General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Murrays Pharmacy, 2 Lowndes Road, STOURBRIDGE, West Midlands, DY8 3SS

Pharmacy reference: 1122125

Type of pharmacy: Community

Date of inspection: 03/10/2019

Pharmacy context

This is a busy community pharmacy located inside a large health centre on the outskirts of the town centre. It supplies mainly NHS prescriptions but it dispenses some private prescriptions including some for homeopathic medicines. It sells a small range of over-the-counter (OTC) medicines and offers several other services including Medicines Use Reviews (MUR), emergency hormonal contraception (EHC) and flu vaccinations during the relevant season. The pharmacy has a Wholesale Dealer's License and is regulated by the Medicines and Healthcare products Regulatory Agency (MHRA).

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	4.3	Standard not met	Stock medicines are not suitably managed. The pharmacy cannot demonstrate that it stores all medicines appropriately or that it carries out enough checks to show that they are suitable for supply.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy has written procedures to help make sure team members complete tasks safely and it keeps the records it needs to by law. Its team members understand how to keep people's private information safe and they complete some training to help them identify and manage the health and wellbeing of vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) to cover operational tasks and activities. Several procedures had been updated in 2019, but there were others including those which covered the collection and delivery of prescriptions and the ordering and receipt of controlled drugs (CDs), which had not been reviewed since March 2014 and February 2015 respectively, so they may not reflect current practice. The procedures outlined staff responsibilities and an audit trail was kept to confirming their acknowledgement and understanding, but this was sometimes incomplete. Team members were observed to work within their roles and demonstrated an understanding of their responsibilities, including an awareness of the activities which were permissible in the absence of a responsible pharmacist (RP). Insurance covering the provision of pharmacy services was provided through the National Pharmacy Association (NPA).

A paper near miss log was available in the dispensary. The team reported that this was used to record the details of near misses and entries were then populated onto an electronic system. The paper records were sporadic, showing only a limited number of entries and a report indicated that only two near misses had been recorded electronically in 2019. There was no record of any regular near miss review, which may mean that some underlying themes go undetected. The team reported that they discussed concerns such as medicines with similar packaging to raise awareness amongst the team and help prevent errors. A dispenser recalled a recent dispensing incident and explained the actions that had been taken to help prevent a reoccurrence. A problem with the incident reporting system meant that records of previous incidents were unavailable in the pharmacy on the day. However, the pharmacist obtained a report from head office confirming that incident reports had been submitted for review by the superintendent pharmacist in line with company procedures.

The pharmacy had a complaint procedure, but this was not clearly advertised so people may not always know how they can raise a concern. The pharmacy also sought feedback through a Community Pharmacy Patient Questionnaire (CPPQ). A previous survey showed positive results.

An RP notice was conspicuously displayed behind the medicine counter. The RP log was generally in order, but in the sample portion viewed, there was one entry which did not record the pharmacist's registration number and another which did not state the time at which RP duties ceased, so it was not fully compliant. A private prescription register was available, but some private prescription entries were recorded using dispensing labels, which may remove or fade and compromise the integrity of the audit trail. Specials procurement records provided an audit trail from source to supply and CD registers were in order. They recorded a running balance and regular balance checks were carried out. A patient

returns CD register was also in use and previous destructions were signed and witnessed.

Pharmacy team members had completed information governance training and several procedures were available through the company intranet. The pharmacy was registered with the Information Commissioner's Office. A copy of its privacy policy was not seen on the day. A pharmacy technician confidently discussed how people's private information was kept safe in the pharmacy. Confidential waste was segregated and taken for appropriate disposal and completed prescriptions were stored out of public view. The appropriate use of NHS smartcards was seen on the day.

Registrants had completed safeguarding training. A dispenser identified some of the types of behaviours which might raise a concern and explained how these would be escalated and managed. The pharmacist reported that safeguarding concerns would be discussed with head office prior to escalation. A chaperone policy was displayed in the consultation room.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members hold the appropriate qualifications for their roles, they work well together and use their professional judgement to make decisions. The pharmacy's current dispensing workload is difficult to manage and the team members are not always able to complete some tasks on time. But the pharmacy has recently reviewed its staffing profile and allocated additional staff resource to help with the increasing volume of work.

Inspector's evidence

On the day of the inspection, the pharmacy manager was working alongside a locum pharmacist. The pharmacy manager worked at the branch one and a half days each week and spent the remainder of the week working at another nearby branch. The pharmacy had previously had a regular second pharmacist who worked on the other weekdays. However, he had moved to work in a different branch the week prior to the inspection. A replacement regular pharmacist was yet to be arranged, and so cover was being provided through locum pharmacists in the interim period. Double pharmacist cover was provided for four half-days each week. The remainder of the pharmacy team comprised of three registered pharmacy technicians, two of whom were relief staff, and three qualified dispensing assistants. The workload in the pharmacy was busy. There was a backlog of work, and on the day the team were dispensing prescriptions which had been received three days prior to the inspection and baskets of prescriptions which were awaiting a final clinical check were stacked at a height of three to four baskets along the length of the work bench. The team discussed challenges with the workload and reported that they were focussed on trying to manage the dispensing volume, so other activities, such as medicines management and house-keeping duties were difficult to complete.

Staff rotas were planned to try and help assign duties and tasks, but the team reported that there were sometimes unplanned changes and a lack of communication around this. For example, the pharmacist had been unaware that two relief staff were being sent to replace regular staff members until they had arrived in the branch on the day. The pharmacy had another branch nearby, and staff were often asked to divide their time and provide cover for leave and sickness at this pharmacy. The team planned their leave in advance and where possible, relief staff provided cover in the pharmacy. Since the beginning of 2019 it was identified that, due to numerous circumstances, the pharmacy’s workload had increased by approximately 1500-2000 items each month and approximately 16,000 items were now being dispensed each month. The team reported that a review of the staffing level had not taken place in response to this, despite concerns being raised by the team. The superintendent pharmacist subsequently confirmed that a review had taken place, taking into account prescription item numbers, the assembly of compliance aid packs and other service provision. He explained that two new members of staff had been recruited in July 2019, of which one post was in response to the increase in workload volume, but this planned increase in staff had been impacted by long term sickness of another team member. For which relief cover was being provided, where possible. The company's management had also recently recruited another employee, who was due to commence work in the coming weeks. And recruitment for a full-time pharmacist was ongoing to help create more stability within the branch.

Pharmacy team members were trained for their roles and were observed to work within their competence. A dispenser discussed issues that she would highlight to the pharmacist as part of

dispensing processes. This included newly prescribed medicines and dose changes. Team members provided several examples where inappropriate requests for OTC medicines had been referred to the pharmacist and the sale had been refused. A dispenser discussed the types of questions that she would ask to help make sure that a sale of medication was appropriate and provided an appropriate response to a question regarding the purchase of a pseudoephedrine-based medicine.

Pharmacy team members completed some ongoing training through an e-Learning platform. It was estimated that modules were released at least every two months and the team reported that they tried to complete module within work time. But protected learning time was not always available. A dispenser who was completing the NVQ3 was not currently receiving protected training time due to the busy workload in the pharmacy. The team previously had regular one-to-one reviews with a senior member of staff within the team to help identify and address development needs. The frequency of the reviews had declined since the staff member left her post in July 2018.

There was an open dialogue amongst the pharmacy team who were comfortable in discussing issues amongst themselves and raising ideas to help manage the difficulties. The team were happy to approach the company's head office with their concerns but felt that issues were not always addressed. The company had a whistleblowing policy to facilitate anonymous concerns. The team were set some targets for professional services, but the pharmacist stated that he had not considered the targets for a while due to the busy workload in the pharmacy. The team prioritised dispensing prescriptions as safely as possible.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a secure and professional environment for the delivery of healthcare services. It has a consultation room to enable it to provide members of the public with access to an area for private and confidential discussions.

Inspector's evidence

The pharmacy was in a good state of repair. It was finished to a high standard and looked professional. The premises were rented from the GP surgery who arranged for any necessary repair work. There could sometimes be delays to this process due to the involvement of several contractors, as previously experienced when resolving an issue with a metal shutter. The team carried out daily cleaning duties and although generally clean, there were some areas of the premises which looked untidy, and some items were being temporarily stored on the floor, which could create a trip hazard for team members. There was adequate lighting throughout the premises. There were air conditioning units located in the GP surgery waiting area, which was just outside the pharmacy. However, these were not in operation, and the team used portable fans and kept a door open to help regulate the air flow during warm weather. A thermometer on the day read 21oC, which was appropriate for the storage of medicines.

To the front of the pharmacy was a small reception area. Several shelves displayed a small range of suitable healthcare-based goods and pharmacy restricted medicines were placed behind the medicine counter to help prevent self-selection. A large waiting area with chairs was shared with the GP surgery. This was located near to the entrance of the pharmacy.

The pharmacy had a consultation room which was accessed via a corridor. The room was generally appropriately maintained but there were some boxes of rubbish which required removal. It had a desk and seating to enable private and confidential discussions and a large blind was fitted over the window to afford privacy to people using the room.

The dispensary was adequately sized. There was a large front work bench, which had a dispensing terminal for walk-in prescriptions and a separate area for accuracy checking. A second large work bench was located behind this and was used to additional dispensing space. A shelf above the work bench was used to store prescriptions which were awaiting a final accuracy check. This was stacked with baskets throughout the inspection. Large units of drawers and shelves were fitted for the storage of stock medicines and completed prescriptions. The pharmacy also had a sink for the preparation of medicines, which was equipped with appropriate hand sanitiser.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy suitably manages its services and they are reasonably accessible to people with different needs. But it does not systematically identify people on high-risk medications, so people may not always get the information they need to take their medicines properly. The pharmacy sources medicines appropriately but stock medicines are not well organised or managed. It cannot fully demonstrate that all medicines are stored appropriate or that it carries out robust checks to make sure that they are fit for supply.

Inspector's evidence

The pharmacy was located inside a large health centre. It was clearly signposted from both the outside and the main entrance of the building. The centre had automatic doors and a step-free access to aid people with mobility issues. A notice was displayed at the pharmacy reception advising customers to inform staff of any accessibility needs. The pharmacy had a hearing loop and large print labels could be printed from the computer system, to aid people with visual impairment.

There was some advertisement of the pharmacy's services on boards surrounding the premises. Posters promoting the appropriate use of antibiotics and this year's flu vaccination campaign were located near to the medicine counter along with some additional health promotion literature. Team members had access to some information to support signposting.

Prescriptions were dispensed using colour coded baskets, to prioritise the workload and reduce the risk of medicines being mixed up. An audit trail for dispensing and checking was maintained on dispensing labels. The pharmacy did not routinely highlight prescriptions for high-risk medicines to help make sure that people received appropriate monitoring. The use of valproate-based medicines in people who may become pregnant was discussed. The pharmacist was aware of the risks and safety literature that was available. The inspector advised on where the materials could be obtained from, as copies could not be immediately located on the day.

Patients contacted the pharmacy to request repeat prescriptions. Team members kept a diary to record which requests had been sent to the GP surgery, but they did not proactively review this to identify unreturned requests or prescription discrepancies. Delivery sheets were provided, showing that some signatures were obtained to confirm delivery. Others were recorded a delivered by the delivery driver. A card was left for any patient who was not in at the time of delivery and medications were returned to the pharmacy.

The pharmacy assembled a small number of compliance aid packs on the premises and others were assembled at the nearby internet-based pharmacy using a medicine pouch system. Pharmacy team members ordered the compliance aid medicines which were required each month. They kept records to make sure that all requests were back, and packs were assembled for the required date. No high-risk medicines were placed into compliance aid packs. For the compliance packs which were assembled off-site, prescriptions returned from the GP surgery were checked against a master record of medication and data was then sent electronically after being clinically checked by the pharmacist. An audit trail was kept for this process. Once dispensed, weekly packs were matched with the original prescription and additional medications were added, as required. Packs stated descriptions of individual medicines, but

patient leaflets were not always supplied in line with requirements. So, people may not always have all the information they need to take their medicines properly. The pharmacist discussed a form which was completed to obtain information from new patients requesting a compliance aid. He reported that most requests came from care providers facilitating hospital discharges.

The pharmacy supplied Abnoba injections against private prescriptions. Prescriptions were written from specialist centres which used the homeopathic treatment and the pharmacy received them via the post. The product was requested from the company's warehouse, who held the necessary import license and records of supplies were kept in the private prescription register. Supplies were posted to the patient using the Royal Mail special delivery service, which required a signature and could be tracked. The product was posted in standard jiffy bags. The manufacturer advised that the product is sensitive to frequent and excessive temperature fluctuations and thus should be stored in a cool and dark place, such as a refrigerator. A dispenser stated that deliveries had previously been delayed during periods of warm weather as they currently had no way of regulating the temperature of the product during the delivery process.

The pharmacist had completed training for the flu vaccination within the last two years and a declaration of competence had been submitted to PharmOutcomes. Copies of in-date patient group directives (PGDs) were available. The pharmacy had a sharps bin and adrenaline auto-injectors for the treatment of anaphylaxis.

Stock medications were obtained from reputable wholesalers and specials from a licensed manufacturer. Stock medicines were stored on large shelving units and were usually in their original container. However, some examples were seen where loose tablets were being stored in the box. There was no indication of when the medication had been removed from the original blister strip. These were removed from the shelves, as were several expired medicines which were identified during random checks. The medicines had expired between September 2018 and April 2019 and had not been marked in line with date checking procedures. The team explained the date checking processes and stock exchange systems which were in place and they had carried out some recent checks in a small area of the dispensary. But it had been several months since other checks had been completed. The team reported that this was due to time constraints associated with the workload. The storage of medicines was also unorganised in some areas, which may increase the risk of a picking error. Expired and returned medicines were stored in medicine waste bins. The pharmacy was not yet fully compliant with the requirements of the European Falsified Medicines Directive (FMD). A pilot was being carried out in another branch and the team were awaiting further instructions on the planned roll-out throughout the company. Drug alerts were received through the company intranet portal and were actioned accordingly.

The pharmacy had two refrigerators which were both fitted with maximum and minimum thermometers. There had been several instances in recent months were the maximum temperature had exceeded the recommended range. The refrigerators were full of stock, which was felt to be contributing to temperature deviations. The pharmacist believed that the company health and safety manager was trying to obtain a new refrigerator, but he had not received an update in recent weeks. Both refrigerators were within the recommended temperature range on the day. CDs were stored appropriately with expired and returned CDs segregated from stock. Random balance checks were found to be correct and CD denaturing kits were available.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. Team members use equipment in a way that protects people's privacy.

Inspector's evidence

The pharmacy had paper-based reference including the British National Formulary (BNF). Unrestricted internet access supported additional research and the pharmacist access resources including the Electronic Medicines Compendium (EMC), when required. A range of glass crown stamped measures were available for measuring liquids. A separate one was marked for use with CDs. Counting triangles for loose tablets were clean and a separate triangle was kept for use with cytotoxic medicines.

Electrical equipment had been PAT tested and was in working order. The computer system was password protected and screens were located out of public view. A cordless phone enabled conversations to take place in private, if required.

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.