

# Registered pharmacy inspection report

**Pharmacy Name:** Morrisons Pharmacy, The Waterside, 127 High Street, Brentford, Middlesex, TW8 8EW

**Pharmacy reference:** 9012216

**Type of pharmacy:** Community

**Date of inspection:** 20/03/2024

## Pharmacy context

A Morrisons community pharmacy in the centre of Brentford. The pharmacy is within a branch of a Morrisons supermarket which relocated approximately six months ago. The pharmacy provides a prescription dispensing service. And it sells a range of over-the-counter medicines. It gives general healthcare advice. And provides a range of other services such as a hypertension case finding service, the Pharmacy First service. And sexual health services including chlamydia screening.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy has suitable written procedures in place to help ensure that its team members work safely. And the team understands and follows them. The pharmacy has insurance to cover its services. And it completes the records it needs to by law. The pharmacy team knows how to protect the safety of vulnerable people. And it protects people's confidential information properly. The pharmacy identifies and manages the risks associated with its services. Team members respond appropriately when mistakes happen. And they take suitable action to prevent mistakes in the future.

### Inspector's evidence

The pharmacy had a system for recording its mistakes. And it generally reviewed them each month. The responsible pharmacist (RP) was also the manager. And she worked at the pharmacy full time. She highlighted and discussed 'near misses' and errors as soon as possible with the team member involved to help prevent the same mistake from happening again. In general, records for individual near misses showed why a mistake might have happened but not what the team member had learned or what they would do differently next time to improve. The inspector and RP discussed the importance of ensuring that near miss records were used to encourage team members to learn and improve. But it was clear that the team acted in response to its mistakes. It had discussed the risk of making mistakes with look-alike sound-alike medicines (LASAs). It had also separated common products which could be mistaken for each other. And team members made additional checks when dispensing them. As a result, the pharmacy had not had any LASA mistakes in recent months. The RP described how she often circled the form or strength of less commonly prescribed items on a prescription. She did this to alert the team to select the right one. The team were also aware of the risk of dispensing the wrong quantity of medicine. And so, the RP had reminded team members to mark all split packs of stock items clearly. They did this to make it clear to other team members that the pack was not full when they came to dispense it. The team used a bound record book to record near misses. And to record its findings from its reviews each month. This made it easy to reflect not only on the month currently under review but also the months before. And so, the RP could monitor whether the improvements and learnings from previous months had been sustained.

The pharmacy had a set of up-to-date standard operating procedures (SOPs) for its team members to follow. Team members had read and signed them. And they appeared to understand and follow them. The medicines counter assistant (MCA) was also a dispensing assistant (DA). She consulted the RP when she needed her advice and expertise. And she asked appropriate questions before handing people's prescription medicines to them. Or selling a pharmacy medicine. She also gave appropriate advice to people whose medicines were unavailable. She did this to ensure that people could choose to go to another pharmacy. And to ensure that, where possible, they did not go without their medicines. The RP had placed her notice on display where people could see it. The notice showed her name and registration number as required by law.

People gave feedback directly to team members with their views on the quality of the pharmacy's services. The pharmacy also had a complaints procedure to follow. The pharmacy had a leaflet which it could provide to people. The leaflet had details of the pharmacy's services. And it had details of how people could register a complaint with head office or the NHS if they needed to. The team could also obtain details of the local NHS complaints procedure online if necessary. But the team usually dealt

with any concerns at the time. And it worked closely with local surgeries to ensure that people did not go without essential medicines. And it arranged for alternatives when it received a prescription for an item that it could not get. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers.

The pharmacy generally kept its records in the way it was meant to, including its emergency supply records. And its controlled drug (CD) registers. It kept a record of its CD running balances. And a random sample of stock checked during the inspection, matched the total recorded in the register. The pharmacy had a CD destruction register. So that it could account for the receipt and destruction of patient-returned CD medicines. And this was complete and up to date. Its RP record and its private prescription records were also in order. The pharmacy kept appropriate records for any emergency supplies it made. And team members understood the need to include a clear reason for making the supply. It was clear that the team understood the importance of ensuring that all the pharmacy's essential records were up to date and complete.

The pharmacy's team members understood the need to protect people's confidentiality. And they had completed suitable training. They discarded confidential paper waste into separate waste containers as they worked. And they shredded the contents of the containers regularly throughout the day. And they kept people's personal information, including their prescription details, out of public view. Team members had completed appropriate safeguarding training. And they knew to report any concerns to the pharmacist. The team could access details for the relevant safeguarding authorities online. And it had made a safeguarding referral recently.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough suitably trained and skilled team members for the tasks it carries out. The pharmacy team manages its workload safely and effectively. And team members support one another well. They are comfortable about providing feedback to one another, so that they can improve the quality of the pharmacy's services.

### Inspector's evidence

On the day of the inspection the RP worked with a locum technician and four DAs. One of the DAs worked mainly on the counter. The locum technician worked at the pharmacy periodically. And he was there to provide additional support when the pharmacy was short staffed. The technician had trained in surgery support services. And he had also trained in mental health and all the pharmacy's services including Pharmacy First. So that he could support the team. The DAs had all worked at the pharmacy for some time and were established members of the team. Team members all attended to their allocated tasks. Their tasks included the dispensing of multi-compartment compliance packs, downloading and preparing the days electronic prescriptions or completing prescriptions with outstanding items to be dispensed. The DA responsible for managing and dispensing compliance packs had read the relevant compliance pack SOP. And he followed the steps described in the SOP. The team attended promptly to people at the counter. They were efficient and calm. And they supported one another, assisting each other when required. The team had the daily workload of prescriptions in hand. And it kept on top of its other responsibilities. Team members assisted each other when needed. And together they dealt with queries promptly.

Team members had formal appraisals about their work performance each year. And they discussed issues as they worked day-to-day. They described feeling supported in their work. And they could make suggestions about how to improve the general workflow. They could also raise concerns with the RP if they needed to. The RP felt supported by the area manager and the SI. And while she had a small number of NHS targets to meet, she felt that she could manage these. And she felt able to make day-to-day professional decisions in the interest of people.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises provide an environment which is adequate for people to receive its services. And they are sufficiently clean, tidy and secure. But the pharmacy did not have enough storage space.

### Inspector's evidence

The pharmacy was situated on a side wall within the supermarket. And people could access it without having to enter the main retail area of the store. After the supermarket relocated to its new site six months ago, the pharmacy had been newly fitted out. And it had a professional appearance. The pharmacy had a consultation room and a small retail area with seating for waiting customers. The consultation room provided a place for people to receive pharmacy services or have a private conversation with the pharmacist. And the room was close to the counter and dispensary. The pharmacy kept the consultation room door locked from the patient access side. And people did not enter the room without being accompanied by a team member. The pharmacy had a short pharmacy counter with an opening on one side. The opening provided access to the dispensary and the area behind the counter for staff and authorised visitors. The pharmacy kept its small range of pharmacy medicines behind the counter. General, non-pharmacy medicines could be found within the general store.

The pharmacy had enough space for team members to dispense prescriptions including the pharmacy's multi-compartment compliance packs. It had dispensing worksurfaces on three sides. Which were used for all the pharmacy's dispensing activities. And it had storage facilities above and below the worksurfaces. It also had full height drawer units running along its remaining wall. The pharmacy had a cleaning routine. And it tried to keep its worksurfaces tidy and organised. It cleaned its work surfaces and equipment regularly. Team members also cleaned floors regularly and it tried to keep them tidy. But it had a lack of storage space for storing its dispensed prescription items. And so, it had to store them in several different areas of the dispensary including the floor. This made the dispensary cluttered in areas. At the time of the inspection room temperatures were appropriate to keep staff comfortable and were suitable for the storage of medicines. The pharmacy did not have its own staff facilities. But team members used those provided for all store staff.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides its services safely and makes them accessible to people. It supports people with suitable advice and healthcare information. The pharmacy team gets its medicines and medical devices from appropriate sources. And team members make the necessary checks to ensure they are safe to use and protect people's health and wellbeing. The pharmacy ensures that all its medicines are stored correctly and safely.

### Inspector's evidence

The supermarket had a large open doorway which provided step-free entry. And the pharmacy was at ground level close to the supermarket entrance. The area around the pharmacy was free of unnecessary obstacles, making it suitable for people with mobility issues. The pharmacy could also order people's repeat prescriptions if required. And it had information on its windows promoting its services. The team used baskets to hold individual prescriptions and medicines during dispensing to help prevent errors. It also supplied medicines against private prescriptions, some of which came from private online prescribing services.

The pharmacy received most of its prescriptions from the local health centre. The RP worked there on a part-time basis. And she had a good working relationship with them. The pharmacy provided medicines in multi-compartment compliance packs for people living at home who needed them. The pharmacy managed the service according to a four-week rota. And each month it checked and verified any changes to prescriptions. And it updated people's records. Completed compliance packs had been labelled with a description of each medicine, including colour and shape, to help people to identify them. The pharmacy supplied patient information leaflets (PILs) with new medicines and with regular repeat medicines. And so, people had all the necessary information about their medicines to help them to take their medicines properly. The RP gave people advice on a range of matters. And she would give appropriate advice to anyone taking higher-risk medicines. The pharmacy had additional leaflets and information booklets on a range of medicines including sodium valproate. And it had a small number of people taking sodium valproate medicines, some of whom were in the at-risk group. The RP counselled people when supplying the medicine to ensure that they were aware of the risks associated with it. And to ensure they were on a pregnancy prevention programme as appropriate. The RP also provided warning cards and information leaflets with each supply. And she was aware of recent changes in the law about supplying valproate medicines in their original packs. The pharmacy offered the recently introduced NHS Pharmacy First service. This allowed people to access medicines for seven common conditions after an appropriate consultation with the pharmacist. And without having to see a GP. The pharmacy had received requests directly from people. But referrals from its local GP surgeries were currently low. The team understood this to be due to GP practices not yet fully understanding the way the service worked. The pharmacist had the appropriate protocols to follow. And she kept the necessary records for each supply. It was clear that she understood its limitations and when to refer people to an alternative health professional. The pharmacy offered a hypertension case finding service. The RP had referred several people to their GPs following a high blood pressure reading. And she kept appropriate records. People identified as not suitable for the service had been referred to another healthcare professional where appropriate.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate

licences. And the team stored its medicines, appropriately. And stock on the shelves was tidy and organised. The pharmacy checked the expiry dates of its stocks, regularly. And it kept records so that team members knew what had been checked. And when. This meant that the team could monitor the pharmacy's entire stock for expiry dates effectively. When the team identified any short-dated items it highlighted them. And it only dispensed them with the patient's agreement where they could use them before the expiry date. The team put its out-of-date and patient-returned medicines into dedicated waste containers. And a random sample of stock checked by the inspector was in date. The team stored its CD and fridge items appropriately. And it monitored its fridge temperatures to ensure that the medication inside it was kept within the correct temperature range. The pharmacy responded appropriately to drug recalls and safety alerts. But the team had not had any stock affected by recent recalls.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide services safely. The team uses its facilities and equipment to keep people's private information safe.

### Inspector's evidence

The pharmacy had the appropriate equipment for counting tablets and capsules and for measuring liquids. And its equipment was clean. Team members had access to a range of up-to-date reference sources. The pharmacy had several computer terminals which had been placed in the consultation room and in the dispensary. Computers had password protection. And they had a time-out function to ensure they did not remain accessible when unattended for any length of time. Team members understood the importance of using their own smart cards. And they understood that this was necessary to ensure that they each had the appropriate level of access to records for their job roles. And to maintain an accurate audit trail. The pharmacy had cordless telephones to enable team members to hold private conversations with people. And it stored its prescriptions in the dispensary out of people's view.

### 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.