

Registered pharmacy inspection report

Pharmacy Name: Shoreham Pharmacy, 255 Shoreham Street,
SHEFFIELD, South Yorkshire, S1 4SS

Pharmacy reference: 1039372

Type of pharmacy: Community

Date of inspection: 18/07/2019

Pharmacy context

The pharmacy is near to a GP surgery close to Sheffield city centre. The pharmacy dispenses NHS and private prescriptions. It supplies medicines in multi-compartmental compliance packs to help people take their medication. And it delivers medication to people's homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	The pharmacy apprentice carries out dispensing activities for which they are not appropriately qualified or trained.
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 has written procedures that the pharmacy team follows. The pharmacy keeps the records it needs to by law. People using the pharmacy can raise concerns and provide feedback. And the pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. And they discuss what occurred and act to prevent future mistakes. But they don't complete full records of errors or fully review the mistakes. This means the team does not have useful information to help identify patterns and reduce errors. The pharmacy has adequate arrangements to protect people's private information. But it doesn't display details about how it protects people's private data.

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 team had read and signed the SOPs signature sheets to show they understood and would follow them. 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 records of these errors. A sample of the error records looked at found the team didn't record details of what had been prescribed and dispensed to spot patterns. Some records included the learning points such as the person involved to be more focused or to double check the medication picked. Many entries in the section detailing the actions to prevent similar errors were limited to a single statement of yes. Or that the team member involved had changed the incorrect item. Rather than a reflection of individual thought and actions. The pharmacy used community pharmacy patient safety forms to record dispensing incidents. The pharmacist stated that dispensing incidents were rare. One report dated 03 October 2017 captured an error with multi-compartmental compliance packs. The report detailed the actions the team took to prevent further errors. This included the team prioritising the workload of these packs. The pharmacy didn't review errors to identify patterns or record the actions the team took to prevent the same mistakes from reoccurring.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. But it didn't have information to provide people with details on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

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. Records of private prescription supplies, and emergency supply requests 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). The team had not received training on the General Data Protection Regulations (GDPR). The pharmacy did not display a privacy notice in line with the requirements of the GDPR. The

team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The team had not had the occasion to report such concerns.

Principle 2 - Staffing Standards not all met

Summary findings

Most of the pharmacy's team members have the qualifications and skills they need to provide safe and efficient services. But the pharmacy apprentice carries out dispensing activities for which they are not appropriately qualified or trained. The team members receive some feedback about their performance. And they discuss how they can make improvements to their ways of working. The pharmacy gives its team members opportunities to complete more training to keep their skills and knowledge up to date.

Inspector's evidence

Regular pharmacists covered most of the opening hours. Locum pharmacists provided support when required. The pharmacy team consisted of one full-time trainee pharmacy technician, two part-time qualified dispensers, a pharmacy apprentice doing counter assistant training and a delivery driver. The part-time dispenser had increased their hours to support the team during a colleague's sickness. The team provided support to the pharmacy apprentice who could approach team members to ask questions. And got feedback from the pharmacist and trainee pharmacy technician on how they worked. Many of the recorded errors from the dispensing process named the pharmacy apprentice. These records went back to December 2018. This meant that the pharmacy apprentice was also involved with dispensing. But their training course did not cover this activity.

The pharmacy provided extra training through e-learning modules. The pharmacy did not provide formal performance reviews to the team. But the team members received informal feedback. Team members could suggest changes to processes or new ideas of working. The trainee pharmacy technician suggested the process of putting people's initials on the tops of bottles holding methadone doses. So, the team could do an extra check to ensure the correct person's medication was selected. If people had the same initials, the trainee had suggested using the first and second letter of the person's first name. Evidence of this was seen. The pharmacy did not set targets for services such as Medicine Use Reviews (MURs). 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 had alcohol gel for hand cleansing. The pharmacy used wooden benches on the floor against one of the walls to hold baskets containing dispensed medicines. This helped to keep the floor spaces clear and reduce the risk of trip hazards.

The pharmacy had a soundproof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. 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 generally manages its services well. The pharmacy keeps its records about prescription requests up to date, so it can resolve any queries effectively. But it does not get signatures of receipt for all deliveries of medicines to people's homes. So, the team doesn't have confirmation that the person has received their medicine if a query arose. The pharmacy gets its medicines from reputable sources and generally stores and manages its medicines appropriately.

Inspector's evidence

People accessed the pharmacy via steps or a ramp with handrails. The window displays were limited to the opening times. The pharmacy didn't have information providing people with details of the services it offered and the contact details of 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 pharmacy provided multi-compartmental compliance packs to help around 81 people take their medicines. People received monthly or weekly supplies depending on their needs. The trainee pharmacy technician managed the service. And got support from others in the team. To manage the workload the team divided the preparation of the packs across the month. The trainee pharmacy technician dispensed the medication in to the packs before the prescription arrived. The trainee referred to the backing sheet that went with the packs. This listed the person's current medication, dosage and dose times. This meant there was a risk of the team not identifying changes. And increasing the team's workload when spotting changes to the medicines after dispensing. The dispensed packs were stored on dedicated shelves awaiting the final check by the pharmacist when the prescription arrived. The dispenser kept the empty packets of the dispensed medicine for the pharmacist to refer to when checking the packs. The team used a section to the rear of main dispensary to dispense the medication in to the packs. This was away from the distractions of the retail area and pharmacy counter. The team sometimes recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets. The team stored completed packs in tote boxes labelled with the day of the week of supply to the person. The pharmacy received copies of hospital discharge summaries. And asked the hospital team to send a copy to the person's GP. The team checked the discharge summary for changes or new items. The team separated packs for people in hospital. And recorded hospital admissions on a board so all the team knew.

The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy stored the prepared doses in the controlled drugs cabinet with the prescription attached to the dose due. And wrote the person's initials on bottle tops containing the doses. To reduce the risk of selecting the wrong one. The pharmacy provided a repeat prescription ordering service. The team members usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. And they kept a record of the request including the number of medicines ordered. The team regularly checked the record to identify missing prescriptions and chase them up with the GP teams. The team informed people who had their

medicines from the repeat dispensing process when they had two sets of prescriptions left. This gave the person the chance to arrange the next set of prescriptions. And to attend the GP surgery if a review or blood test were due.

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 team had checked if anyone met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found no-one who did. The pharmacy didn't have the PPP pack to provide information to people when required. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. 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. But this was only for CD deliveries. So, the pharmacy didn't have a full audit trail or proof of delivery for all prescriptions.

The pharmacy team checked the expiry dates on stock. And it had a template to record this. But, the last date check recorded was on 18 October 2018. The team used coloured dots to highlight medicines with a short expiry date. No out of date stock was found. The team members usually 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. But an opened bottle of cetirizine oral solution with six months use didn't have a date of opening 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 controlled drugs (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 equipment to meet the requirements of the Falsified Medicines Directive (FMD). And a computer software upgrade was due. 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 but only sometimes kept a record.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect 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. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. The fridge had a glass door that allowed the viewing of stock without the door being open for a long time.

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 private information in the dispensary and rear areas, which had restricted access. 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.