General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 1a Cobnar Road, SHEFFIELD, South Yorkshire, S8 8QA

Pharmacy reference: 1039273

Type of pharmacy: Community

Date of inspection: 11/04/2019

Pharmacy context

The pharmacy is on a side street in a large suburb of Sheffield. The pharmacy is opposite a large health centre, but access is across a busy road. The pharmacy dispenses NHS and private prescriptions. It provides a repeat prescription ordering service and delivery of medicines to people at home. The pharmacy provides a flu vaccination 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	1.2	Good practice	The pharmacy team members respond well when errors happen. And they discuss what happened and they take action to prevent future mistakes.
2. Staff	Standards met	2.2	Good practice	The pharmacy team members get feedback on their performance. And they receive opportunities for more training.
		2.5	Good practice	The pharmacy team can make suggestions and get involved with improving services.
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 identifies and manages the risks associated with its services. And it keeps most of the records it needs to by law. The pharmacy has written procedures that the team follows. And it has adequate arrangements to protect people's private information.
The pharmacy team members respond well when errors happen. And they discuss what happened and they take action to prevent future mistakes. People using the pharmacy can raise concerns and provide feedback. The pharmacy team has training, guidance and experience to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a range of up to date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The pharmacy kept the SOPs electronically. The team accessed the SOPs and answered a few questions to confirm they had read and understood them. The pharmacist manager monitored completion of this. The pharmacy received alerts about new SOPs or changes via an internal notification system.

The pharmacy provided separate areas for the labelling, dispensing and checking of prescriptions. The team used baskets throughout the dispensing process to hold stock, prescriptions and dispensing labels. The team members referred to the prescription when selecting an item from the shelves. To help ensure they picked the correct product. The pharmacist when checking prescriptions and spotting an error told the person involved of the mistake. Rather than getting the person involved to identify their error. The team recorded the error on to an electronic recording system, known as DATIX. A sample of logs looked at showed details about the prescription and dispensed item to spot patterns. The team recorded their learning and the actions taken to prevent similar errors. The pharmacy recorded dispensing incidents electronically. And printed them off for reference. The pharmacy completed monthly patient safety reports. A recent report recognised the importance of recording errors to help the team learn. The team members separated any items that looked or sounded alike (LASA). As they were at greater risk of being associated with errors. And they highlighted to each other any pack changes or other differences. The team reduced the risk of handing out medication to the wrong person by asking for the date of birth along with the name and address. The team had also generated a list of patients with similar names. And attached it to the pharmacist checking area for reference.

The pharmacy had a poster with information on how to make a complaint. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy checked CD stock after receiving items or supplying to the patient. A sample of Responsible Pharmacist records looked at found they met legal requirements. Details of private prescription

supplies met legal requirements. But the book used was not bound. This meant pages could be removed. And the records lost. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy had up to date indemnity insurance.

The pharmacy stored completed prescriptions away from public view. And it held most of its private information in the dispensary and rear areas, which had restricted access. But the team kept the bag holding confidential waste for offsite shredding in the consultation room. This meant that people in the room could look in to the bag and see other people's information. The team didn't lock the filing cabinet holding the repeat prescription forms. These had people's names and addresses on. The team had read General Data Protection Regulation (GDPR) information.

The pharmacy had procedures informing the team of the steps to take if concerned about vulnerable people. The pharmacist had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The delivery driver reported to the team any concerns they had about people they delivered medication to. This included signs of neglect. The team shared this information with other people such as the person's GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has the qualifications and skills to support the pharmacy's services. The team members discuss how they can make improvements. And they can raise concerns. They agree new processes to support the safe and efficient delivery of these services. And they share information and learning particularly from errors when dispensing. The pharmacy team members get feedback on their performance. And they have opportunities to complete more training. So, they can keep their skills and knowledge up to date.

Inspector's evidence

A regular pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of five qualified dispensers and a delivery driver. One of the dispensers was the pharmacy manager. Who developed a rota to plan team hours and ensure enough team members were on duty at the busiest times.

The pharmacy provided additional training through an online portal. Recent topics included handling patient returned medication. This had led to the team discussing the use of a tray for people to place returned medicines in to. The team identified that this would help to see if the returned items included controlled drugs (CDs). As people may not know when asked if CDs were with the returned medicines.

The team members received annual performance reviews. These gave them a chance to receive feedback and discuss development needs. Team members could suggest changes to processes or new ideas of working. The team had introduced a basket to hold the repeat prescription order forms after supplying the medication. One team member filed the forms at the end of the day. Rather that after each supply, as the team did before. This meant they worked more efficiently. The team could raise concerns with the company. The team had highlighted to the area manager concerns with the service providing multi-compartmental compliance packs. The team pointed out that the pharmacy did not have the space or team numbers to do this. And often the team were preparing the packs close to the time of supply. This increased the risk of errors. The company relocated the service to a nearby branch with capacity to do this.

The pharmacist was set targets for services such as medicine use reviews (MURs). And she met them whilst ensuring they benefitted people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was small with limited bench space. The team managed this by keeping work space tidy and free of clutter. The pharmacy was clean and hygienic with separate sinks for the preparation of medicines and hand washing. The pharmacy displayed notices describing effective hand washing techniques next to the sinks. The team kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy had a good sized, signposted and sound proof consultation room. The team regularly used this. And had cordless telephones for confidential conversations.

The premises were secure. The pharmacy had restricted access to the dispensary when the pharmacy was open. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. The pharmacy manages its services well. It keeps records of prescription requests and deliveries it makes to people. So, it can deal with any queries effectively. The pharmacy gets its medicines from reputable sources. And it generally stores and manages medicines appropriately.

Inspector's evidence

People accessed the pharmacy via a ramp with hand rails. And the pharmacy had a hearing aid loop. The pharmacy didn’t have an information leaflet available for people to pick up detailing the services offered, the opening times and the contact details of the pharmacy. The team accessed the internet to signpost patients requiring other healthcare services. A range of healthcare information leaflets were available. Team members wore name badges detailing their roles.

Until November 2017 the pharmacy didn’t have a consultation room. This had limited the type of service provided. The pharmacy started the flu vaccination last winter. And found it to be popular.

The team provided a repeat prescription ordering service. And placed requests one week before supply. This gave time to deal with issues such as missing items. The pharmacy kept a record to help identify missing prescriptions. The team passed information from the GP team on to the person such as the need to attend the surgery for a medication reviews or blood tests. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to add these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit.

The pharmacy team recorded information such as latest test results given by people on high risk medication like warfarin. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found no people within the category. The pharmacy had the PPP pack containing information cards and leaflets to pass on to patients. But the sections holding the valproate products didn't state where to find the pack for locum pharmacists to know. A poster in the dispensary reminded the team of the PPP requirements.

The pharmacy had checked by/dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing what was owed. And it kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The team was up to date with the checks. The team used a sticker with ‘use this pack first’ printed on to highlight medicines with a short expiry date. The team members usually recorded the date of opening on liquids. This

meant they could identify products with a short shelf life once opened. And check they were safe to supply. But an opened bottle of cetirizine oral solution with six months use once opened did not have a date of opening recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range.

The pharmacy had appropriate medicinal waste bins for out of date stock and patient returned medication. The team separated out of date and patient returned controlled drugs (CD) from in date stock in a CD cabinet that met with legal requirements. The team recorded patient returned CDs and used denaturing kits for CD destruction. The pharmacy had 2D scanners and Well head office was arranging for a computer update to meet the requirements of the Falsified Medicines Directive (FMD) that came out on 9 February 2019. The team had completed online training on the subject. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via the internal notification system. The team actioned the alert and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up to date clinical information. The pharmacy used a range of CE quality marked measuring cylinders equipment to accurately measure liquid medication. The pharmacy had a pharmacy fridge to store medicines kept at these temperatures. The fridge had a glass door that allowed the viewing of stock without the door being open for a long time. The pharmacy completed safety checks on its electric equipment.

The computers were password protected and access to patients' records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The team made sure the computer in the consultation room was screen locked when not in use.

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.