General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Wm Morrison Pharmacy, Wm Morrison Supermarkets Plc, Lakeside Parkway, SCUNTHORPE, South Humberside, DN16 3UA

Pharmacy reference: 1091743

Type of pharmacy: Community

Date of inspection: 08/01/2024

Pharmacy context

The pharmacy is in a supermarket, on the outskirts of Scunthorpe in North Lincolnshire. It is open seven days a week. The pharmacy's main services are dispensing prescriptions and selling over-the-counter medicines. It provides a seasonal flu vaccination service, and it supplies a range of medicines to people for the treatment of minor ailments and illnesses. It also supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines.

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	1.2	Good practice	Pharmacy team members work well together to reduce risk following the mistakes they make during the dispensing process. They keep their actions under review to help measure their effectiveness.
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 acts effectively to identify and manage risks associated with providing its services. And overall, it keeps the records required by law in good order. Pharmacy team members act with care to reduce risk following the mistakes they make during the dispensing process. And they keep these actions under review by engaging in regular and comprehensive patient safety reviews. Pharmacy team members know how to manage feedback and concerns. They protect people's confidential information. And they understand how to act to help safeguard vulnerable people.

Inspector's evidence

The pharmacy had a comprehensive range of up-to-date standard operating procedures (SOPs) to support its safe and effective running. Training records confirmed its team members had read and understood the SOPs relevant to their role. One team member was currently working through this learning as part of their induction programme. The responsible pharmacist (RP) was a locum. They explained how they completed declarations confirming they had read and understood the SOPs through a secure online platform prior to booking a shift at the pharmacy. And they received regular updates about any changes to the company's SOPs to help keep their learning up to date. Pharmacy team members had a clear understanding of their roles and responsibilities. They understood what tasks could not take place if the RP took absence from the pharmacy. And they used checklists to support them in completing a range of day-to-day housekeeping tasks. These tasks helped to ensure the pharmacy was running safely. The pharmacy employed a pharmacy technician who had undergone further training allowing them to complete the final accuracy check of medicines during the dispensing process, known as an accuracy checking pharmacy technician (ACPT). Team members were aware the ACPT could not have a direct role in the labelling and assembly of medicines they were checking. And they understood the need for prescriptions to be clinically checked by a pharmacist prior to the ACPT undertaking the final accuracy task.

Where possible, the pharmacy assigned a different team member to each part of the dispensing process. Team members explained this helped to reduce risk by introducing independent checks throughout the prescription journey. Pharmacy team members routinely recorded mistakes made and identified during the dispensing process, known as near misses. They used the records to identify contributory factors and any immediate actions taken to reduce risk. This information fed into a monthly patient safety review. The pharmacy team also reported mistakes that were identified following the supply of a medicine to a person, known as dispensing incidents. These reports were thorough and investigation notes showed how the team used the reports to identify the root cause of a dispensing incident. And the pharmacy shared anonymised details of these reports through the NHS 'Learn from Patient Safety Events' portal to inform wider learning across the healthcare sector. The team kept a comprehensive record of its monthly patient safety reviews. It used these reviews as an opportunity to explore learning and actions following mistakes. It also shared learning about the actions required following medicine alerts issued by the Medicine and Healthcare products Regulatory Agency (MHRA). Team members identified three key action points each month to help reduce risk. And they reflected on these actions the following month to help measure their effectiveness. Conversations with team members found them to be knowledgeable about current action points, and the reason these had been agreed. They also used learning shared with them by the superintendent pharmacist's team to

inform risk reduction actions. And they provided examples of both local and company-led actions they had implemented. For example, changes they had made to separate similar looking and sounding medicines within the dispensary. And changes to the checks team members made during the dispensing process when dealing with prescriptions handed in at the medicine counter.

The pharmacy had a complaints procedure. And its team members knew how to manage feedback and how to escalate a concern when required. The pharmacy's practice leaflet provided people with information about how they could raise a concern or provide feedback about the pharmacy. And it informed them how the pharmacy managed their personal information. Team members engaged in mandatory learning on confidentiality, and they asked visitors to sign confidentiality agreements. The pharmacy held all personal identifiable information in the staff-only area of the premises. Confidential waste was segregated and securely disposed of. The team engaged in safeguarding learning to help protect vulnerable people. They were knowledgeable about safety initiatives designed to offer a safe space to people experiencing domestic violence. And they knew how to recognise and report safeguarding concerns.

The pharmacy had current indemnity insurance. The RP notice on display contained the correct details of the RP on duty. A sample of pharmacy records examined were found to be kept in good order and they mostly complied with legal requirements. But there was no entry in the RP register for 31 December 2023. Team members confirmed the pharmacy was open on this date and were able to identify who the pharmacist was from other records they kept. They agreed to bring this learning point to the pharmacist's attention when they were next working at the pharmacy. The pharmacy maintained running balances in the CD register and completed full balance checks of physical stock against the register weekly. A random physical balance check of a CD conducted during the inspection complied with the running balance in the register. The team recorded patient-returned CDs in a separate register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a dedicated team of people who work together well. Team members engage in regular discussions and learning to support the safe delivery of the pharmacy's services. They understand how to provide feedback about the pharmacy, and they can raise a professional concern if needed.

Inspector's evidence

The RP on duty was a regular locum pharmacist. They were working alongside two dispensers and a medicine counter assistant; another dispenser joined the team on duty towards the end of the inspection. The pharmacy also employed another dispenser and an ACPT. A new team member had joined the team very recently and were engaging well in the pharmacy's induction programme. The pharmacy was recruiting for a permanent pharmacist to join the team and had been doing so for some time. The team reported they worked with regular locums, and a pharmacist manager from another Morrison's pharmacy worked one day a week at the pharmacy to provide some management support. Team members worked flexibly to cover for both planned and unplanned leave when required.

The team completed regular learning relevant to their roles. This included mandatory e-learning on topics such as information governance and manual handling. And learning to support the team in delivering pharmacy services safely and in providing them with confidence to have meaningful conversations with people about their health and wellbeing. All team members on duty worked together well and treated each other with respect. The pharmacy had some targets for the team to meet. Team members did not feel pressurised by these targets and the RP was clearly able to apply their professional judgement when delivering pharmacy services.

Pharmacy team members engaged in structured patient safety reviews each month. They also engaged in regular briefings following weekly management conference calls. They recorded information from the patient safety review to inform ongoing learning. The pharmacy had a whistle blowing policy and its team members understood how they could raise and escalate a concern at work. A team member explained that some resources to support staff health and wellbeing were available in the staff-only area of the supermarket.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and suitably maintained. It offers a professional image for delivering its services. People using the pharmacy are able to speak to a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy premises were secure and clean. Overall, the pharmacy was well maintained, and team members knew how to report maintenance issues. There was one outstanding maintenance request waiting for attention as several lightbulbs required replacing. Lighting was adequate and ventilation was appropriate with air conditioning used to keep an ambient temperature. Pharmacy team members had access to hand washing facilities, including antibacterial hand wash and hand sanitiser.

The premises consisted of the medicine counter, a consultation room, and the dispensary. The dispensary was an appropriate size for the work activity taking place. Workflow was efficient with separate areas used to label, assemble and accuracy check medicines. And there was a defined area for undertaking higher risk dispensing tasks, such as the assembly of multi-compartment compliance packs. The pharmacy’s consultation room was a good size and accessible to all. It was professional in appearance and team members promoted its availability to people wishing to have a quiet word with the RP.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are readily accessible to people. It obtains its medicines from reputable sources. And overall, it stores them safely and securely with effective processes to ensure they remain safe to supply to people. Pharmacy team members provide relevant information to people to help them take their medicines safely.

Inspector's evidence

The supermarket was accessed through automatic doors and there was plenty of parking available onsite. The pharmacy was in the foyer of the supermarket. It advertised its opening times and information about how people could access pharmacy services in the town outside of its normal operating hours. And it provided a range of helpful information to people. For example, it advertised local mental health support services, and a local support group for carers. Pharmacy team members knew how to signpost people to other pharmacies or healthcare services when the pharmacy was unable to provide a service or supply a medicine.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. Team members were observed following procedures when responding to requests for P medicines. They discussed applying vigilance when managing requests for higher-risk P medicines which were liable to abuse. And they knew when to refer a request to the RP. The RP had good supervision over the medicine counter from the dispensary. Pharmacy team members had access to current information and protocols to support them in providing pharmacy services safely. For example, up-to-date patient group directions were readily available for pharmacists to refer to when administering flu vaccinations. And pharmacists delivering the service provided evidence of their training and declarations of competency ahead of providing this service. Pharmacy team members referred to the local NHS minor ailments protocol when making supplies of medicines through this service.

The pharmacy team used a reference guide to support them in identifying higher-risk medicines during the dispensing process. They monitored the supply of CDs well by highlighting these prescriptions and clearly recording their expiry date on the top of the prescription to help inform legal checks when handing CDs out. Team members marked prescriptions for some other higher-risk medicines to ensure appropriate counselling took place when handing out these medicines. But pharmacists did not routinely make a record of these types of interventions on the patient medication record (PMR) to help support continual care. The team engaged in medicine audits periodically. It had completed a recent anticoagulant audit to ensure the team followed safe practices when dispensing these higher-risk medicines. Team members were aware of the requirements of the valproate Pregnancy Prevention Programme (PPP). Team members explained they did not currently dispense to people within the at-risk group. And they dispensed valproate in original packs only to comply with recent legal changes about the supply of the medicine.

Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. They followed an effective system for managing medicines owed to people. This included providing people with a copy of an owing slip detailing the medicine that was owed to them. The pharmacy dispensed some medicines in multi-compartment compliance packs. The team had an

effective system for managing this service by holding medicines for each person receiving this service in individual baskets. And it ordered prescriptions in good time to help support an effective workflow. The team used individual records for each person on this service to support it in managing the supply of medicines in this way. The records included clear details of people's medicine regimens and suitability assessments that provided assurances that supplying medicines in this way was in a person's best interests. The team documented changes to people's medicine regimens clearly with supporting information about the checks they made to confirm these changes. A sample of assembled compliance packs contained full dispensing audit trails and clear descriptions of the medicines inside the compliance packs. The team supplied these medicines weekly to people. Team members explained they provided patient information leaflets alongside compliance packs at the beginning of each four-week cycle.

The pharmacy obtained its medicines from licensed wholesalers and a licensed specials manufacturer. It stored them neatly and within their original packaging. It kept records of regular date checking activities, including lists of medicines with short expiry dates. And the team highlighted short-dated medicines with stickers. It also separated stock expiring within the next three months. If a team member used the short-dated stock when dispensing a prescription, they followed a process to ensure people were aware of the short expiry date. A random check of stock found some expired adrenaline ampoules in the consultation room. A discussion took place about the need to ensure appropriate stock of adrenaline was available before offering a flu vaccination appointment to a person. The consultation room was not on the current date checking matrix. But a team member took the opportunity to add this to the matrix during the inspection to help reduce the risk of this happening again. The team marked liquid medicines with details of their opening dates. This prompted additional checks during the dispensing process to ensure they were safe to supply to people. The pharmacy kept CDs in an orderly manner within a secure cabinet. Medicines inside the pharmacy's fridge were stored neatly, but storage for medicines requiring cold storage was at capacity. Fridge temperature records showed that the fridge was operating within the required range of two and eight degrees Celsius.

The pharmacy had appropriate medicine waste bins and CD denaturing kits available to support the safe disposal of medicine waste. The pharmacy team received medicine alerts by email. It kept an audit trail of the action it took in response to these alerts, and it sent a declaration of the checks it made to its superintendent pharmacist's office. And each month the team printed a summary of the alerts issued within the current calendar year to ensure it had not missed an alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. It carries out appropriate checks to ensure the equipment remains in safe working order. And its team members use the equipment with care to protect people's confidentiality.

Inspector's evidence

Pharmacy team members had access to written and digital reference resources. They also had internet access to assist them with obtaining information. The pharmacy protected its computers from unauthorised access by using passwords and NHS smart cards. It stored bags of assembled medicines safely in a retrieval area within the dispensary. Pharmacy team members used a cordless telephone handset when speaking to people over the telephone. This allowed them to move out of earshot of the medicine counter when speaking to people over the phone.

The pharmacy team used a range of appropriate equipment to support it in delivering the pharmacy's services. For example, crown-stamped measuring cylinders for measuring liquid medicines and weighing scales for counting tablets and capsules. The team calibrated the weighing scales weekly against three assorted sizes of tablets to ensure they were working correctly, and they kept a record of this activity. The pharmacy's equipment was from recognised manufacturers. And it was subject to periodic checks. For example, there was evidence of some electrical safety checks within the last year.

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.