General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Basegreen Pharmacy, 39 Jaunty Way, Basegreen, SHEFFIELD, South Yorkshire, S12 3DZ

Pharmacy reference: 1039323

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). 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

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	4.1	Good practice	The pharmacy team reaches out to the community to help people improve their health and wellbeing. The team demonstrates how it helps people with specific needs take their medicines safely and effectively.
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 to help them complete tasks safely and effectively. 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 changes to their ways of working to reduce the risk of mistakes happening again.

Inspector's evidence

The pharmacy had a good-sized retail area. The dispensary was located behind the 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 to discuss confidential matters without being overheard by people in the retail area. The pharmacist used the bench closest to the retail area to complete final checks on prescriptions. And so, he could listen in to conversations the pharmacy's team members were having with people.

The pharmacy had a set of up-to-date electronic standard operating instructions (SOPs) in place. The SOPs included processes such as dispensing, taking in prescriptions and responsible pharmacist regulations. The SOPs did not have an electronic index available. So, it was difficult to find a specific SOP. They were prepared in June 2018 and were due to be reviewed in June 2020. 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 pharmacist or accuracy checking technician (ACT) highlighted any near miss errors made by the team when dispensing. 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. No entries had been made since December 2019. 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. So, they 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 had put up some posters around the dispensary to remind them of LASAs that were common in near miss errors. For example, propranolol and prednisolone, and quinine and quetiapine. They had also attached warning stickers next to where these medicines were stored. The stickers were to remind the team members to take more care when they were selecting them when dispensing. The pharmacy had a basic process to handle dispensing incidents that had reached the patient. The details of any incidents were recorded onto an incident report form. And the form was kept in the pharmacy for future reference and learning. The team members held a patient safety meeting if they were made aware of any incidents. And they talked about how they could stop a similar incident happening again. After the most recent incident, the team members decided they would stop interrupting the pharmacist with questions or queries while he was completing any final checks on prescriptions.

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 ACT only completed accuracy checks for multi-compartment compliance packs. The pharmacist first clinically checked the prescriptions. But there was no audit trail of the process. For example, the pharmacist didn't sign to confirm the clinical check had been completed. The ACT signed each pack to confirm she had completed the final accuracy check.

The pharmacy had a formal complaints procedure. And it was on display in the retail area for people to see. 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 superintendent pharmacist. The pharmacy collected feedback each year through questionnaires that were placed on the pharmacy counter for people to self-select and complete. And they were asked to place any completed questionnaires into a box so their responses could remain anonymous. The completed questionnaires were sent to the pharmacy's head office for analysis. Following the most recent survey the pharmacy had installed new plastic chairs to replace fabric cushioned chairs. This was because several participants of the survey felt the fabric cushioned chairs were not easily cleaned and therefore not hygienic. Also, the pharmacy had asked the delivery driver to start his deliveries earlier in the winter months. This was because several elderly people who received a home delivery of their medicines, did not want to receive a delivery in the late afternoon when it had gone dark.

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 was required to complete a full balance check of the CDs every week. But the team did not always do this. For example, the team hadn't checked the balance for some CDs since November 2019. 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 periodically destroyed using a shredder.

The responsible pharmacist and the ACT 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. He was supported during the inspection by a full-time accuracy checking technician (ACT), a part-time counter assistant and two part-time pharmacy assistants. The ACT was also the pharmacy's manager. The pharmacy also employed another full-time ACT, a part-time pharmacy assistant and two part-time delivery drivers. 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 asked 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 informed people of the waiting time for prescriptions to be dispensed and took 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 team members were scheduled to receive a performance appraisal each year. But the process had not been followed for a few years. The team members received informal, ad-hoc feedback about their performance and personal development. A team member had recently asked for support to develop her knowledge about medicines the pharmacy sold. She was given some time to read the packaging of many of the medicines.

The team members felt comfortable to raise professional concerns with pharmacist, the pharmacy manager or the pharmacy's head office. The pharmacy had a whistleblowing policy. So, the team members could raise concerns anonymously. They were encouraged to give feedback to improve the pharmacy's services. For example, following discussions the team installed a display in the retail area called 'What's on?'. The display had many posters for local services which the team members felt could be of interest to people. The pharmacy set the team 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. The dispensary 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 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 manages its services appropriately and delivers them safely. The pharmacy team reaches out to the community to help people improve their health and wellbeing. The team demonstrates how it helps people with specific needs, to take their medicines safely and effectively. It supports some people to take their medicines effectively, by dispensing them in multi-compartment compliance packs. And it suitably manages the risks associated with this service. The team members identify people taking high-risk medicines. And they support them to take their medicines safely.

Inspector's evidence

The pharmacy had level access from the street to the main entrance door. So, people with wheelchairs and prams could easily access the pharmacy. It stocked a wide range of healthcare related leaflets in the retail area, which people could select and take away with them. For example, leaflets on sexual health. The team members explained they would often help people select leaflets that might give them more information about a service they were interested in. For example, flu vaccinations. They regularly updated the 'What's on?' display. They were aware of events happening locally that may be of interest to people using the pharmacy. The team members had directed people to displays about weekly lunches for elderly people. The counter assistant explained how she discussed this with many people as she felt they may benefit from the social meeting. She had also discussed with people about local coffee mornings for people with dementia. The team had access to the internet to direct people to other healthcare services. And the pharmacy helped several people who had a visual impairment, to take medicines correctly. The team members helped them by attaching numbered dispensing labels on to their medicines. They gave them a separate sheet with large print directions. The sheets were numbered to correspond with the numbers on the dispensing labels.

The team members regularly used stickers to attach to bags containing dispensed medicines, 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. So, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines to reduce the risk of errors. And they were of different colours to help the team manage the workload effectively. The team members used 'CD' stickers to attach to the dispensed medicines bags. And they wrote the last day the CDs could be handed out to people on the stickers. This system helped prevent the team members 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. But the records did not always include a signature of receipt. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own 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 two weeks 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 a segregated area of the dispensary. This was to minimise distractions. The pharmacy managed the workload across four weeks. The team members used people's electronic medication records (PMR) to check off prescriptions and confirm they were accurate. They attached dispensing labels to the packs so people knew the medicines in the packs and the directions of how to take them. They supplied people with patient information leaflets and information to help them visually identify the medicines in the packs. For example, the colour and shape of the tablet or capsule.

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 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 had completed a check to see if any people who regularly used the pharmacy would benefit from information about the programme. No one had been identified.

Pharmacy medicines were stored behind the pharmacy counter. Which prevented people from self-selecting the medicines. Every two months, the team members checked the expiry dates of its medicines to make sure none had expired. No out-of-date medicines were found after a check of several randomly selected 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. The pharmacy received drug alerts via email. 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 fridges 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 team members used tweezers and rollers to help dispense multi-compartment compliance packs. 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.