General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Greenhill Pharmacy, 206 Bocking Lane, SHEFFIELD, South Yorkshire, S8 7BP

Pharmacy reference: 1039265

Type of pharmacy: Community

Date of inspection: 31/01/2020

Pharmacy context

This is a community pharmacy on a parade of shops in a residential area of Sheffield. It dispenses both NHS and private prescriptions and sells a range of over-the-counter medicines. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as the New Medicines Service (NMS) and medicines use reviews (MURs). The pharmacy supplies medicines in multi-compartment compliance packs to some people living in their own homes. And it provides a home delivery service.

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 mostly identifies and manages the risks associated with the services it provides to people. And it has a set of written procedures for the team members to follow. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The team members have some knowledge which helps them safeguard the welfare of vulnerable adults and children. The team members openly discuss mistakes that they make when dispensing. And they make changes to their ways of working to reduce the risk of mistakes happening again. But they don't always keep records of errors. So, they may find it difficult to review how effective their changes are.

Inspector's evidence

The pharmacy had a small retail area. The dispensary was located behind a small pharmacy counter. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The dispensary was set back far enough from the pharmacy counter to allow the team members discuss confidential matters without being overheard by people in the retail area.

The pharmacy had a set of up-to-date electronic standard operating instructions (SOPs) in place. The SOPs had an index, which made it easy to find a specific SOP. They were prepared in October 2019 and were due to be reviewed in October 2022. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team. The team members were currently working through reading and understand the SOPs that were relevant to their role. And they were expected to complete the process by the end of February 2020.

The pharmacist highlighted any near miss errors made by the team when dispensing. There was a paper near miss log that the team could use to record the details of near miss errors. There were sections to record the date and time the error happened and the type of error. The team members didn’t record the potential reasons why an error might have happened. This would enable them to further analyse how specific changes to their practice may reduce the risk of errors. The team members thought that their main reason for many of the most recent errors was because of a lack of concentration or rushing. But they did not investigate these reasons any further. The pharmacist explained she discussed any near misses with the team members that were present at the time. And they discussed ways of improving their practice to reduce the risk of similar errors happening. A pharmacy assistant explained she was often confusing two different, but similarly named nasal sprays. The team members discussed how they could reduce the risk of the error happening again. They decided to affix an alert sticker on the shelves next to where they nasal sprays were stored. The team members all agreed that the alert stickers had helped them take more care and helped reduce the number of similar errors. The pharmacy had a basic process to handle dispensing incidents that had reached the patient. But the pharmacy did not keep any records for future reference and to review any learning. The team were unable to recall any recent incidents that had happened.

The pharmacy displayed the correct responsible pharmacist notice. But it was difficult for people in the retail area to see. So, it may be difficult for them to confirm the identity and registration number of the responsible pharmacist on duty. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn’t do in the absence of a responsible pharmacist.

For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist.

People who used the pharmacy could discuss any concerns or complaints they had with any of the team members. And if the problem could not be resolved, it would be escalated to the pharmacy's owner. The pharmacy collected feedback each year through questionnaires that were placed on the pharmacy counter for people to self-select and complete. The results of the latest survey are available on NHS.uk.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. It kept controlled drugs (CDs) registers. And they were completed correctly. A physical balance check of a randomly selected CD matched the balance in the register. The team completed a full balance check of the CDs every month. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The pharmacy outlined how it handled personal and sensitive data through a privacy notice in the retail area. The team members did not demonstrate the completion of any training on General Data Protection Regulation (GDPR). But they were aware of the need to keep people's personal information confidential. The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed using a shredder.

The responsible pharmacist and a pharmacy technician had completed training on safeguarding vulnerable adults and children through the Centre for Pharmacy Postgraduate Education (CPPE). When asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. A team member explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload. And they feel comfortable to raise professional concerns when necessary. The pharmacy supports its team members to complete training to help them keep their knowledge and skills refreshed and up to date.

Inspector's evidence

The responsible pharmacist worked for the company full-time and spent two days a week in this pharmacy. She was supported during the inspection by a full-time pharmacy assistant, a full-time trainee pharmacy technician and two full-time counter assistants. The pharmacy also employed a full-time accuracy checking technician and another part-time pharmacy assistant. The pharmacy's owner or a locum pharmacist worked on the days the pharmacist was absent. The team members said they felt they had enough staff to manage the workload. The pharmacy owner organised double pharmacist cover to help the pharmacy if it ever fell behind with its dispensing workload. The team members were observed managing the workload well and had a manageable workflow. The team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. The team members often worked additional hours to cover absences and holidays. The team members did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The pharmacy encouraged its team members to undertake some basic training to update and refresh their knowledge and skills. The team members who were not enrolled on a training course did not receive any time to train during the working day. But when the pharmacy was quiet, they took some time to read material that was received by the pharmacy by external training providers. The trainee pharmacy technician was provided with four hours of protected training time to work through her training course. She explained she was well supported by her colleagues. For example, she wanted to learn about anaesthesia. She discussed this with the pharmacy's owner. And she was given a one-to-one training session with the pharmacist to help her understand the subject. The pharmacy did not have a formal appraisal process in place. But the pharmacist explained she planned to begin providing formal performance appraisals within the next year. The team members aimed to hold a team meeting on days when all the team members were working. The meetings were an opportunity for the team members to discuss any issues and ways in which they could improve the quality of the service the pharmacy was providing to people. The team members had recently changed the way they stored dispensed medicines that were ready for people to collect. They changed from storing the medicines by people's surnames to storing the bags in numbered sections. They wrote the number of the section where the medicines were stored at the top of each prescription. The team members explained the changes had helped them reduce the time it took to find people's medicines when they came to collect them.

The team members felt comfortable to raise professional concerns with the pharmacy manager or the pharmacy's owner. The pharmacy did not have a whistleblowing policy in place. So, the team members

may not be able to raise any professional concerns anonymously. They were set various targets to achieve. These included the number of prescription items they dispensed, and the number of service consultations completed. The team members felt the targets were mostly achievable. The targets did not affect their ability to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy premises were clean and highly professional in appearance. There was signage identifying the premises as a pharmacy on the outside of the building. The dispensary was of a suitable size for the services provided. The floor spaces and walkways were kept clear of clutter to prevent the risk of trips or falls. The benches in the dispensary were kept tidy. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a staff toilet with a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member to have a private conversation. The room was signposted by a sign on the door. The pharmacy also had two health suites. One of the suites was rented to a podiatrist and inaccessible during the inspection. The other was used as an area to dispense multi-compartment compliance packs. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. And the pharmacy manages its services appropriately and delivers them safely. Pharmacy team members provide people taking high-risk medicines with additional support and relevant advice. They support people to take their medicines at the right time by dispensing their medicines into multi-compartment compliance packs. They source medicines from licenced suppliers. And mostly manage them appropriately. But they don't keep records of the checks they make. So, it may be difficult to resolve any queries.

Inspector's evidence

The pharmacy had level access from the street to an automatic door. And so, it was easy for people with wheelchairs or prams to enter the premises. There were some car parking spaces outside the pharmacy. The pharmacy advertised its services and opening hours in the main window. There was a large seating area for people to use while they waited for their medicines to be dispensed. The pharmacy displayed many healthcare related leaflets around the area which they could read and take home with them. For example, there were leaflets on asthma and verrucae and warts. The team had access to the internet to direct people to other healthcare services. And people could request large print dispensing labels to help them if they had a visual impairment.

The team members regularly used alert stickers during dispensing, and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. The pharmacy had a system to highlight prescriptions for a CD that was not required to be stored in the CD cabinet. And so, the team members could check the date of issue of the prescription to prevent them from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy 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 pharmacy kept records of the delivery of medicines it made to people. The records included a signature of receipt.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own homes and some local care homes. The pharmacy supplied the packs to people on either a weekly or monthly basis. The team was responsible for ordering people’s prescriptions. And this was done around a week in advance to give the team members the time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the packs in one of the health suites. This was to minimise distractions. The pharmacy managed the workload across four weeks. And it kept all documents related to each person on the service separately. The documents included master sheets which detailed the person's current medication and times of administration. The team members used these to check off prescriptions and confirm they were accurate. The packs were supplied with dispensing labels which listed the medicines in the packs and the directions. The pharmacy kept records of who had collected the packs. The team members said this was useful particularly when a person’s carers were collecting the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin, lithium and methotrexate. The team members used alert stickers which were attached to people's prescriptions as a reminder to discuss the person's treatment when handing out the medicine. The pharmacist explained she did some basic checks with people when they came to collect their medicines. These included ensuring the person had had a recent blood test and checked their current and target INR if they were prescribed warfarin. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. And there was an information poster displayed in the dispensary. The team members demonstrated evidence they had given a person some advice about the programme and discussed pregnancy prevention.

Pharmacy medicines were stored behind the pharmacy counter. Which prevented people from self-selecting the medicines. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. But no records of the checks were kept. No out-of-date medicine was found after a random check of around thirty medicines. The team members recorded the date liquid medicines were opened on the pack to check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people.

The team members were scanning products and undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received training on how to follow the directive and the pharmacy had the correct type of scanners and software installed. Drug alerts were received via email to the pharmacy and actioned. The team did not evidence any records of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinet was secured and of an appropriate size. The medicines inside the fridges and CD cabinet were well organised.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. And there were some cylinders which were only used for dispensing methadone. The team members used tweezers and rollers to help dispense multi-compartment compliance packs. The two fridges used to store medicines were of an appropriate size. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private. The electrical equipment had been safety tested in January 2019.

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.