

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: 08/09/2020

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. And it supplies some medicines in multi-compartment compliance aid packs, to help make sure people take them at the correct time. The pharmacy has a Wholesale Dealer's License and is regulated by the Medicines and Healthcare products Regulatory Agency (MHRA). The inspection was completed during the COVID-19 pandemic.

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	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 associated with its services. It keeps the records it needs to by law and it protects people's private information. Pharmacy team members are clear about their roles and responsibilities and they understand how to raise concerns to help protect the wellbeing of vulnerable people.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) covering operational tasks and activities. Several procedures, including those relating to the management of controlled drugs (CDs), had been recently reviewed. Others had surpassed their review date so they may not reflect current practice. The procedures outlined staff responsibilities and the pharmacy kept some audit trails to confirm staff had read and understood them. Team members were observed to work within their roles and a pharmacy technician clearly discussed 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) and a certificate was displayed which was valid until the end of December 2020.

A paper near miss log was available in the dispensary and entries were then populated onto an electronic system. The records were reviewed periodically to identify any underlying trends and any issues were discussed at team meetings. A dispenser, who had recently been appointed as a 'senior' within the branch was due to assume responsibility for the near miss review moving forward. Dispensing incidents were also reported using the electronic system. The pharmacy manager explained that he had been made aware of an incident in the days preceding the inspection and as part of a review into the incident, he was due to meet with the patient to gain further details.

The pharmacy team had been provided with access to individual risk assessments during the ongoing COVID-19 pandemic. The pharmacy manager said that these had been made available via the company intranet page and team members had been encouraged to complete the assessment if they were in a high-risk category. A risk assessment had not been completed on all team members as standard practice. The locum pharmacist said that she had completed her own personal assessment. Pharmacy team members were wearing personal protective equipment (PPE) as social distancing within the pharmacy was difficult. The pharmacy manager said that any reported cases of COVID-19 amongst team members would be discussed with the superintendent pharmacist, to enable onward reporting as necessary.

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). The results from a survey completed in October 2019 showed positive results.

An RP notice was conspicuously displayed behind the medicine counter and the RP log was suitably maintained. 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. CD registers were in

order, and they recorded a running balance. Regular balance checks were carried out and recorded on a separate audit sheet. A patient returns CD register was also in use and previous destructions were signed and witnessed.

Pharmacy team members had completed information governance training. They had individual NHS smartcards and appropriate use was observed on the day. During the inspection, no patient identifiable data was visible, and a dispenser identified the types of information which required confidential disposal. Confidential waste was segregated and removed for appropriate disposal.

The locum pharmacist had completed safeguarding training. She identified some of the types of behaviours which might raise a concern and explained how these would be escalated and managed. This included a recent concern as part of the substance misuse service. 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 feel able to raise concerns and provide feedback. Team members receive some ongoing training to help them identify and address any gaps in their knowledge.

Inspector's evidence

On the day of the inspection, a locum pharmacist was working alongside two registered pharmacy technicians. A dispenser, who was enrolled on the pharmacy technician course and two qualified dispensers, one of whom held the role of senior within the branch were also present. The pharmacy also employed another pharmacy technician and three additional dispensers, who were not present. The pharmacy manager also attended the branch for most of the inspection and an additional locum pharmacist arrived towards the end of the inspection. The pharmacy usually had double pharmacist cover for a portion of each weekday. The pharmacy manager worked at the branch one and a half days each week and the remaining cover was provided through locum pharmacists. There were some locum pharmacists who worked a few regular shifts each week, which provided some continuity. The workload in the pharmacy had remained busy during the ongoing pandemic. The team supported one another well and were allocated daily duties using a rota, to help ensure that all tasks were completed during the day. There had been some staffing changes following the previous inspection and the team were managing the workload on the day and were up to date with dispensing. There was some relief cover available from the company to cover leave, although this could be difficult to obtain during busy periods, such as the summer holiday season.

Pharmacy team members were trained for their roles and exercised their professional judgement. A pharmacy technician discussed how a concern regarding a frequent request for a medication susceptible to abuse had been managed, and outlined questions that she would ask to help make sure that sales of the medicines were safe and appropriate. Concerns were referred to the pharmacist and the pharmacy technician described the support that the pharmacy manager and locum pharmacist provided when queries were referred.

Pharmacy team members completed some ongoing training through an e-Learning platform. There had been limited training completed since the beginning of the pandemic. Most of the updates that the team had received in recent weeks were involving the COVID-19 pandemic and were disseminated by the company's head office. Staff development was reviewed through one-to-one reviews. The senior reported that the pharmacy manager had completed some reviews during the pandemic, to monitor development and review team members wellbeing during what had been a difficult period. The senior said that she would now assume responsibility for ensuring that development reviews were completed moving forward.

There was an open dialogue amongst the pharmacy team. Team members worked well together in a busy and challenging environment. They were happy to discuss concerns amongst one another and also escalate issues to the pharmacy manager, or company management, including the superintendent pharmacist where necessary. The locum pharmacist also felt comfortable in raising concerns if the need occurred. The company had a whistleblowing policy to support anonymous concerns being raised. The senior confirmed that there were no targets in place for professional services.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy provides a professional environment for the delivery of healthcare services. Temporary access arrangements mean the pharmacy's consultation facilities are not available.

Inspector's evidence

The pharmacy was in a good state of repair. The premises were rented from the GP surgery who arranged for any necessary repair work. During the pandemic, there had been some difficulties in access arrangements for the pharmacy, as the GP surgery had closed their doors to the public. An emergency exit in the consultation room was being used as the main access door to the premises. From this area people were directed to pass through the consultation room into a corridor where they were able to access the medicine counter. No confidential information was visible when passing through the room on the day. But this arrangement did mean that the consultation room could not currently be used for its usual function. And the pharmacy was not currently able to offer services such as the flu vaccine, as arrangements regarding confidentiality were still being discussed.

Near to the medicine counter there were several shelves, which displayed a small range of suitable healthcare-based goods and pharmacy restricted medicines were placed behind the medicine counter to help prevent self-selection. Chairs and hazard taped barriers were used to help promote social distancing amongst patients who were waiting for their prescriptions and there was a restriction on the number of people that could be in the immediate vicinity of the medicine counter at one time.

The team carried out daily cleaning duties and although the pharmacy was generally clean and tidy, there were some areas of the premises where items were being temporarily stored on the floor, which could create a trip hazard for team members. There was adequate lighting throughout the premises and the ambient temperature was suitable for the storage of medicines.

The dispensary was adequately sized. There was a large front work bench, which had a dispensing terminal 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. The pharmacy also had a sink for the preparation of medicines, which was equipped with appropriate hand sanitiser.

Principle 4 - Services ✓ Standards met

Summary findings

Pharmacy services are suitably managed, so people receive appropriate care. But the pharmacy does not always identify prescriptions for high-risk medications, so some people may not always get all the information and advice they need to take their medicine properly. The pharmacy gets its medicines from reputable sources and team members carry out some checks to make sure they are suitable for supply.

Inspector's evidence

The pharmacy was located inside a large health centre. The new access arrangements were clearly signposted from the main car park and the access was step-free. 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 and health promotion literature was displayed, including information on the symptoms of coronavirus and the action that people should take in response to any concerning symptoms.

Prescriptions were dispensed using colour coded baskets, to prioritise the workload and reduce the risk of medicines being mixed up. Team members signed 'dispensed' and 'checked' boxes as an audit trail. The pharmacy did not routinely highlight prescriptions for high-risk medicines to help make sure that people received appropriate advice and monitoring. It had some of the safety literature required when making supplies of valproate-based medicines to people who may become pregnant, but this did not include access to warning labels to over label any supplies made outside of the original packaging.

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. The delivery process had been reviewed in light of the ongoing pandemic. The delivery driver observed the collection of medication from the doorstep at a suitable distance and then recorded the name of the individual who had collected it. Delivery sheets were retained in the pharmacy as an audit trail. The pharmacy's delivery service had been supplemented by local volunteers during the early part of the pandemic.

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. The system was managed using a four-week cycle and pharmacy team members ordered the medicines which were required each month. They kept records to make sure that all prescription requests had been received, and packs were assembled in advance of the date they were required. For the compliance packs which were assembled off-site, the prescription details were recorded on the PMR system as an audit trail and they were then transcribed onto a separate database to be sent electronically to the internet pharmacy. A dispenser said that the pharmacist oversaw this process as a clinical check. A paper record which confirmed the details of the prescriptions submitted each day was signed by the pharmacist as confirmation of this. These records were held at the off-site location, but the dispenser confirmed that they could be recalled if required. Packs stated descriptions of individual medicines, and the dispenser

said that patient leaflets were supplied each month.

The pharmacy supplied homeopathic Abnoba injections against private prescriptions. Prescriptions were written by doctors registered with the General Medical Council, working in specialist centres which used the homeopathic treatment. The pharmacy received the prescriptions via the post and the product was requested from the company's warehouse, who held the necessary import license. Records of supplies were kept in the private prescription register and specials records were also held at the company warehouse providing an audit trail from source to supply. Once dispensed the injections were posted to the patient using the Royal Mail special delivery service, which required a signature and could be tracked.

Stock medications were obtained from licensed wholesalers and specials from a licensed manufacturer. Stock medicines were stored on large shelving units and were generally in order. The pharmacy had date checking procedures in place. Recent checks had been completed and short-dated medications were suitably highlighted. Obsolete medicines were stored in medicine waste bins. The pharmacy was not yet fully compliant with the requirements of the European Falsified Medicines Directive (FMD). The senior had been involved in the implementation of FMD processes as part of a pilot in another branch, but details of a full company roll-out were not known. Drug alerts were received through the company intranet portal and were actioned accordingly.

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. The pharmacy refrigerators were both fitted with maximum and minimum thermometers and the temperature was checked and recorded daily. Both refrigerators were within the recommended temperature range on the day. But there had been several instances in recent months where the maximum temperature had exceeded the recommended range. The team confirmed that action was taken in response to this, but this was not documented. So, team members may not always be able to demonstrate that suitable action was taken in response to temperature deviations. Both refrigerators were full of medicines and stock arrangement was unorganised in parts, which may increase the risk of a picking error.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

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

Inspector's evidence

The pharmacy had paper-based reference sources including the British National Formulary (BNF) and internet access was available to support further research. A range of glass crown stamped measures were available for measuring liquids. A separate one was marked for use with CDs. Counting triangles used for loose tablets were clean and a separate triangle was kept for use with cytotoxic medicines.

Electrical equipment was in working order. Computer screens were located out of public view and systems were password protected. The pharmacy had a cordless phone to enable conversations to take place in private, if required. In response to the COVID-19 pandemic the pharmacy had installed a Perspex screen at the medicine counter and PPE was available including 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.