

Registered pharmacy inspection report

Pharmacy Name: Stevenson; F.F. & R., 389a James Reckitt Avenue,
HULL, North Humberside, HU8 0JE

Pharmacy reference: 1032099

Type of pharmacy: Community

Date of inspection: 26/03/2024

Pharmacy context

This community pharmacy is amongst a small parade of shops in a large suburb of Hull. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The GPhC imposed conditions on this pharmacy after failings were identified at a previous inspection. These conditions remain in force at the time of this inspection.

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 adequately identifies and manages the risks associated with its services. It generally completes the records it needs to by law and it protects people's private information properly. Team members clearly understand their role to help protect vulnerable people. Team members identify potential risks to the safe dispensing of prescriptions and they act to prevent errors. But they don't keep records of errors for them to review and improve their practice. Team members follow the pharmacy's written procedures but there is no evidence that the procedures have recently been reviewed. This means there is a risk that team members may not be following up-to-date procedures.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) for various key processes. The SOPs had a review date of July 2018 but there was no evidence the SOPs had been reviewed since this date. The trainee dispenser had read some of the SOPs and signed the SOPs signature sheets to indicate they'd read and understood them. However, the other dispenser in the team, who had been in post since August 2023, had not read the SOPs. Team members demonstrated a clear understanding of their roles and worked within the scope of their role.

Team members were asked to find and correct errors spotted at the final check of a prescription. The pharmacy had a book to record these errors, known as near miss errors, but no entries had been made. One team member advised they had recently dispensed the wrong quantity of a prescribed medicine. The pharmacist had discussed the error with the team member, but no record had been made. Team members highlighted to each other medicines that looked alike and sounded alike to reduce the risk of the wrong medication being picked. The pharmacy had a procedure for managing dispensing incidents that were identified after the person received their medication. But no records were kept, the pharmacist explained there had not been any dispensing incidents to report. The pharmacy had a procedure for handling complaints raised by people using the pharmacy and it had a poster providing people with information on how to raise a concern.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers generally met legal requirements. The RP record was last completed on 21 March 2024. The pharmacist clearly displayed their RP notice, so people knew details of the pharmacist on duty.

The pharmacy displayed information on the confidential data it kept and how it looked after this information. Team members kept people's private information safe, they separated confidential waste and they regularly shredded it onsite. The pharmacy had procedures and guidance for team members to follow when safeguarding concerns arose about vulnerable people. And they responded appropriately when safeguarding concerns arose.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has a small team with the appropriate range of experience and skills to provide its services. Team members work well together and are good at supporting each other in their day-to-day work. They openly discuss errors so they all can learn from them and improve their skills. Team members do not regularly receive formal feedback on their performance and they have limited opportunities to complete ongoing training. This means they could find it harder to keep their knowledge and skills up to date.

Inspector's evidence

The pharmacist owner covered all the opening hours as RP. The pharmacy team consisted of a dispenser who worked four days a week and a full-time dispenser. At the time of the inspection all team members were on duty. The trainee dispenser had some protected training time at work and the pharmacist helped them with any queries from the training modules.

The team's workload had increased after a number of people had changed to the pharmacy to have their prescriptions dispensed from other pharmacies in the area. Team members worked well together to manage the workload and they ensured people presenting at the pharmacy were promptly helped. They received some additional training but this was limited to information shared by the pharmacist such as articles from pharmacy magazines. The pharmacy did not provide formal performance reviews for the team members. This meant they did not have a chance to receive feedback and discuss development needs. The team received informal feedback from the pharmacist.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. The pharmacy has adequate facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy was clean with separate sinks for the preparation of medicines and hand washing. Team members kept the pharmacy tidy and there was enough storage space for stock, assembled medicines and medical devices.

The pharmacy did not have a consultation room, but the team had access to a room at the rear of the dispensary. The team members used this if people wanted to speak to them in private. They escorted the person through to the room via an area of the dispensary where no confidential information was stored. The pharmacy was secure and it had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy mostly manages its services well to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and team members store the medicines properly. They carry out appropriate checks to make sure medicines are in good condition and suitable to supply. However, they do not always supply medicines that are properly labelled to ensure people have all the information available to know how to take their medication correctly.

Inspector's evidence

People accessed the pharmacy via a small step. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. And the team had access to the internet to direct people to other healthcare services when required. Team members asked appropriate questions of people requesting to buy over-the-counter medicines to ensure the most appropriate product was supplied. And they knew when to refer requests to the pharmacist. Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) including the requirement to supply original manufacturer's packs of valproate. The pharmacist reported no-one prescribed valproate met the PPP criteria.

The pharmacy provided multi-compartment compliance packs to help a few people take their medicines. Team members ordered prescriptions several days before supply to allow time to deal with issues such as missing items. And they usually prepared the packs later in the day when the pharmacy was less busy with other services. The team recorded the descriptions of the medicines within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medication.

The pharmacy provided sufficient space for dispensing and checking of prescriptions to take place. The team did not use equipment such as baskets to isolate individual people's medicines and to help prevent them becoming mixed up during the dispensing process. The team did not initial the dispensing labels attached to the dispensed medicines to record which team members had completed the dispensing and checking of the prescription. Team members did not attach dispensing labels to all the manufacturer's packs when more than one pack of the same medicine was prescribed. They placed a rubber band around the packs and attached one dispensing label attached to the top box. When this was highlighted during the inspection, team members removed the bands and attached dispensing labels to each pack. And they would check other completed prescriptions after the inspection had finished to ensure all the dispensed medicines were correctly labelled. The pharmacist delivered medicines to people when the pharmacy was closed. But records of the deliveries were not kept as the pharmacist explained they knew who had received their medication.

The pharmacy obtained medication from several reputable sources. Team members kept the shelves holding stock tidy and they securely stored CDs. Team members checked the expiry dates on stock as it arrived from the wholesaler and when performing the final check of a dispensed medicine. They didn't routinely check all stock or mark any medicines with a short expiry date. Two medicines with expiry dates in April 2024 and May 2024 were found without any markings on. No out-of-date medicines were found. The team monitored fridge temperatures each day and kept a record of the readings. However, the thermometer used to monitor fridge temperatures only gave one reading. There were no maximum

and minimum readings to show that stock in the fridge was being kept at the correct temperature each day. At the time of the inspection the fridge temperature was within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and returned medication. The pharmacist received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacist actioned these alerts but didn't keep records of the actions taken.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. And it uses its equipment appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference resources and access to the internet to provide the team with up-to-date information. The pharmacy used a range of CE equipment to accurately measure liquid medication and it had a suitable fridge to store medicines kept at these temperatures. The computer was password protected and access to people's records was restricted by the NHS smart card system. The pharmacy positioned the computer in a way to prevent disclosure of confidential information. And it stored completed prescriptions away from public view. Team members held private information in the dispensary and rear areas, which had restricted public access.

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.