

# Registered pharmacy inspection report

**Pharmacy Name:** Well, 517a Manchester Road, Stocksbridge,  
SHEFFIELD, South Yorkshire, S36 1DH

**Pharmacy reference:** 1039338

**Type of pharmacy:** Community

**Date of inspection:** 10/02/2023

## Pharmacy context

This community pharmacy is located on a parade of shops in the village of Stocksbridge, Sheffield. Its main services include dispensing NHS and private prescriptions and selling over-the-counter medicines. It provides some people and one local care home with their medicines in multi-compartment compliance packs. And it delivers some medicines to people's homes.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy appropriately identifies and manages most of the risks associated with the services it provides. It has written procedures to help the team carry out specific tasks. And it completes the records it needs to by law. Team members know how to protect the welfare of vulnerable people. But they don't keep records of the mistakes made during the dispensing process. And so, the team may miss opportunity to learn from these mistakes and make the pharmacy safer.

### Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs). The SOPs provided the team with information to help them complete various tasks. They were held electronically, and each team member had password protected access to them. Team members were required to read the SOPs that were relevant to their role and complete a short quiz to assess their understanding of them. They were required to do this within the first few months of starting employment at the pharmacy. Team members showed a clear understanding of their roles and were observed working within the scope of their role.

The pharmacy had a process to record any mistakes made during the dispensing process which were identified before the medicine was supplied to a person. These mistakes were known as near misses. Team members had access to an electronic system known as Datix, to keep these records. Within the system they were able to record when the near miss had happened and the type of near miss. For example, if they wrong number of tablets or capsules were dispensed. But the team had not used the process for several months and they were unsure how to access Datix in the absence of the pharmacy's resident pharmacist. Team members were informed if they had made a near miss error, and they corrected the mistake immediately. The team demonstrated limited learning from the near misses to prevent similar mistakes happening again. Team members explained they had recently talked about trying not to multi-task while dispensing to reduce distractions. And they were aware of dispensing with extra caution when dispensing medicines that had similar packaging or had similar names. The pharmacy used Datix to record and report any dispensing incidents that had reached a person. But the team was unable to demonstrate how they could use it in the absence of the resident pharmacist. The pharmacy had a concerns and complaints procedure which was displayed on a notice located in the retail area. Any complaints or concerns were verbally raised with a team member. If the team member could not resolve the complaint, it was escalated to the pharmacy's superintendent pharmacist's (SI) office.

The pharmacy had up-to-date professional indemnity insurance. It displayed the right responsible pharmacist (RP) notice. The RP register had been completed correctly. The pharmacy kept appropriate records of supplies against private prescriptions. The pharmacy retained complete controlled drug (CD) registers. And the team kept them in line with legal requirements. The team were required to completed balance checks of the CDs each week. But some CDs had not been balance checked for approximately three months. The balance of three randomly selected CDs were checked and were found to be correct. The pharmacy kept records of CDs returned to the pharmacy for destruction.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. The pharmacy displayed a privacy notice and how it managed people's

confidential data. The team placed confidential waste into a separate bag to avoid a mix up with general waste. The waste was periodically destroyed via a third-party contractor. Team members understood the importance of securing people's private information and they had all completed training on General Data Protection Regulations (GDPR). The pharmacy had a formal written procedure to help the team raise concerns about safeguarding of vulnerable adults and children. And team members had completed some basic training on the subject. Team members described hypothetical safeguarding situations that they would feel the need to report. They had access to the contact details of the local safeguarding teams.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough team members to manage its services. And they have the right qualifications and skills to provide the pharmacy's services. Team members can give feedback on ways the pharmacy can improve. And they complete ongoing training to keep their knowledge and skills up to date.

### Inspector's evidence

The RP on the day of the inspection was a locum pharmacist. The RP was supported by two trainee pharmacy assistants and a qualified pharmacy assistant. The pharmacy employed another qualified pharmacy assistant and a delivery driver. All the assistants worked part-time. The pharmacy had a full-time pharmacist manager. Locum pharmacists covered days when the pharmacist manager didn't work. Team members worked additional hours to cover each other's planned or unplanned absences. The team was observed working well together during the inspection. They were seen involving the RP when talking to people about their health and when considering a suitable over-the-counter medicine to help people manage specific health conditions. Team members were managing the pharmacy's dispensing workload well and they were a few days ahead of the workload. This helped them work without time pressures. The team explained they had been working in this way since the pharmacist manager had joined the team. Prior to this, the pharmacy was mainly managed by locum pharmacists. Team members described this time as stressful, but they were happy the pharmacy was now more organised, and the workload was manageable.

The pharmacy provided each team member with access to a third-party training programme to help support them update their knowledge and skills. The programme consisted of a range of online healthcare related modules for team members to work through. Most modules had a short assessment for team members to complete to assess their understanding. Team members who were enrolled on a training course were given additional time to work through their respective courses. Each team member was given around one to two hours of protected time each month to complete their training so they could do so without interruption. Most recently, the team had completed training on weight management, identifying cases of domestic violence and spotting signs of cancer.

Team members attended informal team meetings where they could discuss any professional concerns and give feedback on ways the pharmacy could improve. Recently the team had decided to reorganise medicines stored in the dispensary. These medicines were now stored tidily, and team members described how this measure had reduced the time they took to complete the dispensing workload. The team was set some targets to achieve. The team did their best to achieve the targets but focused on aiming to provide an efficient service for the local community.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy keeps its premises clean and secure. And they are suitable for the services the pharmacy provides for people. The pharmacy has a suitable consultation room where people can have private conversations with team members.

### Inspector's evidence

The pharmacy was clean, well maintained and highly professional in appearance. Throughout the inspection, the team kept benches in the dispensary well organised with baskets containing prescriptions and medicines awaiting a final check by the RP. The dispensary was spacious, and the floor space was kept clear from obstruction. There were clearly defined areas used for the dispensing process and there was a separate bench used by the RP to complete the final checking process. The pharmacy had ample space to store its medicines. There was a small staff area at the rear of the premises. It was occasionally used by the team to complete some dispensing activities. There was a private, soundproofed and signposted consultation room available for people to have private conversations with team members.

The pharmacy had separate sinks available for hand washing and for the preparation of medicines. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Team members controlled unauthorised access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's services are easily accessible to people. And it generally manages its services well to help people manage their health effectively. The pharmacy sources its medicines appropriately and the pharmacy team completes checks of the expiry dates of the medicines to make sure they are fit for purpose.

### Inspector's evidence

People had level access into the pharmacy through the automatic main entrance door from street level. This made it easy for people using wheelchairs or pushchairs to enter the pharmacy. The pharmacy advertised its services in the main window. The pharmacy had a facility to provide large print labels to people with a visual impairment. The team helped some people who didn't speak English via translation applications. There were some healthcare related information leaflets for people to take away with them. Team members were aware of the importance of not covering braille on medicine packaging with dispensing labels.

Team members demonstrated a basic awareness of the Pregnancy Prevention Programme (PPP) for people in the at-risk group who were prescribed valproate, and of the associated risks. They were unsure of the advice they would give in a hypothetical situation, but they explained they would highlight any prescriptions for valproate for the attention of the RP. Team members used various stickers to attach to bags containing people's dispensed medicines. They used these as an alert before they handed out medicines to people. For example, to remind team members to ask people if they wished to book in for a flu vaccination, or the presence of a fridge line or a CD that needed handing out at the same time. Team members signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. The pharmacy had owing slips to give to people when the pharmacy could not supply the full quantity prescribed. The pharmacy offered a delivery service and kept records of completed deliveries. And it kept an audit trail of the service.

The pharmacy sent several prescriptions to be dispensed at the Well offsite hub pharmacy. This was to help reduce the dispensing workload pressure on the team. The team inputted data from the prescriptions onto an electronic system. The pharmacist then accuracy checked the data and completed a clinical check of the prescriptions before submitting the data electronically to the hub pharmacy. Prescriptions were usually dispensed at the hub pharmacy and then delivered to the pharmacy in around three days. The team had the ability to 'recall' prescriptions from the hub pharmacy. Team members did this if people needed their prescriptions dispensing immediately at the pharmacy. Dispensed medicines arrived in sealed, barcoded bags. Team members scanned the barcodes to confirm the pharmacy had received the medicines.

The pharmacy dispensed medicines for some people into multi-compartment compliance packs. These packs were designed to help people to remember to take their medicines at the correct times of the day. The medicines were dispensed into small, sealed pods relating to the day and time of the day they should be taken by the person. For example, Tuesday, morning. The dispensing workload for the packs was spread evenly over a four-week period to help the team efficiently manage the workload. The team

ordered prescriptions for people supplied with the packs a week in advance of them being due for collection or delivery. This gave the team plenty of time to manage any queries, such as medicines that were missed off prescriptions. Team members used master sheets to cross-reference prescriptions to ensure they were accurate. The packs were not always supplied with patient information leaflets, but they were annotated with descriptions of the medicines inside. For example, green, round, tablet. The team didn't keep records of any changes to people's treatment. For example, if the team was informed by a person's GP that a particular medicine was not required to be dispensed in the packs. This meant that an audit trail was not in place.

The pharmacy stored some pharmacy-only (P) medicines directly behind the pharmacy counter and some in clear, plastic containers located around the retail area. There was a notice displayed on the front of each box asking people to seek assistance if they wished to purchase any of the medicines inside. The pharmacy had a process for the team to check the expiry date of the pharmacy's medicines. Team members explained they were up to date with the process, but they were unable to demonstrate any records to confirm this. No out-of-date medicines were found by the inspector following a check of approximately 30 randomly selected medicines. The pharmacy's medicines were tidily stored in the dispensary. The pharmacy had one fridge to store medicines that needed cold storage. At the time of the inspection the fridge was operating between the correct temperature ranges. But the team had not kept daily records of the fridge's temperature ranges. There were no records kept for February 2023. Following the inspection, the inspector spoke with the pharmacist manager. The pharmacist explained he had regularly checked the fridge temperature ranges but did not always record them. The pharmacist gave assurances that the team would make daily records of the fridge temperature ranges following the inspection. The team marked liquid medicines with details of their opening dates to ensure they remained safe and fit to supply. The pharmacy had medicine waste bags and bins, sharps bins and CD denaturing kits available to support the safe disposal of medicine waste. It received medicine alerts electronically through email and the company intranet. The team actioned the alert and kept a record of the action taken.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the appropriately maintained equipment that it needs to provide its services. And it uses its equipment appropriately to help protect people's confidentiality.

### Inspector's evidence

Team members had access to up-to-date reference sources. The pharmacy used a range of CE marked measuring cylinders. The pharmacy used an electronic blood pressure monitor which was due to be replaced every two years.

The pharmacy stored dispensed medicines in a way that prevented members of the public seeing people's confidential information. It suitably positioned computer screens to ensure people couldn't see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that 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.