

Registered pharmacy inspection report

Pharmacy Name: Campbells Chemist, 175 Poulton Road, WALLASEY, Merseyside, CH44 9DG

Pharmacy reference: 1034739

Type of pharmacy: Community

Date of inspection: 22/04/2021

Pharmacy context

The pharmacy is situated amongst a small number of retail shops in a residential area of Wallasey, in the Wirral area of Merseyside. The pharmacy dispenses approximately 9,500 NHS prescription items each month. It provides original pack dispensing to one care home with approximately 50 residents. It also provides a substance misuse service to 25 people (one supervised consumption), multi-compartment compliance aids for approximately 120 community patients and prescription collection and delivery as services. Conditions are in place on this pharmacy premises that prevent some services being provided. These conditions were imposed after failings were identified on a previous inspection and they remain in force.

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
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 generally manages the risks associated with its services and protects peoples' information. Members of the pharmacy team are clear about their roles and responsibilities. They record their mistakes so that they can learn from them. And act to help stop the same sort of mistakes from happening again. The pharmacy keeps the records required by law, but some information is missing, which could make it harder to understand what has happened if queries arise.

Inspector's evidence

Dispensing errors were reported on an incident report form which was reviewed by the superintendent. Near miss incidents were discussed with the pharmacy team member at the time and reported on the near miss log. The near miss log provided a history of near miss errors reported during the last 12 months. Near miss incidents and dispensing errors were reviewed for trends and patterns each month, and the outcome of the review was shared with the pharmacy team. Copies of previous reviews were present.

The pharmacy had a screen installed in front of the medicines counter. Social distancing measures were in place for people entering the premises, including, a restriction of the number of people permitted to enter the retail area at any one time. All team members wore personal protective equipment (PPE) throughout the day, which included a facial mask. And they had access to alcohol hand gel. A Covid-19 premises risk assessment had been carried out by the pharmacist.

Stickers were used to highlight prescriptions containing fridge medicines and controlled drugs (CD) that required safe custody. Prescriptions containing schedule 3 and 4 CDs were not highlighted. A dispenser explained that when prescriptions were handed out to patients, the name and address of the patient was clarified to ensure they received the correct medicines and she was observed following this process.

The responsible pharmacist (RP) notice was displayed conspicuously in the pharmacy. There were up to date Standard Operating Procedures (SOPs) for the services provided, with a signature sheet showing that members of staff had read and accepted them. Roles and responsibilities of staff were defined in the SOPs. A dispenser was seen to be following the 'dispensing' SOPs and was able to clearly describe her duties.

A customer satisfaction survey was carried out annually and the results of a previous survey were displayed in the pharmacy window. Where the pharmacy team had received patient feedback regarding stock availability issues, the prescriber had been contacted and asked to consider prescribing an alternative medicine. A dispenser explained how she dealt with customer complaints and said she referred to the pharmacist when necessary. The pharmacist aimed to resolve the complaint in the pharmacy at the time in his role as superintendent. A complaints procedure was available.

The pharmacy had public and professional indemnity insurance arrangements in place. The private prescription record and CD registers were in order. Records of CD running balances were kept and generally regularly audited, with exception of methadone which had been audited once in the last two months. Patient returned CDs were recorded and disposed of appropriately. The responsible

pharmacist (RP) record had the time the RP ceased their duty missing from some entries in the record. The emergency supply record had the reason for supply missing from some entries. The specials procurement record had the patient details missing from some records.

Confidential waste was placed in a designated bin and collected by an authorised carrier. A dispenser described what it meant to maintain patient confidentiality, including ensuring that no patient information was visible at the counter and said she had read and signed a confidentiality agreement as part of her employment contract. Assembled prescriptions were positioned on shelving or the floor in the dispensary, in a manner that protected patient information from being visible to customers. The computer was password protected for pharmacy staff. A dispenser said she would speak to the pharmacist if she had any concerns about children or vulnerable adults. Up to date numbers for safeguarding contacts were available. The pharmacist had completed safeguarding training with CPPE. Safeguarding children and vulnerable adult SOPs were in place.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. The team members are comfortable about providing feedback to the pharmacist. And they receive feedback on their performance. The pharmacy enables its team members to act on their own initiative and use their professional judgement, but they lack a structured approach to ongoing training could mean their skills and knowledge may not always be up to date.

Inspector's evidence

There was the superintendent pharmacist, three dispensers and two medicines counter assistants on duty at the time of the inspection. The staff appeared to manage the workload adequately. Mandatory training for team members involved reading the SOPs relevant to their roles, including, any revisions or new SOPs introduced. A dispenser explained that she and the other team members had completed online training modules periodically and providing training certificates for a mental health module completed in the last six months. She said she had not completed any further training recently. All team members had received an appraisal with the superintendent in the last year, but copies of these were not present.

A dispenser said she felt there was an open and honest culture in the pharmacy, she wasn't blamed for near miss or dispensing errors that she was involved with and they were an opportunity to learn. The pharmacy team members said the superintendent and other part-time pharmacists were supportive and answered any pharmacy related questions they may have had. The pharmacy team members were aware of who to speak to if they had a concern about another member of the team. i.e. in the first instance they said they would normally speak to the superintendent.

The pharmacist had provided the medicines counter assistants with a list of medicines sold over the counter, that may be liable to abuse. The list was displayed behind the medicines counter and when any of these medicines were requested it was referred to the pharmacist for their approval of the sale. A counter assistant was clear about her role. She knew what questions to ask when making a sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and was clear what action to take if she suspected a customer might be abusing medicines such as co-codamol. i.e. she referred them to the pharmacist for review. The pharmacist said he had not set any specific performance targets.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy is safe, clean, and properly maintained. The layout is appropriate for the services provided.

Inspector's evidence

The pharmacy's retail area and dispensary were clean. The retail area had a waiting area. All pharmacy staff were responsible for keeping the premises clean and tidy, with all areas cleaned on a regular basis. The temperature in the pharmacy was controlled by heating units. Lighting was adequate. The pharmacy premises were maintained and in an adequate state of repair. Maintenance problems were reported to the superintendent. Pharmacy team facilities available were clean, including a kettle, fridge, microwave and sink, a WC with hand basin that had hot and cold running water and antibacterial hand wash.

There was consultation room available which was clean. This room was usually used when customers required a private area to talk or the pharmacist was providing one of the services, although, at present due to Covid-19, the room was not in use. The pharmacy was locked and alarmed when closed. Metal shutters were fitted over the front of the pharmacy premises when closed. Panic alarms that were linked to the police were fitted in the pharmacy. The back door to the premises was secure.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy's services are accessible to most people and they are generally well managed, so people receive their medicines safely. But members of the pharmacy team do not always know when high-risk medicines are being handed out. So, they may not always make extra checks or give people advice about how to take them. The pharmacy team sources and generally stores medicines safely and carries out some checks to help make sure that medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible for all patients, including those with mobility difficulties and or wheelchair users. Staff were clear about what services were offered and where to signpost to a service if this was not offered e.g. needle exchange. There was a range healthcare leaflets' in the retail area on display.

Baskets were used in the dispensary to reduce risk of medicines becoming mixed up. A dispenser explained that high risk medicines prescribed for patients including warfarin, methotrexate and lithium were not highlighted during the dispensing process. The pharmacy team was aware of the risks associated with supplying valproate. An audit of valproate had been carried out and had not identified anyone who met the risk criteria. Patient information resources for the supply of valproate were present.

A dispenser explained the process for assembling and providing the MDS trays for patients in community. An audit trail was in place for changes to therapy and these were documented on the patient medication record (PMR) and on the MDS medication record for each patient. Tablet identifications were not routinely included on MDS trays, unless a patient requested this to be done. Patient information leaflets were included, and each MDS tray included a dispensing audit trail. A dispenser explained how the care home MDS service was provided. Original pack dispensing was in place. Each care home resident had a medicines administration record (MAR) chart produced by the person dispensing and these were reviewed by the pharmacist as part of the accuracy checking process, to ensure they were correct.

The work flow in the pharmacy was organised into areas – a designated area for the assembly of MDS trays, a dispensing bench and a designated checking area for the pharmacist. The delivery driver explained the process for delivering medicines to patients. Separate CD delivery records were kept, and the driver was signing for receipt of each prescription delivered to patients, due to Covid-19. There were two CD cabinets which were bolted to the wall. Patient returned CDs were destroyed using denaturing kits and records made in a designated book. CD keys were kept under the safe custody of the pharmacist. A CD balance check for matrifen 12mcg patches was carried out and found to be correct.

A small number of assembled prescriptions awaiting collection were stored directly on the floor in bags. The date of opening was written on stock bottles of liquid medicines with limited shelf life. The pharmacist said that no extemporaneous dispensing took place in the pharmacy. Date checking was carried out and documented. Short dated medicines were highlighted with a sticker attached to the medicine container. Several medicines were checked and no out of date medicines were found as stock.

The pharmacist said drug alerts and recalls etc. were received via e-mail. These were read, acted on by a member of staff, with a record kept in the pharmacy.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide services safely. It is generally appropriately maintained, and it is used in a way that protects privacy.

Inspector's evidence

An up to date BNF and BNFC were available. The pharmacist and team members also used the internet to access websites for the most up to date information. e.g. Electronic Medicines Compendium. There was a clean fridge for medicines with minimum/ maximum thermometer that appeared to be in working order. The minimum and maximum temperature was recorded daily, and the record was complete.

Any problems with equipment were reported to the superintendent. The electrical equipment all appeared to be in working order and had been PAT tested for electrical safety in January 2017. There was a selection of liquid measures with British Standard and Crown marks, including designated measures for methadone solution. The pharmacy had tablet triangles for counting loose tablets and capsules, including a designated triangle for cytotoxic medication. The computer screen was positioned so it was not visible from the public area of the pharmacy.

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.