General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Armstrong's Pharmacy, 867-9 Gleadless Road, SHEFFIELD, South Yorkshire, S12 2LG

Pharmacy reference: 1039303

Type of pharmacy: Community

Date of inspection: 06/02/2020

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). And it provides a home delivery 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	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 identifies and manages the risks associated with the services it provides to people. And it has a set of up-to-date 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 know when to raise a concern to safeguard the welfare of vulnerable adults and children. The team members openly discuss mistakes that they make when dispensing. And they make some records of these mistakes. So, they can make changes to their ways of working to reduce the risk of mistakes happening again.

Inspector's evidence

The pharmacy had a set of up-to-date electronic standard operating instructions (SOPs) in place. The SOPs included processes such as taking in prescriptions and responsible pharmacist regulations. The SOPs had an electronic index. And so, it was easy to find a specific SOP. They were prepared in January 2020 and were due to be reviewed in January 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 had each signed the SOPs that were relevant to their role. Which showed they had read and understood the SOPs contents.

The pharmacists highlighted any near miss errors made by the team when dispensing. And the team members immediately discussed why the near miss errors might have happened and how they could stop a similar error happening again. There was a paper near miss error log that the team could use to record the details of near miss errors. But it was not used to record every near miss error made. Only five entries had been made between November 2019 and February 2020. The team members explained they did not always have the time to make the entries. There were sections to record the date and time the error happened and the type of error. The team members didn’t record the reasons why an error might have happened. And so, could have missed the opportunity to make specific changes to their practice to reduce the risk of a similar error happening again. The near miss errors were occasionally analysed for any trends or patterns. The team had recently had a focus on reducing the number of near miss errors involving medicines that looked or sounded similar (LASAs). The team members spoke about the errors to raise awareness of the risks of errors with LASAs. And they separated ramipril tablets and capsules on the dispensary shelves to reduce the risk of them being selected in error. The details of any incidents that had reached the patient were recorded onto an incident report form. And the form was kept in the pharmacy for future reference and learning. The team members discussed patient safety in a meeting if they were made aware of any incidents. And they talked about how they could stop a similar incident happening again.

The pharmacy displayed the correct responsible pharmacist notice. 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.

The pharmacy had a formal complaints procedure. And it was on display on the pharmacy’s website for people to see. People who used the pharmacy could discuss any concerns or complaints they had with

any of the team members. The pharmacy collected feedback each year through questionnaires that were placed on the pharmacy counter for people to self-select and complete. The pharmacy had recently installed more chairs for people to use while they waited for their prescriptions to be dispensed.

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 two months. 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 had undertaken training on General Data Protection Regulation (GDPR). And they had all signed confidentiality agreements. 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 collected and destroyed by a third-party contractor.

The pharmacy’s two resident pharmacists 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. There was written and electronic guidance available to the team members to help them manage and report any potential concerns.

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 if 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 at the time of the inspection was the pharmacy's full-time resident pharmacist and the pharmacy's owner. He was supported by another full-time resident pharmacist, a full-time pharmacy technician, a part-time pharmacy assistant and a full-time trainee pharmacy assistant. The pharmacy also employed three other part-time pharmacy assistants and a delivery driver. The team members felt they had enough staff to manage the workload. They 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 provided the team members with a structured training programme. The programme involved team members completing various e-learning modules through a system called Virtual Outcomes. The modules covered various healthcare related topics and could be chosen voluntarily in response to an identified training need. The team members received protected training time during the working day to complete the modules. So, they could do so without any distractions. The team had recently completed training on topics such as sepsis. The trainee pharmacy assistant had been enrolled on her course for a few weeks. She received protected training time on Wednesdays to help her work through her course. The pharmacy did not have a formal performance appraisal process for its team members. But a formal process was due to be introduced later in the year. The team members had the opportunity to discuss their performance and personal development on an ad-hoc basis. A team member had recently asked for support to develop her knowledge about the incontinence products the pharmacy sold. She was given some protected time to help her achieve her goal.

The team members felt comfortable to raise professional concerns with the pharmacists. The pharmacy had a whistleblowing policy. And so, the team members could raise concerns anonymously. They were encouraged to give feedback to improve the pharmacy's services. The team set various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure, hygienic 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 was clean and professional in its appearance. The building was easily identifiable as a pharmacy from the outside. Although the dispensary was small, it was kept tidy and well organised during the inspection and the team used the bench space well to organise the workflow. Floor spaces were kept clear to minimise the risk of trips and falls. There was a small store room that was accessible from the retail area. It had a key coded lock to prevent unauthorised access. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with a sink with hot and cold running water and other facilities for hand washing. 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 smart and professional in appearance and was signposted by a sign on the door. 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 easily accessible to people. The pharmacy mostly manages its services appropriately and delivers them safely. It provides a popular flu vaccination service. And it suitably manages the risks associated with this service. The team members identify people taking high-risk medicines. And they support these people to take their medicines safely. The pharmacy sources its medicines from licenced suppliers. And it mostly manages and stores its medicines appropriately.

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. The pharmacy advertised its services and opening hours in the main window. There was a seating area for people to use while they waited for their medicines to be dispensed. The pharmacy displayed many healthcare related leaflets around the seating area which they could read and take home with them. For example, there was information on the importance of regular eye screening for diabetics. 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 small, laminated cards 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 dispensers signed the dispensing labels to show the dispensing process was complete. But the pharmacists did not countersign the labels to confirm they had completed a final check. And so, the pharmacy did not have a robust audit trail of the dispensing process in place. They used baskets to hold prescriptions and medicines which helped them organise the workflow effectively. The pharmacy did not have a system to highlight prescriptions for a CD that was not required to be stored in the CD cabinet. And so, the team members didn't always 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 dispensed high-risk medicines for people such as warfarin, lithium and methotrexate. The team members used written alerts which were attached to people's prescriptions as a reminder to discuss the person's treatment when handing out the medicine. The responsible pharmacist explained he did some basic checks with people when they came to collect their medicines. He checked 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. The team members demonstrated evidence of the advice they had given about the programme and that they had discussed pregnancy prevention.

The pharmacy provided a popular flu-vaccination service. It had completed around 400 vaccinations in the 2019-2020 season. The pharmacist who provided the service had certificates which showed he had the relevant training to provide it. And an up-to-date patient group direction (PGD) was seen. The

pharmacist completed all vaccinations in the consultation room and had various items readily available to help him administer the vaccinations safely. These included adrenaline pens, a sharps bin, gloves, plasters and alcohol hand gel.

Pharmacy medicines (P) were stored behind the pharmacy counter to prevent people self-selecting them. The pharmacy stored its medicines in the dispensary tidily. The team members were scheduled to check the expiry dates of its medicines to make sure none had expired. But they were not up to date with the process. They had last completed a full check in September 2019. No out-of-date medicines were found after a check of thirty randomly selected medicines. And the team members used alert stickers to help identify medicines that were expiring within the next six months. They didn't always record the date liquid medicines were opened on the pack. So, they couldn't 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. And the team had access to CD denaturing kits.

The team was 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. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record 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 cabinets were secured and of an appropriate size. The medicines inside the fridge and CD cabinets 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. The 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.

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.