

# Registered pharmacy inspection report

**Pharmacy Name:** Birchall & Haydock, The Square, Wickham,  
FAREHAM, Hampshire, PO17 5JQ

**Pharmacy reference:** 1031704

**Type of pharmacy:** Community

**Date of inspection:** 23/09/2020

## Pharmacy context

This is an independently run, local community pharmacy, in the village of Wickham. It dispenses prescriptions and sells over-the-counter medicines. And it supplies medicines in multi-compartment compliance aids. It provides a delivery service for the vulnerable and housebound. And the pharmacy also provides drug treatment services to people who have developed a dependency from substance misuse. The pharmacy was also offering a flu vaccination service. The inspection was conducted during the COVID-19 pandemic. The pharmacy had limited its range of services due to the 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
<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 satisfactorily identifies and manages the risks associated with the provision of its services. And it has working practices which reduce risks to people's safety during the COVID-19 pandemic. Team members manage people's personal information securely. And they respond well to feedback. The pharmacy has written procedures in place to help ensure that its team members work safely. The pharmacy has insurance to cover its services. Team members know how to protect people's private information and know how to protect the safety of vulnerable people. The pharmacy has adequate procedures to learn from its mistakes. But by not reviewing them more frequently it could be missing further opportunities to learn and improve.

### Inspector's evidence

The most recent figures showed that the number of cases of COVID-19 in the area was lower than the national average for England for the previous week. To help reduce the risk of spreading coronavirus, the pharmacy had reviewed its working practices to reduce risk for its team members and the public. Team members wore masks when they were speaking to people at the counter and generally tried to keep more than one metre apart from them. Although not all staff wore masks when working in the dispensary, they generally worked at their own workstations such that they faced away from one another. And in general, only one assistant worked at the medicines counter at any time. The pharmacy had placed a limit on the number of people coming into the pharmacy, where no more than three to four people should be in at one time. Team members had also applied tape lines to the floor, two metres apart, to show people where to stand when they were waiting to approach the counter. When the pharmacy got busy, people stood outside waiting their turn to come in. The inspector and RP discussed how the pharmacy team would manage to maintain this in poor weather. The RP and inspector also discussed the importance of having contingency plans in place to ensure that the pharmacy would be able to maintain its services in the event of closure due to the COVID-19 pandemic. The RP was reminded of the requirement to report any COVID-19 infections, believed to have been contracted at work, to the relevant authorities.

The pharmacy had procedures for managing risks in the dispensing process. Team members discussed every incident, including their near miss mistakes, as soon as they were discovered. And they recorded them. They did this to help prevent the same or similar, mistakes from happening again. The inspector and RP discussed these records and the importance of recording the learnings and actions arising from near misses. They agreed that records should show what staff could do differently to help prevent similar mistakes in future. Team members made each other aware of similarly packaged items and look-alike-sound-alike drugs (LASAs) like bendroflumethiazide 2.5mg tablets and bisoprolol 2.5mg tablets which they had separated onto different shelves to help prevent staff from picking the wrong ones. They had also placed warning stickers on shelf edges in front of products at risk of error. But while the pharmacy had a process for reflecting on and reviewing its mistakes, it had not held a formal review meeting for a few weeks. So, while it was clear that the team recognised and acknowledged any apparent risks to safety, including any mistakes it made, it could be missing further opportunities to learn and improve.

The team worked under the supervision of the responsible pharmacist (RP). The RP's notice had been

placed on display for people to see. The pharmacy had a set of standard operating procedures (SOPs) for team members to follow. The SOPs had been reviewed earlier in the year. Several procedures included additional measures to help reduce the risk of coronavirus being transmitted in the pharmacy. The pharmacy team sought customer feedback through satisfaction surveys and general conversations with people. The customer satisfaction survey from 2019 demonstrated a high level of customer satisfaction overall. The pharmacy had responded well to a GPhC inspection conducted several months earlier and had taken action to improve on the points raised at the time. But the team had also received complaints from people who did not understand why the pharmacy was restricting the number of people coming into the pharmacy and did not want to wait outside. It had also received complaints when the team decided to close the pharmacy so that it could catch up on its dispensing workload. Some people had been aggressive towards them. The team took time to explain its responsibilities to people. Staff offered the pharmacy's delivery service and, on occasion, took people's prescriptions to them while they waited in their cars. But the team agreed that this additional demand on their time could not be sustained longer term.

The pharmacy had a complaints procedure which corresponded with NHS guidelines. It had leaflets on display explaining the procedure for people. And it had a SOP for staff to refer to. But customer concerns were generally dealt with at the time by the regular pharmacist. Staff could provide details of the local NHS complaints advocacy service and the Patient Advice and Liaison service (PALS) if necessary. The pharmacy had professional indemnity and public liability arrangements so it could provide insurance protection for the pharmacy's services and its customers. Insurance arrangements were in place until 31 March 2021 when they would be renewed for the following year.

The previous inspection found that in general the pharmacy was keeping its records in the way it was meant to, but some records were incomplete. This inspection found that the team was now recording its private prescriptions in the way it should. And record keeping for unlicensed medicines was now in order. This inspection also found that RP records showed who the RP was each day. But on a few occasions the RP had not logged out at the end of their shift prior to a different RP logging on the next morning. The RP on duty recognised the importance of maintaining an accurate record and agreed that the records should be up to date and accurate.

The pharmacy's team members understood the need to protect people's confidentiality. They shredded any unused labels and old prescription tokens as they worked. And emptied the shredder daily. The pharmacy stored its completed prescriptions in the dispensary where they were out of people's view. The RP had completed appropriate safeguarding training. And other team members knew to raise any concerns with her. The RP could access details for the relevant safeguarding authorities online. Staff had not had any specific safeguarding concerns to report. But felt that they had been of good service to people locally throughout the pandemic by answering their queries, listening to their concerns and signposting when appropriate.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy team manages the workload safely and effectively. And team members work well together. They are comfortable about providing feedback to one another, so that they can maintain the quality of the pharmacy's services.

### Inspector's evidence

The pharmacy had a medicines counter assistant (MCA) and two dispensers on duty with the RP at the time of inspection. Staff had read all the relevant SOPs. And the MCA was observed consulting the pharmacist when she needed to. During the early days of the pandemic the RP had identified vulnerable members of the team who had been required to shield. But since then the pharmacy had not carried out specific risk assessments for individual team members. The inspector discussed this with the RP who agreed that she would seek the support of head office. So she could complete the assessments and identify any individual vulnerabilities for her team.

Team members were observed to work effectively together. They were seen assisting each other when required and discussing prescription issues. The daily workload of prescriptions was in hand and customers were attended to promptly. The pharmacy had a small close-knit team and staff could to raise concerns and discuss issues when they arose. The RP was able to make her own professional decisions in the interest of patients. She did not have any specific targets other than to manage the daily workload while keeping each other, and people using the pharmacy, safe.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises provide a suitable environment for people to receive its services. They are sufficiently clean and secure. The pharmacy has made some sensible adjustments to help keep people safe during the pandemic

### Inspector's evidence

The pharmacy was located inside a listed building with three floors. The dispensary and shop area were on the ground floor. A stock room, staff areas and a room used by a chiropodist were on the first floor. The second floor was not used. The dispensary was small but had adequate space available to dispense prescriptions. The pharmacy was bright, well-ventilated and professional in appearance. And it was clean. The pharmacy had access to hot and cold running water downstairs and in the staff WC. The pharmacy had a consultation room near the dispensary entrance which the pharmacist used for private conversations and services including flu vaccinations. The room was of a suitable size for the pharmacy's services and was free of confidential information. Staff were seen to clean down the consultation room and other surfaces and equipment during the inspection.

The medicines counter was immediately in front of the dispensary. And it had a plastic screen across the area where most people would stand, to help reduce the spread of the coronavirus. There were notices in the window near the entrance advising people of the need to maintain social distancing and to wear a face covering. There was also a notice limiting the number of people in the pharmacy to three at a time. The pharmacy had a consultation room available for confidential conversations, consultations and the provision of services. The pharmacy also had a small seating area for waiting customers. Room temperatures were appropriately maintained to keep staff comfortable and were suitable for the storage of medicines.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides its services safely. And makes them readily available to people. Staff understand the actions to take if any medicines or devices are not safe to use to protect people's health and wellbeing. The pharmacy team gets its medicines and medical devices from appropriate sources. And checks the appropriateness of its medicines to ensure that they are supplied safely.

### Inspector's evidence

The pharmacy had a small step at its entrance. But team members would assist anyone with restricted mobility as soon as they saw them. This included wheelchair users and those with a physical disability. The pharmacy had a sign in its front window advertising the times of opening and services provided. It also had a range of healthcare leaflets on display. The retail area was free of obstructions. So, it was suitable for wheelchair users. The consultation room was also suitable for wheelchair access. Staff could provide large print labels if required and had equipment to help people with visual impairment, including a magnifying glass. They would also provide written communications for people who were partially deaf when appropriate.

The pharmacist gave advice on a range of matters. She was aware of the guidance about pregnancy prevention to be given to people in the at-risk group who took sodium valproate. And would give appropriate advice to anyone taking other high-risk medicines. The pharmacist discussed how she would check International Normalised Ratio (INR) values for people taking warfarin before supplying it, to ensure the dose was appropriate. She was also in talks with local GPs to identify people who may be affected by the discontinuation of Priadel.

The pharmacy team used baskets to hold individual prescriptions and medicines during dispensing. It did this to keep prescriptions and their corresponding medicines together. It also had a retrieval system which made it relatively efficient to find a completed prescription. And the team highlighted CD prescriptions with a 28-day expiry date so that they were not supplied after the appropriate date. Prior to the pandemic lockdown the pharmacy removed any uncollected items after two to three months. But the team had fallen behind with this in recent months. The RP agreed that this was a task that should be completed regularly to ensure that prescriptions were not inadvertently handed out after their expiry date, and also to free-up valuable storage space. The pharmacy supplied medicines in multi-compartment compliance packs for a number of people. Compliance packs had been labelled appropriately and had the required advisory information to help people take their medicines properly. The labelling information on compliance packs gave the medicine's shape and colour to assist with easy identification. And the pharmacy included patient information leaflets (PILs) with each compliance pack to make sure that people had the manufacturer's additional information if they needed it.

The pharmacy offered a flu vaccination service although was having difficulty obtaining enough vaccines. The pharmacist carried out a vaccination during the inspection and was observed to follow an appropriate routine when donning and doffing PPE. She was observed washing or sanitising her hands before and after each consultation and before and after donning and doffing PPE. The MCA was seen to clean down all surfaces, equipment and door handles in the consultation room after use. People were asked to sanitise their hands at the pharmacy entrance and again before entering the consultation room and after leaving it. And were provided with a mask to wear if they had forgotten to bring their

own face covering.

The pharmacy obtained its medicines and medical devices from suppliers holding the appropriate licences. The team stored its medicines, appropriately and in their original containers. And stock on the shelves was generally tidy to assist selection of the correct item. The pharmacy team regularly date-checked its stock. And a random selection of stock showed it to be in-date. The team put its out-of-date and patient returned medicines into dedicated waste containers, as appropriate. The pharmacy team stored its CDs and fridge items as required. Fridge temperatures were within range. And records showed that the fridges stored medicines correctly between 2 and 8 degrees Celsius. CD stock was stored appropriately. And the pharmacist carried out a stock balance of a CD each time it was dispensed from the CD cabinet.

The team was aware of the separate disposal arrangements for hazardous medicines and had a dedicated waste bin for their disposal. Team members also had a list of hazardous waste to refer to. The list was on display next to the waste bins to ensure that they disposed of all medicines appropriately. Team members were also aware of the importance of responding to drug recalls and safety alerts and they were prompt in identifying and responding to these.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

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

### Inspector's evidence

The pharmacy used crown marked measures for measuring liquids. It had equipment for counting tablets and capsules, including a separate tablet triangle for methotrexate. Team members had access to a range of up-to-date reference sources. And they had access to PPE, in the form of face masks, aprons and gloves, which were appropriate for use in pharmacies. Team members had sanitisers to hand. They washed or sanitised their hands at regular intervals throughout the day and after handling money. The pharmacy had a legally compliant CD cabinet and a fridge.

The pharmacy had three computer terminals with a facility for keeping patient medication records (PMRs). Two of these were in the dispensary where they were needed most. The third, in the consultation room, did not function well and so was not used. The team had an additional computer which was solely for care home dispensing. This computer was not linked to the pharmacy's PMR system. The dispensary computers had been positioned in a way that meant that staff members using them were either suitably apart or facing away from one another. Computers were password protected and positioned so that people could not view them. Team members generally used their own smart cards when working on PMRs, so that they could maintain an accurate audit trail and ensure that access to patient records was appropriate and secure. The pharmacy had a shredder so that it could dispose of confidential waste appropriately.

### 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.