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: 06/02/2024

Pharmacy context

This is a busy community pharmacy located inside a large health centre on the outskirts of the town centre. It dispenses prescriptions and it sells a small range of medicines over the counter. The pharmacy offers additional services including the New Medicine Service (NMS), Pharmacy First and blood pressure testing. And it also supplies some medicines in multi-compartment compliance aid packs, to help make sure people take them at the correct time.

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	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 keeps people's private information safe, and its team members understand how to raise concerns to protect the wellbeing of vulnerable people. They follow procedures to help make sure they work safely. But some of the procedures seen have not been reviewedfor more than two years, so they may not contain the most up to date information. And team members do not always record near misses and incidents in a timely manner, so some opportunities for learning may be missed.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) covering operational tasks and activities. The procedures were available in a digital format. Some procedures did not appear to have been updated within the last few years, so they may not contain the most up to date information. Team members explained that they were made aware of any changes to processes, and they demonstrated a clear understanding of their roles and responsibilities. The pharmacy had professional indemnity insurance and a certificate displayed was valid until March 2024.

Team members discussed any near misses with the pharmacist when they were identified. They were then recorded on a paper log sheet, before being transcribed onto an electronic record. The last entry recorded on the paper log was in December 2023. Team members believed that further entries had been made after that time, but those records could not be located. Changes had previously been made to help prevent near misses from reoccurring, such as separating medicines to help prevent picking errors. The pharmacist explained the actions that he would take if a dispensing incident was reported to the pharmacy, this included apologising and rectifying the incident. But he was unsure of the recording process. A pharmacy team member explained how errors were recorded on an electronic system. There were a couple of recent errors which had been discussed by the pharmacy team, and the medicines segregated in a basket, but reports had not yet been completed on the system. This may mean that some opportunities for learning are missed.

The pharmacy had a complaint procedure, and the details of head office were displayed in the dispensary, to support team members in escalating any concerns that could not be resolved in the pharmacy. People could also leave reviews of the pharmacy online.

The correct responsible pharmacist (RP) notice was displayed behind the medicine counter. There was an RP log, but there were some entries where the time RP duties ceased had not been recorded, so it was not technically compliant. Controlled drug (CD) registers kept a running balance and regular balance checks were completed. Patient returned CDs were recorded in a designated register. And records for the supply of unlicensed specials were in order. The pharmacy had a paper-based private prescription register. Some supplies against private prescriptions had not been recorded in the register within the necessary timeframe. And dispensing labels were used to create the record, which could be removed or fade over time and may compromise the integrity of the audit trail. Team members explained how a second private prescription register was maintained electronically. This was up to date, but records did not always state the correct details of the prescriber. The use of two registers may

make supplies more difficult to reconcile in the event of a query.

Pharmacy team members had previously completed some training on confidentiality. They had an understanding of data protection and ensured that no confidential information was visible from the medicine counter. Confidential waste was segregated and removed by an external contractor for suitable disposal. Team members had their own NHS Smartcards.

There was a safeguarding procedure and the pharmacist confirmed that he was up to date with his safeguarding training. The details of local safeguarding agencies were accessible if needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably trained for the jobs they do. They work well together and feel comfortable raising concerns and providing feedback. The workload in the pharmacy is busy, which creates some pressure, and means that team members don't always have enough time to complete less urgent tasks. And ongoing learning and development opportunities are limited. So, the pharmacy may not always be able to show how it keeps team members' knowledge and skills up to date.

Inspector's evidence

The pharmacy team comprised of a locum pharmacist, three registered pharmacy technicians and two dispensers. A second locum pharmacist arrived at the end of the inspection, as did a relief dispenser who was providing cover for a part-time team member in the afternoon. The pharmacy was operating with two team members less than usual on the day. It had been heavily reliant on locum pharmacists in recent weeks, after the previous regular pharmacist had left. A new regular pharmacist was expected to commence their role imminently. Team members worked additional hours to help provide cover when needed. And leave was planned in advance where possible to help to manage staffing levels. But the workload in the pharmacy was very busy. The team were generally managing to stay up to date with dispensing, but there were some prescriptions from the previous day which were still being assembled. The busy workload also meant the team found it harder to find time to complete some less urgent housekeeping tasks.

Pharmacy team members were trained for the roles in which they were working, but ongoing learning and development opportunities were limited. Team members had completed some training in modules such as antimicrobial resistance as part of the NHS quality payments scheme, but other training and continuing professional development was generally sourced and completed by team members outside of working hours. Team members had received appraisals periodically in the past and were in the process of arranging current reviews with a senior member of the pharmacy team.

The sale of medication was discussed, and a team member explained the questions that would be asked to help ensure that any sales were safe and appropriate. Previous inappropriate or frequent requests for medicines had been referred to the pharmacist.

There was an open dialogue amongst team members, who were happy to approach a senior member of the pharmacy team with any concerns. The area manager was also available, and a team member confirmed that she felt listened to and had been acknowledged when she had previously provided feedback.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a professional environment suitable for the delivery of healthcare services. There is a consultation room, so people can speak to members of the pharmacy team in private.

Inspector's evidence

The pharmacy was in a good state of repair and looked professional. There was adequate lighting throughout and the ambient temperature was suitably maintained. Team members had access to WC facilities and appropriate handwashing facilities were available.

Behind the medicine counter there was a small range of pharmacy restricted medicines which were secured from self-selection. Chairs were available in the large GP waiting area, for use by people waiting for their medicines. A consultation room was available down a corridor from the medicine counter. A notice was displayed advising people of its availability and team members were seen to offer use of the room during the inspection. The consultation room was equipped with a desk and seating to facilitate private and confidential discussions.

The dispensary was adequately sized. There was a large amount of work bench space with several dispensing terminals available for use. A separate area was reserved for accuracy checking. And there was additional storage space located behind the main dispensing area. There were some areas where prescription baskets were stacked on the workbenches and a couple of tote boxes were being temporarily stored on the floor which could cause a trip hazard.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy's services are suitably managed, so people receive appropriate care. But team members do not identify prescriptions for high-risk medicines so some opportunities to provide additional counselling may be missed. The pharmacy gets its medicines from reputable sources and team members complete some checks to help make sure they are fit for supply. But they do not always keep suitable records of this, so they may not always be able to show how the pharmacy stores and manages medicines appropriately.

Inspector's evidence

The pharmacy had a step free access and was easily locatable within the medical centre. There was limited advertisement of the pharmacy's services or other health promotion literature.

Prescriptions were dispensed using baskets in order to keep them separate and reduce the risk of medicines being mixed up. Baskets were colour coded to help prioritise the workload. And pharmacy team members signed 'dispensed' and 'checked' boxes as an audit trail. The pharmacist explained that a 'see pharmacist' sticker could be used to identify prescriptions where additional counselling was required but prescriptions for high-risk medicines were not routinely identified. Team members were aware of recent changes regarding the dispensing of valproate-based medicines. Prescriptions for CDs were highlighted to help ensure that supplies were made within the valid 28-day timeframe.

The pharmacy ordered repeat prescriptions for people who received their medicines in compliance aid packs. An audit trail was kept ensuring prescriptions were ordered in a timely manner and tracked to identify any outstanding requests. Master records of medication were maintained for each patient. Prescriptions were labelled using the patient medication record (PMR) system and the data input was checked by the pharmacy, before being sent electronically to a dispensing hub, where compliance aid packs were assembled. Completed compliance aid packs had descriptions of individual medicines and QR code links to patient leaflets.

In recent weeks the pharmacy delivery service had been ad hoc, due to staffing shortages. Couriers had been used on some occasions to provide the service, which used a delivery App and medications from failed deliveries were returned to the pharmacy.

The pharmacist was trained for most of the services offered under the Pharmacy First scheme, but the pharmacy did not currently have an otoscope, so services requiring an ear examination were unavailable. The pharmacist had signed an electronic master copy of the patient group directive (PGD) master sheet, which had been submitted to the company's head office.

The pharmacy sourced its medicines from a variety of reputable wholesalers and unlicensed specials from a specials manufacturer. Team members completed date checks during the dispensing process. A previous date checking schedule had also been in place, where short-dated medicines were identified and shelves were tidied. But team members were behind on these checks and date checking records

could not be located. There were a couple of small areas where the dispensary shelves were untidy, which may increase the risk of a picking error. One expired item was identified during random checks of the dispensary shelves. This was suitably segregated, and the pharmacy had medicines waste bins. Alerts for the recall of faulty medicines and medical devices were received electronically.

Both pharmacy refrigerators were within the recommended temperature range and a daily log was completed. However, there were occasional entries where the maximum temperature had exceeded the recommended temperature range. No audit trail was kept demonstrating the action that had been taken in response to this. CDs were stored securely, and random balance checks were found to be correct. The pharmacy had some CD denaturing kits available.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. The equipment is suitably maintained, and team members use it in a way that protects people's privacy.

Inspector's evidence

The pharmacy had access to paper reference materials including a copy of the British National Formulary (BNF). Internet access was also available for additional research. There was a range of approved glass measures, which were clearly marked for use with different liquids. Tablets counters were also available with a separate one for methotrexate. Equipment seen was suitably maintained.

Electrical equipment was in working order. Computer systems were password protected and screens all faced away from public view. The pharmacy had cordless phones to enable 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.