General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, 439 Richmond Road, SHEFFIELD, South Yorkshire, S13 8LU

Pharmacy reference: 1039365

Type of pharmacy: Community

Date of inspection: 27/02/2020

Pharmacy context

This is a community pharmacy 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 through its NHS services. The pharmacy supplies medicines in multi-compartment compliance packs to some people living in their own homes. And it provides a substance misuse service and a home delivery service.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 has an up-to-date set of procedures to help identify and manage risks to its services. The pharmacy's team members follow them to make sure they work 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 and how to raise a concern to safeguard the welfare of vulnerable adults and children. The team members record, discuss and analyse any mistakes that happen within the dispensing process. They demonstrate how they learn from their mistakes. And how they implement changes to reduce the risk of mistakes happening again.

Inspector's evidence

The pharmacy had an open plan dispensary and retail area. 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 superintendent pharmacist's office reviewed the procedure every two years on a monthly rolling cycle. It sent new and updated procedures to pharmacy team members via the eExpert online training system approximately each month. Once the team members had read the contents of the SOP, they needed to complete a short quiz to test their understanding. They had to pass the quiz to be signed off as having read and understood the SOP. A pharmacy assistant demonstrated that she had completed 99% of the SOPs that were relevant to her role. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team.

The pharmacist highlighted any near miss errors made by the team when dispensing. The team members recorded their own mistakes which helped with their learning. They entered the details of the near miss errors on to an online reporting system called Datix. But they didn't record every near miss error as they didn't always have the time to do so. They discussed the errors made at the time, so all the team members present could be made aware of what went wrong. And what they could do to prevent a similar error happening again. The near miss errors were analysed each month by the pharmacist and the findings were documented into a report. The most common near miss error involved team members selecting the incorrect strength of medicines. The team members held a brief meeting and discussed what they could do to improve. The pharmacist explained he advised the team to avoid unnecessary distractions, such as breaking off from dispensing a prescription to answer the phone. The team members said they had less near miss errors since the discussion. The pharmacy had a process for dealing with dispensing errors that had been given out to people. It recorded incidents on the Datix system. And kept a paper copy in the pharmacy for future reference and learning. A recent report described an occasion where the pharmacy had supplied a person with a soluble form of a medicine instead of its standard form. But the report didn't outline the action the team had taken to prevent a similar incident happening again.

The pharmacy was displaying the correct responsible pharmacist notice at the time of the inspection.

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. It was on display in the retail area to allow people to easily access it. 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's team. 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 up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescriptions 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 week. 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 completed training each year via the eExpert online training system. 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 collected by a third-party contractor and securely destroyed.

The responsible pharmacist 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. And there was some written guidance available to help them manage any concerns. For example, there was written guidance on what to do if a team member suspected abuse of a child. If the team members needed further guidance, they explained they could telephone the pharmacy's superintendent's office for support.

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. The pharmacy team members complete training to keep their knowledge and skills up to date. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns if necessary.

Inspector's evidence

The responsible pharmacist at the time of the inspection was the pharmacy's manager and full-time resident pharmacist. Two full-time trainee pharmacy technicians and a full-time pharmacy assistant supported him. The pharmacy also employed another five part-time pharmacy assistants and a part-time delivery driver who was responsible for collecting prescriptions from surgeries and delivering dispensed medicines to people's homes. The team members felt they had enough staff to manage the workload particularly since the pharmacy had started using the company's offsite dispensing hub. They were seen working efficiently and effectively throughout the inspection. They were working without pressure and the prescription wait time was around five minutes. The team members often worked additional hours to cover absences and holidays. The team members supported each other and were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various e-learning modules through the eExpert online system. The modules covered various topics including health and safety, new and revised SOPs and health conditions such as pain relief. Some modules were mandatory, and others 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. But they were not always able to take the time because of the dispensing workload. They completed training at home if they were unable to complete the training during the working day. The team members were due to receive a performance appraisal every six months. But the process had not been completed regularly.

The team members felt comfortable to raise professional concerns with the pharmacist or the pharmacy's regional development manager. 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, they had recently implemented a process to send letters to remind people to collect their medicines if they had not done so for four weeks. 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 clean, hygienic and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak privately to 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 generally kept tidy, but some benches were cluttered with miscellaneous items. Some boxes containing medicines were stored on the dispensary floor. This caused a risk of a trip or a fall. But this improved as the inspection progressed. 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. It was signposted by a sign on the door. The room was used to store some miscellaneous stock. So, the room didn't look professional. The team members provided assurances the stock would be removed after the inspection. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services appropriately and delivers them safely. It provides some medicines in multi-compartment compliance packs to help people take them correctly. And it manages the risks associated with the service. It keeps audit trails of the dispensing and home delivery services. So, the team can effectively manage any queries. The pharmacy sources its medicines from licenced suppliers. And it manages and stores its medicines appropriately.

Inspector's evidence

The pharmacy had a small step from the street which led to the main entrance door. But there wasn't a ramp available. So, people with prams and wheelchairs may have struggled to access the premises. There was a bell affixed to the pharmacy counter. People could use it to attract the attention of a team member. The pharmacy advertised its services and opening hours in main window. And there were several healthcare related leaflets available for people to select and take away with them. For example, about the local sexual health clinic and smoking cessation. The team members had internet access. They could use the internet to signpost people to other pharmacies or healthcare providers if they were unable to provide a service. There was a hearing loop to help people with a hearing impairment. And the pharmacy could provide large print labels to help people who had a visual impairment. A team member was able to communicate with people in polish if required.

The team members regularly used various stickers that they could use 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 to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. Baskets were available to hold prescriptions and medicines to help manage the workflow efficiently. And they were of different colours to help the team separate different parts of the dispensing workload. For example, blue baskets were used for prescriptions for home delivery. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. The team members gave people owing slips when the they could not supply the full prescribed quantity. One slip was given to the person. And one kept with the original prescription for reference when the remaining quantity was dispensed and checked. The team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. So, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy had recently introduced a new system for dispensing many of the prescriptions it received, at the company's offsite dispensing hub. The system was designed to reduce the team's dispensing workload and allow the team members more time to offer services such as medicine use reviews. The team members made sure they told people if their medicines were dispensed at the hub. And they were given the opportunity to opt out of the service. Each team member had received comprehensive training before the process went live. The team firstly assessed whether a prescription was suitable to be dispensed at the hub. Any prescriptions that were for CDs or fridge items were not sent. The team also avoided sending prescriptions for more urgent items such as antibiotics. Once it was established that a prescription was suitable to be sent to the hub, the data was entered. And then

the pharmacist completed an accuracy and clinical check. Only the pharmacist, using their personal smart card and password, was able to perform the clinical and accuracy check and release prescriptions to the hub. Each item on the prescription was marked with an 'H' if it was to be dispensed at the hub. The hub assembled items using automation. It took around two or three days for prescriptions to be processed and the medicines to be received from the hub. The team marked all prescriptions that were sent to the hub and stored them in a separate box to prevent them being mixed up with other prescriptions. The pharmacy received the medicines that had been dispensed at the hub in sealed bags. The bags were then coupled with the relevant prescription. And then scanned on the shelves in the prescription retrieval area, ready for collection. Each day the pharmacist opened one randomly selected bag that had been dispensed at the hub and completed another accuracy check. This was to ensure the pharmacy completed a regular quality check.

The pharmacy had some basic process to help people safely take high-risk medicines, such as warfarin. The pharmacist provided some verbal counselling when handing out warfarin, which included checking if the person had a recent blood test and their INR was within range. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. The team members used alert stickers to attach to people's medication bags to remind the person handing out that the bag contained valproate. They demonstrated the advice they would give people in a hypothetical situation. The team had access to patient guides and information cards about the programme that they could provide to people to help them take their medicines safely.

The pharmacy supplied methadone to several people as both supervised and unsupervised doses. It used a Methameasure dispensing system to dispense the methadone instalments. The instalments were dispensed when people presented. People were offered a small glass of water after they had taken their dose. The pharmacist supervised any doses in the consultation room.

The pharmacy supplied medicines in multi-compartment compliance packs for some people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The workload was managed across four weeks. The team was responsible for ordering people's prescriptions. And this was done in the third week of the cycle. Which gave the team members a week to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the packs in a segregated part of the dispensary. This was to minimise distractions. And they kept all documents related to each person on the service in separate wallets. The documents included master sheets which detailed the person's current medication and time of administration. The team members used these to check off prescriptions and confirm they were accurate. They supplied backing sheets with the packs, which listed the medicines in the packs and the directions. And information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. But this information wasn't always specific. For example, on one backing sheet, two tablets were both described as 'round tablets'. Patient information leaflets were provided.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The medicines in the dispensary were tidily stored. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. And the team was up to date with the process. No out-of-date medicines were found following a check of some randomly selected medicines. The team members used alert stickers to help identify medicines that were expiring within the next twelve months. They recorded the date liquid medicines were opened on the pack. So, they could 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 destruction kits.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received some training on how to follow the directive. The team members were unsure of when they were to start following 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 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 reference sources, including 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. The Methameasure system was cleaned and calibrated each day.

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.