General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Murray Pharmacy, 37 The Murray Square, EAST KILBRIDE, Lanarkshire, G75 0BH

Pharmacy reference: 1042246

Type of pharmacy: Community

Date of inspection: 16/03/2023

Pharmacy context

This is a busy community pharmacy in East Kilbride, Glasgow. It dispenses NHS and private prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy also offers a substance misuse services. Pharmacy team members advise on minor ailments and medicines use. And they supply over-the-counter medicines and prescription only medicines via the NHS Pharmacy First and NHS Pharmacy First Plus services.

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	4.1	Good practice	The pharmacy has implemented various ways to help people with specific needs access the services it provides.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has a comprehensive set of written procedures to help the team manage services safely and effectively. It has processes in place for team members to record any errors made, and they work to improve working practices. The pharmacy keeps people's confidential information secure and team members are adequately equipped to help protect vulnerable adults and children.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs) to help the safe and effective running of the pharmacy. The SOPs provided the team with information to help the complete various tasks. They covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensing processes, and services. The SOPs were reviewed by the pharmacy's superintendent pharmacist (SI) and were then countersigned by one of the pharmacy's owners to confirm their accuracy. The SOPs showed the date they were due for review date of December 2022 and so this meant that a review of them was overdue. The SI confirmed there had been few changes since the SOPs were created and they were largely still relevant. The pharmacy had SOPs for the operation of the pharmacy's automated dispensing machine that the pharmacy used to dispense original packs of medicines. Several team members had signed training records to confirm they had read and understood those SOPs that were relevant to their roles.

The pharmacy had a process to record any mistakes made during the dispensing process which were identified before the medicine was supplied to a person. These mistakes were known as near misses. There was an electronic system used by team members to record any near misses. They recorded details such as the type of near miss, the time it happened and the reason it might have happened. The team had recorded very few near misses since the pharmacy had installed the automated dispensing machine. Team members explained that the use of the machine had almost eliminated the likelihood of selection errors. And so, any near misses were because of labelling mistakes. For example, some records seen showed that team members had occasionally labelled some medicines with the abbreviation 'tds' instead of 'three times daily'. Team members discussed the importance of taking greater care when labelling prescriptions that had been annotated with abbreviated directions. The pharmacy used a similar, electronic recording process to record details of dispensing mistakes that were identified after the person had received their medicines. Most recently, the pharmacy had delivered some medicines to the incorrect person. This was because the person had a similar sounding name to the intended recipient. The pharmacy undertook additional training sessions with its delivery drivers to remind them of the importance of confirming people's names before medicines were handed to them. The pharmacy had a concerns and complaints procedure. Any complaints or concerns were verbally raised with a team member. If the team member could not resolve the complaint, it was escalated to the SI.

The pharmacy had up-to-date professional indemnity insurance. It displayed the right RP notice. The pharmacy kept an RP record, but it was incomplete as on most days, pharmacists had not recorded the time their RP duties had ended. The pharmacy kept electronic records of supplies against private prescriptions. The records were generally correctly completed but, in an example, the pharmacy had recorded the incorrect details of the prescriber that had issued the prescription. The pharmacy retained complete CD registers. And the team kept them in line with legal requirements. The inspector checked

the balances of three randomly selected CDs which were found to be correct. The pharmacy kept records of CDs returned to the pharmacy for destruction. The pharmacy held its records relating to the supply of unlicensed medicines but some of these records were incomplete and so not in line with the requirements of the Medicines and Healthcare products Regulatory Agency.

Team members received some basic training to help them understand data protection requirements and how to protect people's privacy. The pharmacy had a designated container to store confidential waste. The contents of the container were collected periodically and destroyed by a third-party contractor. The pharmacy trained its team members to manage safeguarding concerns. And they had contact details for the local safeguarding agencies. Team members knew to speak to the RP whenever they had cause for concern.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably skilled team members who support each other to help manage a significant dispensing workload. Team members are adequately supported to help them update their skills and develop in their roles.

Inspector's evidence

Present during the inspection were a full-time pharmacist who was the RP during the inspection, a part-time pharmacist, three full-time qualified medicine counter assistants, a full-time trainee accuracy checking technician (ACT), three full-time and one part-time qualified pharmacy assistants and a full-time qualified ACT. The SI joined the team during the inspection to provide some additional support. A part-time qualified pharmacy assistant and four deliver drivers were not present during the inspection. The pharmacy's prescription workload had increased significantly over the last 18 months. The SI estimated the workload had increased by about 40%. This increase in workload had prompted the pharmacy owners' decision to install the automated dispensing machine. The SI stated the team would be unable to manage the workload without the support of the machine. The pharmacy was extremely busy and team members often worked voluntarily outside of the pharmacy's official opening hours to manage the workload. The SI often worked these additional hours to provide extra support. Team members worked additional hours to cover each other's planned or unplanned absences. Locum pharmacists, the SI and one of the pharmacy's owners provided pharmacist cover. The team was observed working well together during the inspection. They were seen involving the SI when talking to people about their health and when considering a suitable over-the-counter medicine to help people manage specific health conditions.

The pharmacy supported its team members to help update their knowledge and skills. Team members were occasionally provided with a range of healthcare-related modules for team members to work through. Most modules had a short assessment for team members to complete to assess their understanding. Team members who were enrolled on a training course were given additional time to work through their respective courses. The pharmacy had an appraisal process for its team members. Appraisals took place annually and were in the form of a private conversations with the SI. Team members were told how they were performing in their roles and asked if they had any personal development plans. Recently, one of the pharmacists had told the pharmacy of their wish to complete the pharmacist independent prescriber course. Team members attended informal team meetings where they could discuss any professional concerns and give feedback on ways the pharmacy could improve. Team members were set some basic targets to achieve. They did their best to achieve the targets but focused on aiming to provide an efficient service for the local community.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services the pharmacy provides to people. The premises are kept clean, tidy and there is ample space for the team to store the pharmacy's medicinal stock. There is a consultation room to help facilitate private conversations between people who use the pharmacy and a team member.

Inspector's evidence

The pharmacy had undergone a full refurbishment around 18 months ago. This coincided with the installation of the automated dispensing machine. The premises was clean, modern, well maintained and highly professional in appearance. The automated dispensing machine was in the centre of the dispensary. And dispensing chutes were located above three separate dispensing benches. Some areas of the dispensary were narrow and so made it difficult for team members to work around each other. Team members organised the dispensary benches for different dispensing tasks. They assembled multi-compartment compliance packs in a designated area with sufficient space. The floor spaces were generally kept clear of obstruction. The pharmacy had ample space to store its medicines. There was a signposted, soundproofed consultation room available for people to have private conversations with team members. The room had a clear window in the main door. People in the retail area could view into the room. The SI explained he was aware that this meant there was limited privacy for people who used the room. The SI gave assurances that a roller window blind would be installed following the inspection.

The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled unauthorised access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a broad range of services that are easily accessible and safely managed. It has put various measures in place to help people with specific needs access the services provided. The pharmacy sources its medicines appropriately and team members regularly check expiry dates of medicines to ensure they are fit for purpose.

Inspector's evidence

The pharmacy had a stepped entrance into the pharmacy. It had a portable ramp to support people with wheelchairs or pushchairs to enter the pharmacy. The pharmacy advertised its services in several external windows. The pharmacy had a facility to provide large print labels to people with a visual impairment. The team helped some people who didn't speak English via translation applications. There were team members who spoke Italian and Urdu and had helped some people in these languages access the pharmacy's services. One team member was trained in using sign language. A local support agency for people with a hearing impairment had signposted many people to the pharmacy and made them aware they could communicate with the team member. The pharmacy adhered to specific request from some autistic people to help them take their medicines safely. For example, team members made sure they didn't dispense medicines that were yellow in colour as some people would refuse to take them.

The pharmacy provided a range of NHS Pharmacy First services including treatment for urinary tract infections, shingles, and impetigo. The RP and the second pharmacist confirmed they had completed the appropriate training to provide the service. Other team members had completed training to be able to complete the initial screening process of people wishing to access the service. The RP had completed training to supply prescription only medicines via the NHS Pharmacy First Plus service. The RP used an up-to-date formulary to help them make appropriate supplies. Team members were aware of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They demonstrated the advice they would give in a hypothetical situation, including checking people were enrolled on a PPP if they fitted the inclusion criteria.

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 the presence of a fridge line or a CD that needed handing out at the same time. Team members signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. The baskets were of different colours to help separate the workload. The pharmacy had owing slips to give to people when the pharmacy could not supply the full quantity prescribed. The pharmacy offered a delivery service and kept records of completed deliveries. And it kept an audit trail of the service. The pharmacy provided a substance misuse service. It used a separate electronic record system for the service. Supervised consumptions were undertaken in the pharmacy's consultation room. The team ensured they contacted the local drug team if people had missed doses to ensure their treatment remained appropriate.

The pharmacy dispensed medicines for many people into multi-compartment compliance packs. These packs were designed to help people to remember to take their medicines at the correct times of the

day. Team members dispensed the packs in an area of the dispensary which was away from the retail area and other dispensing activity. This meant team members were able to manage the workload with limited distractions. The medicines were dispensed into small, sealed pods relating to the day and time of the day they should be taken by the person. For example, Tuesday, morning. The team annotated each pack with the date it should be used from. The dispensing workload was divided equally over a four-week period. This helped the team efficiently manage the workload. The team ordered prescriptions for people supplied with the packs a week in advance of them being due for collection or delivery. This gave the team plenty of time to manage any queries, such as medicines that were missed off prescriptions. Team members used master sheets to cross-reference prescriptions to ensure they were accurate. The packs were supplied with patient information leaflets, and they were annotated with descriptions of the medicines inside. For example, blue and white, capsule. The team kept records of any changes to people's packs. For example, if a medicine had been stopped or a dose had been increased.

The pharmacy stored most of its pharmacy-only (P) medicines directly behind the pharmacy counter. This was to prevent self-selection. But several P medicines, for example, Orajel and Otex ear drops, were found stored in the main retail area and could therefore be self-selected by people. The risk was brought to the attention of the SI during the inspection. The medicines were removed from the retail area before the conclusion of the inspection.

The pharmacy stored most of its dispensary medicines in the automated dispensing machine. And it kept some stock on open shelves. Team members kept the stock neat and tidy and well-organised. The pharmacy assigned a six-month expiry date to stock stored in the automated dispensing machine. Team members checked the machine for stock that was about to expire. Team members manually date-checked the stock that they didn't store in the robot. They did this every three months and kept records of the process. A check of approximately 20 randomly selected medicines did not find any which were out of date. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy had medicine waste bags and bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. The pharmacy had fridges used to store medicines that needed cold storage. Team members kept daily records of the temperature ranges of the fridge. The pharmacy received medicine alerts electronically through email. The team actioned the alert and kept a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available to provide its services. The equipment is properly maintained. And the pharmacy manages and uses the equipment appropriately to help protect people's confidentiality.

Inspector's evidence

The pharmacy had access to a range of up-to-date reference sources, including hardcopies of the British National Formulary (BNF) and the BNF for Children. Team members used crown-stamped measuring cylinders. The pharmacy used an automated dispensing system to dispense methadone doses. A team member calibrated and cleaned the system each morning to ensure accuracy of doses.

The pharmacy used the automated dispensing machine to dispense original packs. The machine was serviced regularly, and the team had the contact details of the service company to use if they had any urgent queries. The company was able to send an engineer to carry out any repairs. The pharmacy stored dispensed medicines for collection out of view of the public waiting area. And it positioned the dispensary computers in a way to prevent disclosure of confidential information. Computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in private. Team members had access to personal protective equipment including face masks and gloves.

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.