

Registered pharmacy inspection report

Pharmacy Name: Chapelhouse Pharmacy, 194 Chapel House Road,
NELSON, Lancashire, BB9 0QW

Pharmacy reference: 1033730

Type of pharmacy: Community

Date of inspection: 17/05/2019

Pharmacy context

This is a community pharmacy in a residential area of the town of Nelson, Lancashire. The pharmacy sells over-the-counter medicines and dispenses NHS and private prescriptions. It also supplies medicines in multi-compartmental compliance packs to people living in their own homes. It is commissioned to provide the NHS health check service.

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 has adequate processes and procedures, so the team can manage the risks to its services. And it mostly keeps the records it must by law. But the team are unsure about how some of these records are kept. This makes it difficult to resolve queries when the regular pharmacist is absent. The pharmacy advertises how people can provide feedback and raise concerns. But the pharmacy team members cannot demonstrate how they have used the feedback to improve its services. The pharmacy generally keeps people's private information safe. It has adequate processes available to its team members, to help protect the welfare of vulnerable people. And the pharmacy team members know what to do if they have a safeguarding concern. The pharmacy's team members record some of the errors that happen with dispensing. And they discuss their learning. They sometimes use this information to learn and make changes to help prevent similar mistakes happening again. But, they don't always record all the details of why errors happen. So, they may miss out on learning opportunities.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). These procedures were set to be reviewed every two years. This ensured that they were still relevant and up to date. An index was not available. So, the team may find it difficult to find a specific SOP. The SOPs covered procedures such as taking in prescriptions and dispensing. The team members were seen working in accordance with the SOPs. The SOPs documented who was responsible for performing each task. The team members knew how important it was to ask the pharmacist if there was a task they were unsure about or felt unable to deal with.

A process was in place to report and record near miss errors that were made while dispensing. The pharmacist typically spotted the error and then made the team member aware of it. And then asked them to rectify it. A log was used to record details of the errors. But the team did not record every error made. No errors had been recorded since March 2019. The team sometimes forgot to record the details of the errors as they were often too busy. The team members rarely recorded the reasons why errors had happened. The regular pharmacist analysed the near misses each month. And the findings were informally discussed with the team. The team members discussed errors they had made in selecting the incorrect strength of simvastatin. The team members had separated the different strengths on the dispensary shelves to reduce the risk of the errors happening again. The team members were not aware of a process to record and analyse dispensing incidents as the regular pharmacist normally handled them. The regular pharmacist was not present during the inspection.

The pharmacy had a notice in the retail area which detailed how people could make a complaint. The pharmacy obtained feedback from people who used the pharmacy, through a community pharmacy questionnaire. The results of the survey covering from April 2018 to March 2019 was displayed in the retail area and were generally positive. But the information could be out of date. The team were not sure of the results of the latest survey. And they could not give an example of how they used the feedback to make any improvements to the pharmacy's services.

The pharmacy had up to date professional indemnity insurance.

The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. The responsible pharmacists did not always record the times that their duties ended. This is not in line with requirements.

A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries were being made in chronological order. Running balances were maintained, but there was limited evidence of regular auditing. A random CD item were balance checked and verified with the running balance in the register (Fentanyl 50mcg X five). The team were unable to locate the CD destruction register for patient returned medicines.

The team were unsure how the pharmacy kept records of supplies of private prescriptions. A prescription register was in place, but it had not been used since 2016. It was possible the records were kept electronically, but the team needed to confirm this with the regular pharmacist. The records were not checked during the inspection. The pharmacy kept appropriate records of emergency supplies.

Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was then destroyed using a shredder.

The pharmacist on duty and a pharmacy assistant had completed training on safeguarding the welfare of vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). The team members gave several examples of symptoms that would raise their concerns. The team had access to the local safeguarding board's contact details. A short 'safeguarding children' guide was on display on a wall in the dispensary.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy employs people with the right skills and qualifications to undertake the tasks within their roles. The pharmacy supports its team members to complete training. And this helps them improve their knowledge and skills. They tailor their training to their own needs.

Inspector's evidence

At the time of the inspection, the responsible pharmacist was a locum pharmacist, who worked every Friday and alternate Saturday. A part-time trainee pharmacy assistant and a part-time counter assistant was supporting the pharmacist. The regular pharmacist was also the pharmacy manager and worked Monday to Thursday. Other team members who were not present included a full-time NVQ2 qualified pharmacy assistant, a pre-registration pharmacy graduate and a counter assistant. The team members often worked overtime to cover both planned and unplanned absences.

The pharmacist supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team was aware of what could and could not happen in the pharmacists' absence.

The pharmacy did not provide its team members with a structured process for ongoing learning. But it supported the team members to undertake training by giving them time to read trade press material sent to the pharmacy. The team members could tailor their learning to their needs. For example the counter assistant had recently asked for additional training on over-the-counter medicines as she wanted to improve her knowledge about active ingredients of the medicines, their age ranges and which conditions they treat. She had spent time reading the packaging of medicines. And was given ample opportunity to ask the pharmacist any questions.

The team members attended a team meeting which was held every one to two months. The meetings were an opportunity for the team to give feedback and suggest ways they could improve the service. The team discussed patient safety and talked about any errors openly and honestly. They could suggest ways to make improvements to the service provided. The team recently discussed creating a 'smoke-free home' window display. The display had advice on how smokers could try to keep their homes smoke-free and protect any babies and children from risk.

The team members confirmed that they were able to discuss any professional concerns with the pharmacist. And they were aware of how they could raise concerns externally if they required.

The pharmacy did not set the team any targets to achieve.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is secure and is adequately maintained. The pharmacy's facilities allow people to have private conversations with the team.

Inspector's evidence

The pharmacy appeared professional. And was generally clean, hygienic and well maintained. Floor spaces were mostly clear, with no obvious trip hazards. There was clean, well maintained sink in the dispensary used for medicines preparation and staff use. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing. The area was free of clutter.

The pharmacy had a sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance.

The first floor contained an office and a spacious stock room. The lighting was bright, and the temperature was comfortable throughout inspection.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides a range of services that can help people to meet their health needs. But not all of its processes are robust. So, it is sometimes difficult to monitor the safe delivery of services or to ensure that the medicines it supplies to people are fit for purpose.

The pharmacy team members give people advice when they supply high-risk medicines. But they don't always give people written information to help them take their medicines safely.

Inspector's evidence

The pharmacy had level access or via a ramp from the street which led to the automatic entrance door. This allowed easy access for people who used wheelchairs or other mobility aids. The pharmacy advertised the services it offered via a display in the front window. It provided seating for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. Several healthcare related posters were displayed in the retail area. The team were observed assisting people by speaking in Urdu.

The pharmacy was an accredited healthy living pharmacy. The team tried to promote a different healthy living campaign every few months. The team set up a window display to reflect each campaign. The team members were encouraged to promote the campaign to people who visited the pharmacy. The team had recently run a 'dry January' campaign.

The pharmacy was commissioned to provide NHS health checks. These checks involved people having a 30-minute consultation with a team member. The team member checked the person's body mass index (BMI), blood sugar and cholesterol levels. The person was given advice by the team member based on their results. The team only promoted the service via word of mouth, but it was a popular service. And they completed an average of five consultations a day.

The team members attached stickers to the prescriptions during the dispensing process to alert the pharmacist during checking of any issues, interactions or new medicines. And this also alerted team members during the hand out process, for example to the presence of a controlled drug or fridge line. The pharmacy had an audit trail for dispensed medication. The team achieved this by using dispensed by and checked by signatures on dispensing labels. The team members used separate areas to undertake the dispensing and checking parts of the dispensing process. They used baskets to keep prescriptions and medicines together. This helped prevent people's prescriptions from getting mixed up.

The team occasionally identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling by the pharmacist, if the pharmacist felt there was a need to do so. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. The pharmacy did not always assess the INR level. The team knew about the pregnancy prevention programme for people who were prescribed valproate. And they demonstrated the advice they would give people in a hypothetical situation. The team did not have access to any literature about the programme that they

could provide to people. The team hadn't completed any audits to identify people they regularly supplied valproate to.

People could request for their medicines to be dispensed in multi-compartmental compliance packs. The team were responsible for ordering the person's prescription. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team queried any discrepancies with the person's prescriber. The team recorded details of any changes, such as dosage increases and decreases, on the master sheets. The details of the prescriber authorising the change were not recorded. The team supplied the packs with backing sheets which contained dispensing labels. But they did not provide any information which would help people visually identify the medicines. The team supplied patient information leaflets to people each month as required by law.

The pharmacy kept basic records of the delivery of medicines from the pharmacy to people. The records did not include a signature of receipt, unless the medicine delivered was a CD. So, there was no audit trail for most deliveries. The pharmacy supplied people with a note when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy gave people owing slips when it could not supply the full quantity prescribed. One slip was given to the person and one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day.

The pharmacy stored pharmacy only medicines behind the retail counter. These medicines could only be sold in a pharmacy, and under the supervision of a pharmacist. The storage arrangement prevented people from self-selecting these medicines.

The team checked the expiry dates of stock every three months and they team kept a record of the activity. But the records were incomplete. No out of date medicines were found following a random check of the dispensary stock. The team used alert stickers to highlight any stock that was expiring in the next six months. The date of opening was not always recorded on liquid medication that had a short-shelf life once opened. And so, the pharmacy could not be certain that the medicine was still fit for purpose. The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The pharmacy did not have any software, installed scanners or a SOP available to assist the team to comply with the directive. The team had not received any training on how to follow the directive. The pharmacy stored medicines that were waiting to be collected, in a way that prevented people's confidential information being seen by members of the public.

The team used digital thermometers to record fridge temperatures each day. A sample of the records evidenced temperatures were within the correct range. But the temperature displayed was outside of the correct range during the inspection. And there was a build-up of ice on the back wall of the fridge. A new fridge was installed following the inspection.

The pharmacy obtained medicines from several reputable sources. It received drug alerts via email and the team actioned them. The pharmacy did not keep records of the action taken after the recall. So, it couldn't check the action taken in the event of a query.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The equipment and facilities the pharmacy uses in the delivery of services are clean, safe and protect people's confidentiality. But the pharmacy does not regularly check all the equipment it uses is fit for purpose.

Inspector's evidence

The pharmacy had several reference sources available. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children. The pharmacy used a range of CE quality marked measuring cylinders. And it had tweezers and rollers available to assist in the dispensing of multi-compartmental compliance packs.

The medical fridge was of an appropriate size. The medicines inside were well organised.

Electrical equipment was not subjected to portable appliance testing.

Two blood pressure machines were used to undertake the NHS health checks. But there was no record that they had been calibrated. The cholesterol monitor was calibrated each day.

The computers were password protected and access to people's records were restricted by the NHS smart card system. And computer screens were adequately positioned to ensure confidential information wasn't on view to the public. The computers were password protected. Cordless phones assisted in undertaking confidential conversations.

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.