

# Registered pharmacy inspection report

**Pharmacy Name:** Halls The Chemist, 85 Saddlebow Road, KING'S LYNN, Norfolk, PE30 5BH

**Pharmacy reference:** 1097663

**Type of pharmacy:** Community

**Date of inspection:** 22/05/2023

## Pharmacy context

This community pharmacy is situated in a largely residential area and is open Monday to Friday. Its main activity is dispensing NHS prescriptions, some of which it delivers to people's homes. It offers seasonal flu vaccinations. And it provides some people with their medicines in multi-compartment compliance packs when they have been assessed as needing this support to take their medicines safely. It supports a few people who are receiving substance misuse treatment. The pharmacy also receives referrals via the Community Pharmacist Consultation Service. And it offers a needle exchange 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
<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

Overall, the pharmacy manages the risks associated with its services effectively. It has procedures which tell staff how to work safely. It makes the records it needs to by law within the required timescales. And it protects people's information well. The pharmacy's team members can learn from their mistakes to make their services safer.

### Inspector's evidence

The pharmacy's team members had written standard operating procedures (SOPs) to refer to when undertaking tasks such as dispensing and selling medicines. These helped make sure activities were carried out safely. There was evidence that all the team members had read these. And the documents were reviewed every two years or so. When asked, team members were aware of when they needed to refer queries to the responsible pharmacist (RP). They understood what they could and couldn't do if there was no RP at the pharmacy. And they could explain the restrictions on sales of some products, including medicines containing codeine. This activity was observed being followed during the inspection.

The pharmacy kept a record about mistakes made and corrected during the dispensing process (known as near misses). The near misses that were made and recorded included some information about why mistakes had happened and what the dispenser should do to try to prevent similar events happening again. The trainee dispenser explained how she was checking quantities more carefully because of previous near misses as she had been used to dispensing only original packs in a different country. There was a process to deal with mistakes that reached people (dispensing errors) which included reporting these to the superintendent pharmacist and reviewing the incidents to identify any learning points. And sharing learnings with the team. To prevent common selection errors of medicines which sounded or looked similar, for example amitriptyline and amlodipine, storage locations were separated. Staff were able to explain how a complaint should be handled and would refer to the pharmacist on duty when needed.

The pharmacy had professional indemnity and public liability insurance in place. There was a notice displayed for the public showing details of the current RP on duty. The record about the RP was available and this was complete. Records viewed about controlled drugs (CDs) were up to date and were well-maintained. Running balances were recorded and checked regularly. The recorded stock of three items chosen at random agreed with the physical stock. CDs returned by people for destruction were recorded in a designated book and there was an audit trail for their destruction. Private prescriptions were recorded in a book and the records viewed were complete. The supply of unlicensed specials was also recorded and the Certificates of Conformity for the items supplied were retained for reference.

There were procedures to protect people's information which team members had read. Computer screens containing patient information could not be seen by the public. Confidential waste was separated from normal waste and disposed of securely. Team members had their own NHS smartcards to access the NHS spine and did not share passwords for these.

The pharmacy manager had completed level 2 safeguarding training. Other staff members had read SOPs about protecting vulnerable people. And had also done training about domestic abuse. There had been no safeguarding concerns to report.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has just enough team members to manage the workload effectively. Its team members work well together, and they feel supported in their work. They have completed or are doing the right accredited training for the roles they undertake.

### Inspector's evidence

The pharmacy manager provided the vast majority of the RP cover at the pharmacy and was on duty during the inspection. He had been at the branch for around four years. Also present was a trained dispenser, a trainee dispenser, and the delivery driver. Another trained dispenser was off work. The team was able to cope with the workload during the visit though the RP explained the pharmacy was currently trying recruit more dispensing staff as the prescription volume had risen significantly recently following the closure of a local pharmacy. Team members were doing extra hours to cover for absence.

The pharmacy's team members had completed or were enrolled on the right training for their roles. The trainee dispenser said she could ask the RP for help with queries. But she did most of her training course in her own time. The pharmacy also had evidence of formal training including through eLearning for Health, that team members had completed to keep their skills and knowledge up to date. This included training about first aid, domestic abuse, infection prevention, and equality and diversity and human rights. The team had regular reviews with a company HR lead to check how they were doing and to identify any learning needs and.

It was a small team and members of the team worked closely together and were seen helping each other during the inspection. When asked, team members said they felt well supported by the pharmacy manager and would speak to them in the first instance if they had any concerns. The team had informal meetings and information about mistakes that happened in other branches of the company was also shared to help make services safer.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy's premises are small but are adequate to provide the pharmacy's services safely.

### Inspector's evidence

The pharmacy's premises were small and had limited storage space, but the team was trying to keep working areas as tidy as possible. One section of dispensing bench was reserved for accuracy checking by the RP to reduce risks. The premises could be secured against unauthorised access. A private consultation room was available and conversations inside the room would not be easily overheard by other people in the pharmacy. The room was kept locked when not in use and there was no confidential paperwork left on display in the room.

The lighting and ambient temperatures during the visit were suitable for the activities undertaken and for storing medicines. The pharmacy was reasonably clean; the team members carried out cleaning tasks themselves. There was limited space for people waiting for services, but the shop floor was kept clear of clutter or trip hazards. Medicines were stored behind the medicines counter and in the dispensary and could not be reached by members of the public. The staff had a small kitchen area and hygiene facilities towards the rear of the premises. These had their own sinks for washing utensils and handwashing. There was a separate sink in the dispensary for preparing medicines. All had hot and cold running water.

## Principle 4 - Services ✓ Standards met

### Summary findings

Overall, the pharmacy manages its services effectively. The pharmacy's team members prepare compliance packs safely. The pharmacy stores and largely manages its medicines appropriately. And the pharmacy tries to make sure that people who receive prescriptions for higher-risk medicines get all the information and advice they need to take their medicines safely.

### Inspector's evidence

The pharmacy was open Monday to Friday 9am to 6.30pm; it did not open at weekends. The RP explained the prescription volume had increased in recent months as another local pharmacy had closed. There was a limited range of health information about self-care displayed in the retail area. The pharmacy had a well-screened consultation room to provide services such as flu vaccinations. But this was not wheelchair accessible. To make sure the service was still accessible, the RP explained that the main door would be locked, and vaccines administered in the shop area when there were no other customers present.

During the dispensing process, baskets were used to keep prescriptions for different people separate. And different coloured baskets were used to manage the workflow. There was an audit trail on the dispensing labels and on the prescriptions to show who had been involved in each stage of the dispensing process from dispensing to handing out the medicines.

The pharmacy supplied medicines in multi-compartment compliance packs to a small number of people who lived in their own homes. The supply of these packs was made after people had been assessed via a local medicine support assessment process. The dispensers prepared these packs on a separate workbench and the pharmacist generally tried to check these as soon as they were done due to space constraints. All packs were sealed as soon as dispensed. The pharmacy had written records for the people receiving these packs and added notes to these records when there were changes or other interventions. Packs seen were labelled with the dose and a description of the medicines in the pack. Patient information leaflets were supplied to some people every four weeks though the pharmacy had stopped supplying other people at their request. The obligations on the pharmacy to supply this information and the benefits of making sure people had up-to-date information about their medicines was discussed. The pharmacy delivered medicines to some people. There was an audit trail for this service to show that medicines had reached the right people.

There were stickers available to highlight prescriptions for higher-risk medicines or prescriptions where the pharmacist wanted to speak with the person when they collected their medicines. This was to ensure people received the information they needed to take their medicines safely. The team was aware of the updated guidance about pregnancy prevention and discussing this when supplying valproate-containing medicines. However, the pharmacy didn't currently supply these medicines to anyone in the at-risk group. The pharmacy usually highlighted prescriptions for CDs so that members of staff could check they were still valid when handing the medicines out. One prescription was found which had not been highlighted but it was still in date.

The pharmacy got its medicines from several licensed suppliers. Medicines were generally stored in an

organised manner on shelves in the dispensary though storage space was limited, making it harder to keep some medicines clearly separated. Methotrexate was kept in a separate basket to prevent dispensing errors. Waste medicines were stored in designated bins, away from dispensing stock. The team made a record of date checks that had been completed. And they highlighted medicines that had short shelf lives. Team members said they hadn't been able to do much date checking in the past couple of months but were checking expiry dates of medicines at the point of dispensing to prevent mistakes happening. When a sample of items was checked during the visit, one out-of-date medicine was found. But it had been highlighted to alert staff when dispensing. Liquid medicines had the date of opening added to the container so dispensers could assess if the medicines were still safe to use.

Medicines that required refrigerated storage were kept in the pharmacy fridge. Maximum and minimum fridge temperatures were monitored and recorded on paper. The fridge temperature at the time of the visit was within the required range. The records showed the temperatures had been kept at suitable levels for safely storing medicines requiring refrigeration. There was enough storage capacity in the fridge and no evidence of ice build-up.

The pharmacy received safety alerts about medicine recalls via email and kept an audit trail to show that stock medicines were checked to see if any were affected by the alerts. When asked, team members could correctly explain the process they followed about these alerts.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it keeps its equipment clean and in good order.

### Inspector's evidence

The pharmacy's computer screens containing patient information could not be seen by members of the public and it had cordless phones so members of the team could hold private conversations out of earshot of the public. The patient medication record system was password protected and team members used their own NHS smartcards to access electronic prescriptions. Electrical equipment was checked to make sure it was safe to use.

The pharmacy had a range of validated glass measures for dispensing liquid medicines and counting triangles for solid dose forms; this equipment was clean. Some of the glass measures were marked for specific use to prevent cross-contamination. The pharmacy fridge was of a suitable size for the volume of medicines that needed refrigeration. The CD cabinet had sufficient space and was kept secure.

### 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.