General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Wm Morrison Pharmacy, Morrisons Supermarket, Dunslow Road, Crosscoates, SCARBOROUGH, North Yorkshire, YO11 3YN

Pharmacy reference: 1038975

Type of pharmacy: Community

Date of inspection: 07/03/2024

Pharmacy context

This pharmacy is in a Morrisons supermarket near to Scarborough, a large coastal town in North Yorkshire. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. It provides several people with their medicines in multi-compartment compliance packs to help them take their medication correctly. The pharmacy provides other NHS services including the hypertension case finding service and the Pharmacy First service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 identifies and manages the risks associated with its services well. It has up-to-date written procedures that team members follow to help ensure they provide the pharmacy's services safely. And it keeps the records it needs to by law. The pharmacy suitably protects people's private information, and it provides team members with training and guidance to help them respond correctly to safeguarding concerns about vulnerable people. Team members respond appropriately when mistakes happen by identifying what caused the error and acting to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. Team members had read the SOPs and signed the signature sheets that accompanied the SOPs to show they understood and would follow them. A set of SOPs had recently been added to cover the delivery of the NHS Pharmacy First Service. Team members were informed of the new SOPs which were highlighted in the SOP folder for them to read and sign. The team members demonstrated a clear understanding of their roles and worked within the scope of their role.

The pharmacy had a procedure for managing errors identified during the dispensing of prescriptions, known as near miss errors. The team member involved was asked to identify the error, correct it and record it. A sample of records showed details of what had been prescribed and dispensed along with the actions taken to prevent the error from happening again. There was a separate procedure for managing errors identified after the person received their medicine, known as dispensing incidents. This included completing an online report and a root cause analysis. All team members were informed of the dispensing incident so they could learn from it and were aware of the actions taken to prevent such errors from happening. One of the accuracy checking pharmacy technicians (ACPT) regularly reviewed the near miss errors and dispensing incidents. And shared the outcome of the review with all team members. A recent review had led to the team separating two medicines that looked alike and sounded alike (LASA) to reduce the risk of the wrong medicine being selected. And warning labels were attached to where these medicines were stored to prompt team members to double check what they had selected. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. A poster displayed by the pharmacy counter provided people with information on how to raise a concern.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records, controlled drug (CD) registers and private prescriptions records met legal requirements. The pharmacy kept a register of CDs returned by people for destruction. The pharmacists regularly checked the balance of CDs in the registers against the physical stock to identify any issues such as missed entries. And a random balance check undertaken during the inspection was correct. The RP clearly displayed their RP notice, so people knew details of the pharmacist on duty. Team members knew what activities could and could not take place in the absence of the RP. To support the NHS Pharmacy First service the pharmacy had a range of patient group directions (PGDs). These provided the legal framework for the pharmacist to provide medication such as antibiotics. The PGDs had been signed by the pharmacists to show they had read them, understood them and would follow them.

The pharmacy and the company website provided people with details on the confidential data kept and how the pharmacy complied with legal requirements. A separate privacy notice was also displayed. Team members had completed training about the General Data Protection Regulations. They separated confidential waste and shredded it onsite. The pharmacy provided the team with safeguarding training and guidance. And team members had completed training relevant to their roles.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with a good range of experience and skills to help safely provide its services. Team members work well together and are good at supporting each other in their day-to-day work. New team members are fully supported while undergoing their training. And team members have some opportunities to receive feedback and complete training so they can suitably develop their skills and knowledge.

Inspector's evidence

Regular locum pharmacists covered the pharmacy's opening hours as the RP. The pharmacy team consisted of a full-time ACPT, two part-time ACPTs, a full-time dispenser, four part-time dispensers, two full-time medicines counter assistants (MCA), one part-time MCA and a trainee MCA. At the time of the inspection one of the regular locum pharmacists and most team members were on duty. One of the full-time ACPTs had taken on the role of the pharmacy supervisor after the pharmacist manager had left. And demonstrated a good knowledge of the requirements of the role. They provided regular support to other team members who in turn supported the supervisor to ensure key tasks were regularly completed. The trainee MCA received lots of support from experienced team members who encouraged the trainee to ask questions and observe their practice.

The team's workload had increased after a number of people had changed to the pharmacy to have their prescriptions dispensed from other pharmacies in the area. Team members worked very well together to manage the workload and they ensured people presenting at the pharmacy were promptly helped. They had some specific roles but were all trained on key tasks. This ensured these tasks were completed regularly, including times when team numbers were reduced such as planned and unplanned absence.

The pharmacy provided team members with additional training to keep their knowledge up to date. This included mandatory training covering legal requirements, and when new services were introduced. Team members regularly received informal feedback on their performance. And they had some opportunities to develop their knowledge and skills. All key pieces of information were captured in the team's diary and on an online communication platform for all team members to read.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and provide an adequate environment for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using its services. Team members work in an organised manner and manage the limited space they work in well to ensure they dispense prescriptions safely.

Inspector's evidence

The pharmacy, in particular the dispensary, was small with limited working space for the volume of work. Team members managed the limited space well. They worked in a tidy and organised manner, and they kept floor spaces clear to reduce the risk of trip hazards. The team kept the premises clean and there was a clean, well-maintained sink in the area where medicines were prepared. This provided hot and cold running water and other facilities for hand washing. The pharmacy maintained its heating and lighting to acceptable levels.

The area that had been used for storing completed prescriptions had become too small to accommodate all the dispensed medicines. To ensure completed prescriptions were safely stored and to reduce the risk of the wrong medication being handed out, a large unit had been installed in the centre of the dispensary. This housed several boxes labelled alphabetically which were used to store the completed prescriptions. However, some larger bags holding completed prescriptions were also being stored on the floor. Team members were aware this additional storage was a potential health and safety hazard as it reduced the space for team members to work in. So, the supervisor had recently arranged a meeting with the area manager to discuss other options. And at the time of the inspection was waiting for further information on the plans being made.

There was a soundproof consultation room which the team used for private conversations with people and when providing services. The team kept the room tidy and the door from the retail area was locked when not in use to prevent unauthorised public access. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible for people. Team members manage the pharmacy services well to help people receive appropriate care and to make sure people receive their medicines when they need them. The pharmacy obtains its medicines from recognised suppliers and it stores them properly. The team regularly carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via the supermarket entrance through an automatic door. Information about the pharmacy including its opening hours was displayed for people to read. Team members wore name badges detailing their role so people using the pharmacy knew who they were speaking to. They asked appropriate questions when selling over-the-counter products and knew when to refer to the pharmacist. Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) including the requirement to supply original manufacturer's packs of valproate. They reviewed people prescribed valproate to identify anyone who may meet the PPP criteria. And reported that no-one prescribed valproate met the criteria.

The NHS Pharmacy First service was popular, and several people had presented since its launch. Team members helped the pharmacists to deliver the service by completing the accompanying paperwork. And providing people with information on the medical conditions that could be treated through this service. Some team members had been trained to support the pharmacists to deliver the NHS hypertension case finding service which many people had used. Several people who had accessed the service were identified as having undiagnosed hypertension and were referred to their GP for further tests and medication.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Pharmacy team members initialled 'dispensed by' and 'checked by' boxes on dispensing labels, to record their actions in the dispensing process. And they used a separate system to capture the pharmacist's clinical check which enabled the APCTs to complete their accuracy check. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item.

The pharmacy obtained medication from several reputable sources and team members followed procedures to ensure medicines were safe to supply. They regularly checked the expiry dates on stock and kept a record of this. Medicines with a short expiry date were marked to prompt the team to check the medicine was still in date before use. No out-of-date stock was found. Team members recorded the dates of opening for medicines with altered shelf-lives after opening so they could assess if the medicines were still safe to use. They checked and recorded fridge temperatures each day and a sample of these records found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. CDs were stored securely and out-of-date CDs were separated and clearly marked. And there were appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare

products Regulatory Agency (MHRA) via email which were printed off and signed by the pharmacist to show they had taken appropriate action.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it makes sure it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference resources and access to the internet to provide the team with up-to-date information. There was equipment available for the services provided which included a range of CE equipment to accurately measure liquid medication. The pharmacy also had a fridge for holding medicines requiring storage at this temperature and an otoscope and blood pressure monitor. The pharmacy completed safety checks on the electrical equipment. And equipment such as the blood pressure monitor was replaced periodically to ensure accurate readings were taken.

The pharmacy's computers were password protected and access to people's records were restricted by the NHS smart card system. Team members used a telephone system with a cordless option to ensure their conversations with people were held in private. They stored completed prescriptions away from public view and they held other private information in the dispensary which had restricted public access.

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.