take more care when dispensing to help reduce the risk of mistakes. Any instances where a dispensing mistake had happened, and the medicine had been supplied (dispensing errors) was investigated and a record was made on the system. Following an incident where someone was supplied with the incorrect strength of propranolol, a root cause analysis had been completed and the team had been briefed. Team members had also been requested to pass on any urgent calls to the SI so concerns could be dealt with promptly.

The pharmacy had current professional indemnity insurance. There was a complaints procedure in place and the SI also checked online feedback and reviews that had been submitted. 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 RP records and controlled drug (CD) registers were well maintained. Running balances were recorded. Private prescription records did not all have details of the prescriber recorded. Which was required to show who had provided the authority to supply the medicine. The pharmacy had not supplied any unlicensed medicines recently, so there were no records available but the team were able to describe the records they would keep.

There was an information governance (IG) policy and team members had been verbally briefed about it. Confidential waste was separated and collected by a third party for destruction. Assembled prescriptions were stored on shelves that were not visible to people using the pharmacy. The SI had access to national care records (NCR) and obtained verbal consent from people before accessing.

A safeguarding policy was available. Some of the team members had completed safeguarding training and approached the pharmacist if they had any concerns. Contact details were available for local safeguarding boards. The SI provided assurance that all team members including delivery drivers would be asked to complete safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload appropriately. 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 SI, a trained dispenser and an apprentice who worked as a pharmacy assistant. Other team members who were not present included another trained dispenser, apprentice, dispenser trainee and delivery driver. A pharmacy technician, who worked in a support role, occasionally helped out with the assembly of compliance packs. Team members felt there were enough staff when everyone was working. Holidays and absences were covered within the team. The team were observed to be up to date with the workload.

Team members asked appropriate questions and provided advice to people before recommending over-the-counter medicines. They were aware of the maximum quantities of medicines that could be sold over the counter and referred to the RP for multiple sales requests. Staff performance was managed informally. The SI worked closely with the team and provided them with ongoing feedback. Team members felt able to speak to the SI if they had concerns, suggestions or feedback. Team meetings were not routinely held, the team discussed things as they came up and information was also shared on the group chat.

Team members completing formal training courses were provided with adequate time and were supported by colleagues. Dispensers used resources from the Centre for Pharmacy Postgraduate Education (CPPE), or other material that was received, to keep up-to-date and were provided with time at work to complete this. There were no targets set for services provided.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally 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 pharmacy had a large dispensary with enough clear workspace available for dispensing. Workspace was allocated for certain tasks and compliance packs were prepared in a room upstairs. There were a number of baskets waiting to be checked on one of the benches. Some areas of the pharmacy were untidy and there were wholesaler totes and packets of drinks stored on the floor which created a trip hazard. The RP explained that he was aware of this and had a plan to address this issue. A clean sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by members of the team, however, as it had not been long since the change in ownership, the RP planned to implement a cleaning rota. The room temperature and lighting were appropriate. The premises were kept secure from unauthorised access.

A signposted consultation room was available and suitable for private conversations. The RP was aware that this needed to be tidied to help maintain a professional appearance. Some assembled medicines bags were stored in a cupboard within the room and the SI gave an assurance that these would be moved.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely. It obtains its medicines from licensed sources and 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 easily accessible from the street for most people. 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. A hearing loop was available and team members would help people who require assistance. Some services were offered via video call for people who were housebound. The pharmacy team were familiar with other services provided locally and signposted people who needed services that the pharmacy did not provide. The SI gave an example where recently there had been a supply issue with equipment for the needle exchange service and many local pharmacies running out. The SI had contacted the suppliers and found details of a local pharmacy that had stock available, and people were referred there.

The SI felt that the 'Care in the Chemist' service had the most impact on the local population. The pharmacy was situated on the edge of West Derby and Norris Green, parts of which were deprived. Where possible the team tried to use the service to help people when they came in with minor ailments. All team members were trained to provide the service and there was a formulary of medicines that could be supplied. The SI described that there was a low uptake of the NHS Pharmacy First service as there were only a small number of referrals from the local surgeries. The SI had spoken to the Local Pharmaceutical Committee (LPC) to help address this. Before the launch of the service the SI had completed online training. They had been trained on using an otoscope as part of a face-to-face training that he attended for the ear wax removal service. Signed patient group directions (PGDs) were in place for the service.

There was an established workflow within the dispensary and prescriptions were assembled by the dispensers and checked by the RP. 'Dispensed-by' and 'checked-by' boxes were available on dispensing labels, and these were seen to be used to create an audit trail showing who had carried out each of these tasks. Baskets were used to separate prescriptions, to prevent them being mixed up and these were colour coded to help manage the workflow. Since the change in ownership the pharmacy had changed the way in which assembled prescriptions were stored. These were now scanned before being placed on the shelves so that they could be located easily.

The pharmacy team were aware of the risks associated with the use of valproate containing medicines. Team members had been briefed to not cover any of the warning signs and not to split packs. The pharmacy had one person who was supplied with sodium valproate in a compliance pack. The SI provided an assurance that a written risk assessment would be completed to demonstrate the risk of not providing the medicines in a compliance pack. Team members were also aware of the guidance for dispensing topiramate. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring. Pharmacist stickers were used by the team to identify prescriptions which would require pharmacist intervention on hand-out.

Some people's medicines were supplied in multi-compartment compliance packs. Prescriptions were ordered by the team and the packs were prepared by the dispensers. The prescriptions were checked against the person's medication backing sheet to identify if there were any medicines missing or any changes to their treatment. At the time of labelling the prescription, the system also prompted if there were any changes. Medicines which had been stopped were marked as 'ended' on the electronic system which automatically made a record. The team were notified of hospital admissions via PharmaOutcomes and they contacted people or their carers to confirm the admission details. Packs were prepared by the team and checked by the SI. If the SI prepared the packs, he obtained a second check. Product descriptions were not always included on everyone's packs which could make it difficult for people to identify what each medication was. Assembled packs seen did not include mandatory warnings. The SI provided an assurance that descriptions would be included, and he would speak to the system provider to enable this. Patient information leaflets were routinely handed out.

Deliveries were carried out by the delivery driver. All deliveries were scanned into an electronic system. A handheld device was used to obtain signatures when medicines were delivered. If people were not available to accept the delivery, the medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and stored appropriately. Fridge temperatures were monitored daily and recorded; they were seen to be within the required range for storing temperature-sensitive medicines. Team members explained that date checking was done every three months and a date checking matrix was available to demonstrate this. A random sample of stock was checked, and no date-expired medicines were found. Out-of-date and other waste medicines were separated and then collected by licensed waste collectors. Drug recalls were received electronically. The team would check the stock and take the action as required; the system was updated once this had been done.

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. Separate measures were used for liquid CDs to avoid cross-contamination. A plastic measure was also available which was unsuitable for use. The RP provided an assurance that he would stop using this. Equipment was clean and ready for use. A large fridge was available.

A blood pressure monitor and an otoscope were available and used for some of the services provided; the RP said these were fairly new but he would check calibration requirements. Up-to-date reference sources were available. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. 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.