

Registered pharmacy inspection report

Pharmacy Name: Mellors Pharmacy, Priory Health Centre, Priory Road, Warwick, Warwickshire, CV34 4NA

Pharmacy reference: 9011848

Type of pharmacy: Community

Date of inspection: 16/01/2023

Pharmacy context

This community pharmacy recently relocated into a brand-new health centre in Warwick. It dispenses prescriptions which are largely generated by the surgery on the same site. It sells a range of medicines over the counter and it supplies medicines in multi-compartment compliance packs to some people who need this support. The pharmacy offers the NHS New Medicine Service, the Community Pharmacist Consultation Service (CPCS), the Discharge Medicines Service (DMS), substance misuse treatment, seasonal flu vaccinations, the Hypertension Case Finding Service, sexual health services and prescription delivery service. It also runs a travel clinic and an otoscopy service.

Overall inspection outcome

✓ Standards 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	2.2	Good practice	The pharmacy has a good skill mix and it provides its staff with ongoing training to help to ensure that their knowledge and skills remain up to date.
3. Premises	Standards met	3.1	Good practice	The pharmacy's premises are fitted to a good standard and they project a professional appearance.
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy offers a wide range of services and these are tailored to the needs of the local community.
		4.2	Good practice	The pharmacy's services are well-organised and are provided by well-trained staff. People have good access to care and advice from pharmacists.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy has safe and effective working practices. It has written procedures to help deliver its services safely. And it keeps the records it needs to, to show that medicines are supplied safely and legally to people. Members of the pharmacy team record and review their mistakes so that they can learn and improve from these events. The pharmacy keeps people's private information securely and its team members know how to protect vulnerable people.

Inspector's evidence

The pharmacy had a range of in-date standard operating procedures (SOPs), and these had been read and signed by team members. The correct responsible pharmacist (RP) notice was on display and team members could explain the tasks they could not undertake in the absence of a pharmacist.

The pharmacy manager explained the process team members would follow to record and report dispensing mistakes. Dispensing mistakes which were identified before the medicine was handed out to a person (near misses) were routinely recorded and reviewed. A report about near misses was generated and discussed with team members to share any learnings. Dispensing mistakes that had reached people (dispensing errors) were recorded, reviewed and submitted to the superintendent pharmacist (SI). Higher-risk medicines including valproate, and medicines with similar names, such as quetiapine and quinine had been highlighted and separated to minimise picking errors. The pharmacy manager said the pharmacy team was very experienced and dispensing mistakes had decreased significantly since the installation of a new, advanced, patient medication record (PMR) system. And the new PMR system had fundamentally changed the way the pharmacy operated. It had created efficiencies in how the pharmacy processed its prescriptions, managed its workflow, handed out prescriptions to people and communicated with them.

The pharmacy had current indemnity insurance. Records about controlled drugs (CDs), RP, unlicensed medicines and private prescriptions were kept in line with requirements. A random balance check of a CD was correct. Running balances of CDs were kept and audited at regular intervals. A separate register was used to record patient-retuned CDs.

The pharmacy had a complaints procedure and it encouraged people to give feedback about the quality of its services. The company also had mystery shoppers which visited the pharmacy every six to nine months to assess how well it was being managed. The pharmacy had performed very well in the last mystery shopper survey. A digital customer feedback machine had been installed by the entrance of the pharmacy and people visiting the pharmacy could rate their overall experience. Feedback was collated centrally at the pharmacy's head office and results were shared with branches monthly. The pharmacy manager said that the relocation of the pharmacy into the health centre had been well received by the local community and the team had received positive feedback.

The pharmacy was registered with the Information Commissioner's Office (ICO) and it displayed a fair data processing notice. Its computers were password protected. And team members used their own NHS smartcards to access electronic prescriptions. Completed prescriptions were stored securely. No person-identifiable information was visible to members of the public. Confidential waste was separated from general waste, and this was taken away by a specialist waste contractor for secure destruction.

The pharmacy had informative governance procedures and members of the pharmacy team had completed training about the General Data Protection Regulation.

The pharmacy manager had completed level 3 training about safeguarding. And the support pharmacist and technicians had completed level 2 safeguarding training. Details about the pharmacy's chaperone policy were displayed in the pharmacy's consultation room.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough skilled team members to deliver its services safely and effectively. Members of the pharmacy team work well together, and they are very well supported by their pharmacy manager. They can raise concerns or make suggestions to help improve the pharmacy's services. And they have access to training resources to help keep their skills and knowledge up to date.

Inspector's evidence

At the time of the inspection, the pharmacy team consisted of a pharmacy manager, a second pharmacist, an accuracy checking technician, three trained dispensers and two medicine counter assistants. Members of the pharmacy team worked well together, and they were managing their workload comfortably. And they demonstrated a good rapport with people visiting the pharmacy. Most of the staff including the pharmacists had worked at the pharmacy for a considerable length of time. A team member said they felt comfortable making suggestions or raising concerns with the pharmacy manager. A whistleblowing policy had been signed by all team members.

Members of the pharmacy team were well supported with on-going training which was provided through the company's in-house training platform. Team members were given time during working hours to help complete their monthly training. And each team member had a training portfolio and records about recently completed training were available in the pharmacy. The pharmacy's head office sent monthly SI newsletters to the branches to share learnings and good practice. There were set targets for team members but the company did not incentivise its services. The pharmacy manager said that the pharmacy was performing well against its targets.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy's premises are fitted to a good standard. And they are professional in appearance and suitable for the provision of healthcare services. They are kept secure from unauthorised access.

Inspector's evidence

The pharmacy was bright, clean and fitted to a good standard throughout. And it was accessible to people with mobility difficulties. The pharmacy's medicines counters and the digital self-booking appointment platform had been fitted at a lower level, making them more accessible to people who used wheelchairs. The retail area was spacious and there was enough seating for people waiting for services. And it was kept clear of slip or trip hazards.

The dispensary had enough space to store medicines and undertake its workload safely. It was separated from the retail area and afforded good privacy for the dispensing operation and any associated conversations and telephone calls. A clean sink with hot and cold running water was available for preparing medicines. Room temperatures in the premises were controllable, and levels of ventilation and lighting were suitable for the activities undertaken. A private signposted consultation room was available and it was kept clean and tidy. The pharmacy could be secured against unauthorised access.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy manages its services well to ensure people get appropriate care and support to manage their medicines safely. People with different needs can access the pharmacy's services. The pharmacy gets its medicines from licensed wholesalers and stores them correctly. And members of the pharmacy team take the right action in response to safety alerts and recalls so that people get medicines and medical devices that are safe to use.

Inspector's evidence

People could access the pharmacy via the health centre. The health centre had a car park for people to use. The health centre had automated doors and its entrance had a ramp from the outside pavement to help assist people with mobility difficulties. The pharmacy's opening hours and the services it offered were very well advertised via various digital screens throughout the retail area. People waiting for services could use the surgery's spacious waiting area. The pharmacy manager said that members of the pharmacy team shared a good relationship with the surgery. And they demonstrated a very good rapport with people visiting the pharmacy.

The pharmacy offered a medicine delivery service mainly to housebound and vulnerable people. The pharmacy's delivery driver kept a record for all deliveries of medicines. The pharmacy also had an automated collection system which meant that people could collect some dispensed prescriptions even when the pharmacy was closed. The pharmacy manager said the system had the capacity of storing at least 200 prescription bags. And approximately 50 collections per week were collected via the automated system. CDs and temperature-sensitive medicines were not included in the automated collection system. The pharmacy manager said that the service had had a very positive impact overall on the workload and enabled people to collect their medicines at their convenience.

The pharmacy manager said the Hypertension Case-Finding service was becoming busier and the pharmacy was receiving referrals from local hospitals and surgeries in the area. An ambulatory blood pressure (BP) monitoring machine was used to monitor people's BP over extended periods of time and team members had completed appropriate training to be able to deliver the service safely. The pharmacy manager said that, prior to commencing the service, he had fitted the machine on himself so that he could understand any issues his patient's may experience wearing it and how to support them better.

The pharmacy had begun delivering its flu vaccination service in late September and had administered approximately 1100 vaccinations to-date. Appropriate anaphylaxis resources were available in the pharmacy.

The pharmacy's otoscopy service was very popular amongst the elderly population. People presenting in the pharmacy with ear problems were asked to consent to a consultation with the pharmacist who then took a clinical history and performed a physical ear examination using an otoscope. People were provided with self-care advice to manage their symptoms (including what to do if their symptoms persisted or worsened) and/or recommended an over-the-counter (OTC) treatment if appropriate. Where the assessment suggested the symptoms were due to something more serious for example an infection, the pharmacy had the facility to transmit photographic evidence to the surgery so that

alternative treatment could be provided.

The pharmacy's dispensing process was mainly automated. The pharmacy's IT system had the facility for pharmacists to undertake clinical checks online and identify any higher-risk prescriptions such as methotrexate, CDs and sodium valproate that needed pharmacist's input at hand-out. The dispensing labels were printed with a QR code which provided a robust audit trail at each stage of the dispensing process. The accuracy checking technicians completed the final accuracy check where appropriate. The workflow in the pharmacy was very well organised. Members of the pharmacy team used baskets during the dispensing process to prioritise workload and minimise the risk of prescriptions getting mixed up. 'Owing' notes were issued to keep an audit trail when the prescriptions could not be supplied in full when first dispensed.

Members of the pharmacy team knew that prescriptions for CDs not requiring secure storage such as Tramadol, had a 28-day validity period. The pharmacy manager said that the pharmacy's digitalised prescription retrieval system also alerted team members if a prescription had expired or if the pharmacist's input was required to provide additional advice on any higher-risk medicines. The pharmacy kept very good records of any interventions and counselling points. And communications with other healthcare professionals were well documented.

Members of the pharmacy team were aware of the additional precautions needed when supplying valproate-containing medicines to people in the at-risk group. The pharmacy was currently undertaking the national valproate clinical audit with the aim of reducing the potential harm caused by taking valproate during pregnancy. The stock packs on the shelves included the appropriate warning cards. The pharmacy had additional information leaflets available but it did not currently supply valproate-containing medicines to anyone in the at-risk group.

The pharmacy ordered its stock medicines from licensed wholesalers, and these were stored tidily on the shelves. No extemporaneous dispensing was carried out. Pharmacy-only medicines were restricted from self-selection. Stock medicines were dated checked and short-dated medicines were marked for removal at an appropriate time. Medicines were randomly checked during the inspection and no date-expired medicines were found amongst the in-date stock. Temperature-sensitive medicines were stored appropriately, and the maximum and minimum temperatures of the fridges were recorded daily. The records showed that the temperatures had been maintained within the required range of 2 and 8 degrees Celsius.

All CDs were stored appropriately in the CD cabinet. The cabinet was tidy and well-organised. Access to the CD keys was managed appropriately. The pharmacy had denaturing kits to dispose of waste CDs safely.

The pharmacy had a process to deal with safety alerts and medicines recalls making sure the medicines it supplied to people were fit for purpose. Records about these and the action taken by team members were kept, providing an audit trail.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

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

Inspector's evidence

Members of the pharmacy team had access to up-to-date reference sources. There was a range of clean crown-stamped measures, with separate marked measures used for certain liquids. Equipment for counting loose tablets and capsules was clean. And a separate triangle was used for cytotoxic medicines. Medicine containers were capped to prevent cross-contamination. The pharmacy's computers were password protected and computer terminals were not visible to people visiting the pharmacy. Hand-sanitising gels were available at the medicines counter and in the dispensary. All electrical equipment appeared to be in good working order.

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.