General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Malvern Pharmacies Group, Maple Road, Enigma Business Park, MALVERN, Worcestershire, WR14 1GQ

Pharmacy reference: 1090887

Type of pharmacy: Community

Date of inspection: 08/03/2024

Pharmacy context

This is a community pharmacy opposite a medical centre in a business park, in Malvern, Worcestershire. The pharmacy dispenses NHS and private prescriptions, sells over-the-counter medicines, and provides health advice. It also offers a range of services such as the New Medicine Service (NMS), local deliveries, blood pressure checks, seasonal flu as well as COVID-19 vaccinations and the Pharmacy First scheme. In addition, its team members provide multi-compartment compliance packs for people who find it difficult to manage their medicines at home.

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	2.2	Good practice	Members of the pharmacy team have the appropriate skills, qualifications and competence for their role and the tasks they undertake.
		2.4	Good practice	The pharmacy is good at implementing an environment where learning and development for team members is encouraged.
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 appropriately manages risks. Members of the pharmacy team understand their role in protecting the welfare of vulnerable people. The pharmacy protects people’s confidential information suitably. And it maintains its records as it should. Team members deal with their mistakes responsibly. But they are not always formally reviewing them. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future.

Inspector's evidence

This was a well-run pharmacy with very competent staff and efficient processes. People were observed to be served promptly. The pharmacy had current documented and electronic standard operating procedures (SOPs) which provided the team with guidance on how to carry out tasks correctly. The staff had read and signed them. Members of the pharmacy team understood their roles well and worked in accordance with the company's set procedures. Staff also rotated tasks which helped them to effectively manage the workload. The correct notice to identify the pharmacist responsible for the pharmacy's activities was on display. This provided details of the pharmacist in charge of the pharmacy's operational activities.

The pharmacy was currently trialling acting as a spoke, in a 'hub and spoke' arrangement whereby medicines for people were prepared and supplied to each 'spoke' or individual pharmacy from a central point (the 'hub'). The pharmacy then functioned as a collection point for people to obtain their medicines from (see Principle 4). All the pharmacies in this arrangement were owned by the same company, (PCT Healthcare Ltd), which is required by law for this type of arrangement. Consent from people using the pharmacy's services, for this activity was described as obtained verbally with the possibility to 'opt-out' if needed.

Once prescriptions had been assembled, the responsible pharmacist (RP) usually carried out the final accuracy-check but the accuracy checking technician (ACT) could also assist with this. When the ACT undertook this task, the RP clinically checked the prescription first before other staff assembled it. The clinical check was marked on the prescription using a specific stamp. This helped identify that this stage had been completed. The ACT was not involved in any other dispensing process other than the final check, and there was an SOP to cover this process.

The pharmacy had suitable internal processes and systems to identify and manage risks associated with its services. Staff concentrated on one task at a time. They took care when dispensing, used prescriptions to select medicines against and ensured a three-way check against the prescription, dispensing label and medicine took place during the assembly process. Team members also worked in set areas and as mentioned above, rotated tasks. One member of staff processed prescriptions on the front dispensing workspace near the RP. Set baskets were used to separate prescriptions for the hub, deliveries, and collections. The prescriptions were then placed inside individual baskets when they were ready to be assembled by another member of staff. Staff explained that they were good at delegating. The team member on the front was also responsible for serving people, so they highlighted and passed back prescriptions for people who were waiting for other people to process if needed. This helped minimise mistakes occurring from distractions. Members of the pharmacy team were also very organised and ensured their workspaces as well as the pharmacy was very tidy.

Staff routinely recorded their near miss mistakes. The details were collated, reviewed, and fed back during staff meetings to help reduce the likelihood of mistakes recurring. The team explained that certain medicines were separated and highlighted to help with this. This included medicines that looked-alike and sounded-alike such as different pack sizes of codeine 30mg tablets and certain eye drops. However, there were no details recorded about the review. The manager oversaw incidents, her process was suitable and in line with requirements, this involved appropriate management of the situation, formal reporting, and investigation to identify the root cause. The necessary changes were then implemented.

Staff had been trained to level one to safeguard the welfare of vulnerable people. The RP and ACT were trained to level three. Team members could recognise signs of concerns and they knew who to refer to in the event of a concern. Contact details for the local safeguarding agencies were easily accessible. The pharmacy's team members had also been trained to protect people's confidential information. No sensitive details were left in the retail area or could be seen from the retail space. This included bagged prescriptions awaiting collection. There were also mats on the floor indicating areas where 'staff only' could access from the retail area into the dispensary. This further restricted access. Staff described using the consultation room to discuss sensitive details. They had signed confidentiality clauses and received regular updates on data protection. Confidential information was stored and disposed of appropriately. Computer systems were password protected and staff used their own NHS smart cards to access electronic prescriptions.

The pharmacy's records were fully compliant with statutory and best practice requirements. This included the RP record and a sample of registers seen for controlled drugs (CDs). On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of CDs that had been returned by people and destroyed at the pharmacy were complete and the pharmacy had suitable professional indemnity insurance arrangements in place. Records about supplies of unlicensed medicines, private prescriptions and to verify that fridge temperatures had remained within the required range had been appropriately completed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to safely manage its workload. Members of the pharmacy team are suitably qualified for their roles. And the pharmacy provides them with resources so that they can complete regular and ongoing training. This keeps their skills and knowledge up to date.

Inspector's evidence

The pharmacy team included one of the regular part-time pharmacists, the ACT who was also the pharmacy manager and two dispensing assistants. There were a few other part-time regular, pharmacists and locums but no other employed staff. The levels of staff compared to the volume of dispensing was therefore low. However, the pharmacy team was up to date with routine tasks and the manager confirmed that the pharmacy had enough staff to support the workload. This was partly due to the hub and spoke arrangement which was currently being trialled but would also include the preparation of the multi-compartment compliance packs. This would further assist the team with the workload.

The pharmacy's team members wore uniforms and name badges. They were observed to work well together. The manager was a long-standing and experienced member of staff, the dispensing assistants were new to pharmacy but fully trained. All were competent and efficient. They knew which activities could take place in the absence of the RP and referred appropriately. Relevant questions were asked before selling medicines and medicines which could be abused were monitored. They described exercising their professional judgement and confidently refused or challenged frequent purchases as well as requests for excessive or inappropriate quantities of OTC medicines. Team members were trained to provide certain services and the manager led the private service to supply vitamin B12 injections.

As they were a small team, meetings and discussions took place regularly, a notebook to communicate relevant details was also used and members of the pharmacy team had their own designated section with individual baskets used to hold relevant information for them. Formal performance reviews took place. The staff were provided with resources for ongoing training through the company's e-learning platform. This helped ensure they continually learnt and kept their knowledge up to date. They also had individual colleague development workbooks issued by the company which were regularly completed and reviewed four times a year. This helped the team to identify and undertake opportunities for further development. Examples of this were provided.

The inspector was told that some targets to achieve services were in place. However, there was no pressure to complete services, the targets were achievable, and staff described linked incentives, rewards, and bonuses for them which was appreciated.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises provide a suitable environment for people to receive healthcare services. The pharmacy is kept clean, it is secure, and well presented. And it has a separate space where confidential conversations or services can take place.

Inspector's evidence

The pharmacy’s premises were well maintained, well-presented, bright, and appropriately ventilated. The ambient temperature was suitable for the storage of medicines and the pharmacy was secured against unauthorised access. The dispensary was spacious. There was plenty of space for staff to carry out dispensing tasks safely and dispensing benches were kept clear of clutter. There was a clean sink in the dispensary for preparing medicines which had hot and cold running water. A signposted consultation room was available for services and private conversations. Conversations at a normal level of volume could take place inside without being overheard. The room was spacious and of a suitable size for its intended purpose.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy’s services are delivered safely. Its team members can make suitable adjustments to ensure everyone can use the pharmacy’s services. The pharmacy sources its medicines from reputable suppliers. It stores and manages its medicines well. The pharmacy has verifiable processes in place to ensure medicines are suitably dispensed and delivered. And team members routinely identify people who receive higher-risk medicines. But they don’t always record any relevant information. This makes it difficult for them to show that people are provided with appropriate advice when these medicines are supplied.

Inspector's evidence

People could enter the pharmacy from an automatic front door with sloped access leading to it. The retail area consisted of clear, open space which helped people with restricted mobility or using wheelchairs to easily access the pharmacy's services. There were a few chairs inside the pharmacy if people wanted to wait for their prescriptions and staff could make suitable adjustments for people with diverse needs. This included printing dispensing labels with a larger sized font for people who were partially sighted, physically assisting them if needed and staff spoke slowly to allow people to lip read. Details about the pharmacy's services as well as its opening times were clearly advertised, and the pharmacy had various leaflets and posters on display to provide information about various health matters. Team members were aware of the local health facilities to signpost people accordingly if this was required. They also had access to documented information to assist with this.

The 'hub and spoke' arrangement was currently being trialled at the pharmacy with only a few people's prescriptions being sent to another part of the company's premises to be assembled. This was to help gradually ease the service into the pharmacy's processes. The prescriptions were labelled through the pharmacy's system and the details were transmitted once staff had processed prescriptions, been accuracy-checked by a different member of staff and the RP clinically-checked them. There was an audit trail to help identify when these processes had taken place. The pharmacy retained the prescriptions at the pharmacy and any prescriptions for CDs, fridge lines, split packs of medicines, cytotoxic or bulky medicines were not sent for dispensing. Dispensed prescriptions were sent back usually within 48 hours. Staff then matched people's details on the bags to prescriptions. This was through the pharmacy's system and the bags were not opened. The manager explained that when the trial finished, assembled bags would be returned to the pharmacy within 24 hours.

The pharmacy provided the NMS and a blood pressure (BP) testing service. The NMS was said to have helped counsel people about their medicines. The BP service was led by staff who had been appropriately trained to undertake this service and referred appropriately. People with undetected high blood pressure had been seen, they were referred to the GP surgery which had resulted in prescribed medication being required. The manager also described a good rapport and link with the nearby surgery.

The pharmacy had also begun providing the recently commissioned Advanced NHS service, Pharmacy First. Suitable equipment was present which helped ensure that the service was provided safely and effectively (see Principle 5). The service specification, SOPs and PGDs to authorise this were readily accessible and had been signed by the RP. There were also flow charts and checklists available for the team to use as reference. In addition, the pharmacy had implemented a specific, designated area to

store the medicines used in this service as well as a list to facilitate ordering these items when needed.

People requiring compliance packs had been identified as having difficulty in managing their medicines. The pharmacy ordered prescriptions on behalf of people for this service and specific records were kept for this purpose. Any queries were checked with the prescriber and the records were updated accordingly. Descriptions of the medicines inside the packs were provided and patient information leaflets (PILs) were routinely supplied. All medicines were removed from their packaging before being placed inside the compliance packs. The pharmacy placed sodium valproate inside the compliance packs for some people. There were risks associated with this practice due to issues with its stability. The pharmacy could, however, justify this situation. Each pack was provided every week, this medicine was only de-blistered into the compliance pack just before it was supplied, and details had been recorded to verify why this was occurring.

The pharmacy provided local deliveries and the team kept records about this service. CDs and medicines requiring refrigeration were highlighted. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended.

Team members were aware of risks associated with valproates. This included the recent updates. Staff ensured the relevant warning details on the packaging of these medicines were not covered when they placed the dispensing label on them, and had identified people at risk, who had been supplied this medicine. People were counselled accordingly. The team routinely identified and knew which people had been prescribed higher-risk medicines. Staff asked details about relevant parameters, such as blood test results for people prescribed these medicines but did not record this information.

The workflow involved prescriptions being prepared by staff in set locations and the RP checked medicines for accuracy from a separate area. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them. They were also colour coded to highlight priority and different workstreams. After the staff had generated the dispensing labels, there was a facility on them which helped identify who had been involved in the dispensing process. Team members routinely used these as an audit trail.

The pharmacy's stock was stored in an organised way. Licensed wholesalers were used to obtain medicines and medical devices. The team date-checked medicines for expiry regularly and short-dated medicines were routinely identified. There were no date-expired medicines seen. Dispensed medicines requiring refrigeration and CDs were stored within clear bags. This helped to easily identify the contents upon hand-out. CDs were stored under safe custody. Medicines returned for disposal, were accepted by staff, and stored within designated containers. This did not include sharps which were re-directed accordingly. A list identifying hazardous and cytotoxic medicines was also on display. This helped staff to separate these medicines. Drug alerts were received electronically and actioned appropriately. Records were kept verifying this.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. Its equipment is clean. And the team ensures they are used appropriately to protect people’s private information.

Inspector's evidence

The pharmacy's equipment and facilities were suitable for their intended purpose. This included access to reference sources, a range of clean, standardised conical measures for liquid medicines, tablet counting triangles, legally compliant CD cabinets and appropriately operating pharmacy fridges. There was also a separate tablet counting triangle for cytotoxic use only. This helped avoid any cross-contamination. The dispensary sink for reconstituting medicines was clean. The pharmacy had hot and cold running water available. The blood pressure machine was new as was relevant equipment for the Pharmacy First service. This included an otoscope, thermometer, and tongue depressors. Computer terminals were positioned in a location that prevented unauthorised access. The pharmacy had cordless telephones so that private conversations could take place if required and confidential waste was suitably disposed of.

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.