General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Morrisons Pharmacy, Unit 1 & 2, Raith Centre, COWDENBEATH, Fife, KY4 8LW

Pharmacy reference: 1042056

Type of pharmacy: Community

Date of inspection: 22/08/2022

Pharmacy context

This is a community pharmacy in the town of Cowdenbeath in Fife. Its main activity is dispensing NHS prescriptions. And it supplies medicines in multi-compartment compliance packs to some people who need help remembering to take their medicines at the right times. It also provides substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And it supplies a range of over-the-counter medicines.

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 suitably identifies and manages the risks with its services. Pharmacy team members follow written procedures to help them safely carry out tasks. They keep the records they need to by law, and they safely keep people's private information. The team is adequately equipped to manage any safeguarding concerns. Team members record and report details of mistakes they make while dispensing and learn from these to reduce the risk of further mistakes.

Inspector's evidence

The pharmacy had put measures in place to keep people safe during the COVID-19 pandemic. It had screens up at the medicines' counter and hand sanitiser at the entrance. The pharmacy team was wearing face masks.

The pharmacy had a set of written standard operating procedures (SOPs), and it kept a folder showing evidence of team members having read and agreed to follow them. Team members were currently working through a set of the latest updates to the procedures. They had a deadline to complete this in the next month. Team members described their roles within the pharmacy and the processes they were involved in. They accurately explained which activities could not be undertaken in the absence of the pharmacist. The pharmacy employed an Accuracy Checking Technician (ACT). Team members were able to describe the process for prescriptions being clinically checked by the pharmacist prior to dispensing. Prescriptions were clearly marked to show when the clinical check was complete. The pharmacy had a business continuity plan to address disruption to services or unexpected closure. Team members described working closely with nearby pharmacies.

Team members used 'near miss logs' to record dispensing mistakes that were identified in the pharmacy, known as near misses. And they recorded errors that had been identified after people received their medicines. Team members described how they reviewed near misses each month to learn from them. A team member gave an example of a common error from picking different strengths of the same inhaler. The inhalers were both stored in the refrigerator and had similar packaging. So the team highlighted these and stored them separately to prevent the same error happening. The team displayed safety bulletins supplied by head office that highlighted look-alike and sound-alike (LASA) medicines. The pharmacy had a complaints procedure and welcomed feedback.

The pharmacy had current professional indemnity insurance. The pharmacy displayed the correct responsible pharmacist (RP) notice and had an accurate responsible pharmacist record. From the sample seen, it had accurate private prescription records including records of emergency supplies and veterinary prescriptions. It kept complete records for unlicensed medicines. The pharmacy kept controlled drug (CD) records with running balances. The balances of three randomly selected controlled drugs were checked during the inspection and were correct. Stock balances were observed to be checked on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy.

The pharmacy backed up electronic patient medication records (PMR) each night to avoid data being lost. Team members were aware of the need for confidentiality. They had recently completed a General Data Protection Regulation (GDPR) training update. They separated confidential waste for shredding

within the pharmacy. The pharmacy had a documented procedure to help the team raise any concerns they may have about the safeguarding of vulnerable adults and children. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. A team member explained the process they would follow if they had concerns and would raise concerns to the RP. For example, if there were repeated requests for medication that was liable to abuse over the counter. They were aware of the Ask for ANI (action needed immediately) system to help people suffering domestic abuse access a safe place. They knew how to raise a concern locally and had access to contact details and processes.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are suitably skilled to provide the pharmacy's services. They complete regular ongoing training relevant to their roles. Team members manage the workload well and support each other as they work. They feel comfortable raising concerns, giving feedback and suggesting improvements to provide a more effective service.

Inspector's evidence

On the day of inspection there was a locum pharmacist who worked in the pharmacy regularly, four dispensers, one trainee dispenser and one trainee medicine counter assistant. They had a full-time pharmacist manager and a part-time Accuracy Checking Technician (ACT) who were not working on the day of inspection. Team members were seen to be managing the workload. Team members seen during the inspection were experienced in their roles and most of them had been working at the pharmacy for several years. They demonstrated a good rapport with many people who visited the pharmacy and were seen appropriately helping them manage their healthcare needs. The pharmacy planned learning time during the working day for all team members to undertake regular training and development. Team members used an online training platform to access updates and complete training on products, conditions, and procedures. A team member was able to discuss previous attendance at a training night organised by the health board for palliative care. Team members had annual appraisals with the pharmacy manager to identify their learning needs.

Team members were observed to work on their own initiative, for example to phone the GP practice to discuss alternative medication. They asked appropriate questions when supplying over-the-counter medicines and referred to the pharmacist when required. They demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open culture and environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the manager or area manager. The pharmacy team discussed incidents and how to reduce risks. The team had occasional team meetings. The pharmacy had a notice in the staff room for a chaplaincy and listening service that was available to all team members.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is suitable for the services it provides. It keeps its premises clean, secure, and well maintained. And it has a suitable, sound-proofed room where people can have private conversations with team members.

Inspector's evidence

These were average-sized premises in a unit separate to the company's main supermarket. It shared the space with a small area for the supermarket’s clothing department and incorporated a retail area, dispensary, and a small area for staff facilities. The premises were clean, hygienic, and well maintained. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. Its overall appearance was professional. There were clearly defined areas used for the dispensing process and there was a separate bench used by the RP to complete the final checking process.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer, and the door closed which provided privacy. Temperature and lighting were comfortable throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people. And it manages its services well to help people look after their health. Pharmacy team members engage people in conversations about the medicines they are taking and they carry out additional checks with people taking higher risk medicines. The pharmacy correctly sources its medicines, and it completes regular checks of them to make sure they are in date and suitable to supply.

Inspector's evidence

People accessed the pharmacy by two separate entrances. The door to the high street had steps and led into the clothing store which joined on to the pharmacy area. A second door to the side of the premises had good physical access by means of a level entrance directly to the pharmacy area. And the central pharmacy counters were low in height for those using wheelchairs. The pharmacy advertised some of its services and its opening hours in the side window. The pharmacy signposted people to other services such as smoking cessation support. And it could provide large print labels for people with impaired vision. All team members wore badges showing their name and role.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used baskets to separate people's medicines and prescriptions. Team members used various stickers to attach to bags containing people's dispensed medicines. 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 CD that needed handing out at the same time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. A second team member completed an extra check and initialled higher risk medicines such as controlled drugs before passing for a final accuracy check. The pharmacy usually assembled items that were owed later the same day or the following day. Some people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy prepared these on a weekly basis up to seven days in advance of when the patient would be due to collect them. They kept records to show the date of supply and an electronic claim was sent when the items were collected. The pharmacy provided a palliative care service. This service involved ensuring a minimum stock level of palliative care medicines and supplying Just in Case boxes of standby medication to terminally ill patients.

The pharmacy supplied medicines in multi-compartment compliance packs to people that needed extra support with their medicines. The pharmacy team managed the dispensing and the related record-keeping for these on a four-weekly cycle. They kept master backing sheets for each person for each week of assembly. These master sheets documented the person's current medicines and administration times. Some folders had notes of previous changes to medication, creating an audit trail of the changes. The pharmacy had a communications diary to share information easily between the team. The details of medication to be changed was sometimes received by written request. But there was no record of who requested changes taken over the phone. So there was no audit trail if there was a query about the change. Team members described good relationships with the local general practice team. Packs were labelled so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the pack. Shelving to store the packs was kept neat and tidy. But there were some baskets stored on the floor on the day of inspection due to the volume of packs awaiting final check. This could pose a trip hazard. The

pharmacy team obtained consent from the General Practitioner (GP) if a person or carer requested to collect more than one week at a time. One person was observed to have clozapine dispensed in their pack. This medication requires extra blood monitoring. A team member described the process of checking for up-to-date blood results for this person to ensure supply continued to be safe and appropriate. The pharmacy also supplied Medication Administration Record (MAR) sheets to people who required them. The pharmacy supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply. They were stored in individually named baskets on labelled shelves. Those containing controlled drugs had an instalment record sheet attached to the prescription to show date of collection and were stored securely. A team member prepared medication supplied in daily instalments once a week. The pharmacist checked these and stored them securely on labelled shelves. The pharmacist took people requiring supervised doses of medicines into the consultation room for privacy.

A pharmacist undertook clinical checks and provided advice and counselling to people receiving higher risk medicines including valproate, methotrexate, lithium, and warfarin. People were supplied with written information and record books if required. The pharmacy team was able to describe the guidance for the valproate Pregnancy Prevention Programme. But they did not record details of when the pharmacist had spoken to people within this group. They recognised that they could do more to record the outcomes of these conversations. They identified an opportunity to record interventions within the patient medication record so they would then have an audit of discussions about people's medicines.

The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) for unscheduled care, the Pharmacy First service, smoking cessation, emergency hormonal contraception (EHC), and impetigo treatment. The pharmacist gave examples of using the urgent supply PGD to ensure people did not go without medication. For example, providing a person with a dose of two 10mg tablets of one medication when the 20mg tablets were out of stock. They informed the person's GP when making these supplies. The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required. The pharmacy had provided 'flu vaccines in previous years and was due to offer this again this year. The pharmacy manager utilised extra pharmacist cover to schedule vaccinations not to disrupt day-to-day working. Team members were trained to counsel and provide treatment for those wishing to stop smoking. They also signposted patients to the local dedicated stop smoking service for those people who required further support.

The pharmacy obtained medicines from recognised suppliers. The pharmacy stored medicines in their original packaging on shelves, in drawers and in cupboards. The pharmacy stored items requiring cold storage in a fridge and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if these went above or below accepted limits. Pharmacy team members checked medicine expiry dates regularly and up-to-date records were seen. They described the process for highlighting stock that would expire within the next twelve months. The details of these items were added to a list for each month. Team members checked this list at the start of each month and removed stock due to expire. A selection of medicines checked during the inspection were found to be in date. The pharmacy had disposal bins for expired and patient-returned stock. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. Team members followed the sale of medicines protocol when selling these. The pharmacy actioned recalls and safety alerts on receipt and kept records. Team members contacted people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as

possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And team members make sure the equipment they use is clean.

Inspector's evidence

The pharmacy had several written resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had internet access allowing access to a range of further support tools.

Team members kept crown-stamped measures by the sink in the dispensary, and separate marked ones were used for substance misuse medicines. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets. The pharmacy stored paper records in a lockable cabinet in the dispensary inaccessible to the public. Team members used passwords to access computers and did not leave them unattended unless they were locked.

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.