General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 503 Gleadless Road, SHEFFIELD, South Yorkshire, S2 2BS

Pharmacy reference: 1039305

Type of pharmacy: Community

Date of inspection: 20/08/2019

Pharmacy context

This community pharmacy is amongst a parade of shops in a large suburb of Sheffield. The pharmacy dispenses NHS and private prescriptions. And it provides medication in multi-compartmental compliance packs to help people take their medicines. The pharmacy offers a repeat prescription ordering service. And it delivers medicines to people's homes. The pharmacy supplies over-the-counter products via a minor ailments scheme.

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 generally 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 for the team to follow. The pharmacy team has training and experience to respond well when safeguarding concerns arise. So, they can help protect the welfare of children and vulnerable adults. The pharmacy has adequate arrangements to protect people's private information. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and they usually act to prevent future mistakes. But they don't record all errors or the outcome from reviewing the errors. This means the team does not have up-to-date information to identify patterns and reduce mistakes.

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 pharmacy received alerts about new SOPs or changes via an internal notification system. The pharmacy had up to date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept electronic records of these errors. But for several months the team had not recorded all the errors. The new pharmacy manager had found little recording of errors. And had identified this was often caused by the team member not having ready access to the computer to record their error. The monthly patient safety report last completed in January 2019 also highlighted a lack of reporting. So, there was not enough information to support a full review. And identify patterns. The new manager had introduced a paper record to support and encourage team members to record their errors. The information from the paper record was then transferred to the electronic system at the end of the month. The pharmacy also recorded dispensing incidents electronically. Following an incident from June 2019 involving Tegretol the team were to separate the different versions of the product to reduce the risk of picking the wrong one. But this had not happened. So, the team had missed an opportunity to reduce the risk of the same error happening again. The pharmacy completed an annual patient safety report. The last report highlighted an error with bagging multi-compartmental compliance packs. Since the error the team members used clear bags to help them to check they had selected the correct pack. The team had separated amlodipine and amitriptyline to reduce the risk of errors when picking these products.

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 provide feedback. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. The team had received training on the General Data Protection Regulations (GDPR). But the pharmacy was not displaying a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding offsite.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The

pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. 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). And a sample of records of private prescription supplies showed compliance with legal requirements. Some records of emergency supply requests did not have the reason for the supply.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist and pharmacy technician had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team received regular Dementia Friends training as part of the mandatory e-learning modules. The team responded well when safeguarding concerns arose.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy’s services. And the team members support each other in their day-to-day work. Team members with managerial responsibility identify improvements to the delivery of pharmacy services. And introduce processes to improve team members efficiency and skills. The pharmacy offers team members opportunities to complete more training. But they have not received formal reviews on their performance for some time. So, they may miss the opportunity to reflect and identify training needs. And progress in their role or take on a new role to help the safe and effective delivery of services.

Inspector's evidence

A branch pharmacist covered most of the opening hours. Locum pharmacists provided support when required. The branch pharmacist was leaving the following day. So, the company had arranged for a regular locum pharmacist to cover during the recruitment of another branch pharmacist. The pharmacy team consisted of a full-time pharmacy technician, one full-time qualified dispenser who was the pharmacy manager and had been in post for four weeks, two part-time dispensers and a part-time trainee dispenser. At the time of the inspection the branch pharmacist, the pharmacy manager, the pharmacy technician, one of dispensers and a Well relief dispenser were on duty.

The new pharmacy manager was training team members on key tasks such as preparing the multi-compartmental compliance packs. So, these services or tasks such as date checking were not affected at times of absence. The new manager had also identified issues impacting on the efficient delivery of services. Such as preparing prescriptions for delivery to people on the day of delivery, which put pressure on the team. The manager worked with the team to introduce a system to enable the team members to have these prescriptions ready the day before delivery.

The pharmacy provided additional training through an online portal. The pharmacy had a process to provide performance reviews for the team. But the team hadn’t received a review for some time. The pharmacy had targets for services such as Medicine Use Reviews (MURs). There was no pressure to achieve them. The pharmacist offered the services when they would benefit 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 clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. And it displayed notices advising the team on correct hand washing techniques. The consultation room contained a sink and alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a large, sound proof consultation room. The team regularly used this for private conversations with people. The premises were secure. And the pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. And it gets its medicines from reputable sources. The pharmacy team stores and manages medicines appropriately. The pharmacy manages its services well. And it keeps records of prescription requests and deliveries it makes to people. So, the team can deal with any queries effectively. But the pharmacy team members don't effectively use the tools available to make sure supplies of some medicines are within the legal timescale of the prescription.

Inspector's evidence

Access to the pharmacy was via a small step. The team had asked for alterations to the step or a temporary ramp to be available. But this had not happened. The team looked out for people presenting at the front door who may need help getting in to the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team wore name badges detailing their role.

The pharmacy provided multi-compartmental compliance packs to help around 80 people take their medicines. The pharmacy was at capacity for this service whilst the team went through changes. The team also supplied the multi-compartmental compliance packs to people living in two care homes of 14 and five bed sizes. People received monthly or weekly supplies depending on their needs. The pharmacy manager currently managed the service. But was training all the dispensers to do this. So, the service was not affected by absence. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. The care home teams ordered the prescriptions. And sent the pharmacy team a list of the ordered medicines. So, they could spot any missing items. The pharmacy delivered the packs to the care home on a Thursday for the next cycle to start the following Monday. This gave the care home teams time to check the supply and chase up any missing medicines. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team used a room to the rear the of the dispensary away from the distractions of the retail area. And kept the empty packs banded together for the pharmacist to refer to when checking. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer's patient information leaflets. The team placed each completed pack in to a clear bag with the prescription attached. And kept the packs for each person in box files labelled with the person's name and address. The team stored the box files in alphabetical order on dedicated shelves. The team marked the box file to show when a person was in hospital. And it received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. The team received requests for medicine changes from the GP team on a specific form. The team kept all information about medicine changes for future reference.

The pharmacy provided methadone and buprenorphine as supervised and unsupervised doses. The team prepared the methadone doses using a Methasoft pump. The pump was linked to a laptop that

the team updated with the methadone doses on receipt of a new prescription. When the person presented at the pharmacy the team selected them from the laptop. And sent the dose to the pump to pour in to a cup for the person to take. The pharmacist asked the person to confirm their date of birth before supplying the dose. This helped to ensure the person received the correct dose. The pharmacist had developed a filing system for the methadone prescriptions that helped the team see who had collected their doses. And who was due to come in. The filing system also had a section holding new prescriptions for entering on to the Methasoft system. The team marked the prescription with the letter 'E' after entering the details in to the Methasoft system.

The pharmacy provided a repeat prescription ordering service. The pharmacy team members usually ordered the prescriptions a week before supply. This gave them time to chase up missing prescriptions, order stock and dispense the prescription. The pharmacy kept a record to help identify missing prescriptions. The pharmacy team members were aware of the valproate Pregnancy Prevention Programme (PPP). But they didn't have the PPP pack containing information to give to people. The pharmacy manager was arranging a pack to be sent to the pharmacy. The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. 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 include these items. The CD stickers had a section to record the date when the supply had to be made. To ensure it was within the 28-day legal limit. But the team used this section to record the name of the CD rather than the date. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And 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 used a 'use this pack first' sticker to highlight medicines with a short expiry date. No out of date stock was found. The team members 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. For example, an opened bottle of fluoxetine oral solution with one month's use once opened had a date of opening of 2 August 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out of date stock and patient returned medication. And it stored out of date and patient returned CDs separate from in date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). The team had been given a date when the equipment would be installed. 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 email. The team printed off the alert, actioned it 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 it mostly protects 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 equipment to accurately measure liquid medication. The pharmacy had two fridges to store medicines kept at these temperatures. One large fridge was for stock. This had a glass door to enable the team to view stock without prolong opening of the door. The other, smaller, fridge was for completed prescriptions awaiting collection. The pharmacy completed safety checks on the electrical equipment.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held most private information in the dispensary and rear areas, which had restricted access. But, some documents with people's names and addresses on were in a basket in the consultation room. The team invited people in to the room on several occasions during the inspection. The team used cordless telephones to make sure telephone conversations were held 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.