General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Charnock Pharmacy, Charnock Health Centre, White Lane, Gleadless, SHEFFIELD, South Yorkshire, S12 3GH

Pharmacy reference: 1087793

Type of pharmacy: Community

Date of inspection: 13/11/2019

Pharmacy context

This is a community pharmacy next to a health centre in the village of Gleadless, 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 services such as the NHS new medicines service, seasonal flu vaccinations and a home delivery service. It supplies medicines in multi-compartmental compliance packs to people living in their own homes.

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 identifies and manages the risks associated with the services it provides to people. And it has a set of written procedures for the team members to follow to help them deliver the services safely and effectively. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The pharmacy's team members openly discuss and record any mistakes that they make when dispensing. So, they can learn from each other. And they implement changes to minimise the risk of similar mistakes happening in the future. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children.

Inspector's evidence

The pharmacy had an average sized retail area which led to the dispensary at the rear of the pharmacy. The pharmacy counter prevented access from the retail area to the dispensary. The area was open plan and the pharmacist on duty used the dispensary bench which was closest to the retail area to complete final checks on prescriptions. So, he could over see any sales of medicines and listen to any conversations the pharmacy's team members were having with people who used the pharmacy. There was a constant flow of people coming into the pharmacy with prescriptions that had been issued by the next-door health centre.

The pharmacy had a set of written standard operating procedures (SOPs) which detailed how the team members should carry out various processes. For example, the taking in and dispensing of prescriptions and the sale of over-the-counter medicines. A separate SOP was available for the dispensing of medicines in multi-compartmental compliance packs. There was a basic index, but the SOPs were not kept in order. And so, it was difficult to locate a specific SOP. The roles and responsibilities of the team members was outlined within each SOP. And each team member had signed the SOPs relevant to their role to show they had read and understood them. Most of the SOPs had been reviewed within the last two years. A team member described how she would ask the pharmacist if there was a task she was unsure about, or unable to deal with.

The pharmacy had completed a risk assessment prior to providing this seasons flu vaccination service. The risks identified included the risk of a needle stick injury and the risk of hepatitis B infection. To manage the risks, the pharmacy had ensured that the pharmacist had up-to-date training on the vaccination technique.

The pharmacy kept records of near miss errors the team made in a paper near miss log. The team members recorded most of the errors they made, but the pharmacist explained they did not always do so as they did not always have time. The details recorded included the time and date the error was made, and the nature of error, for example the wrong label or the wrong quantity. But the team members did not always record the reason the error may have happened or what they had learned from it. And so, they may have missed out on some learning opportunities. The team members openly discussed the errors that happened. And they did this as soon as possible. This was to make sure they did not forget the details of the error and to make the team aware of the learning points straight away. The pharmacist also analysed the errors each month for any trends and patterns. And he documented and discussed his findings with the team. The pharmacy had recently had several errors involving the incorrect selection of different strengths of some medicines such as nitrofurantoin and co-codamol. The pharmacist explained that he felt the best way to prevent similar errors happening again, was to raise

awareness of the potential for errors with these medicines. And, to remind the team to take extra care when they are selecting the medicines. He explained he had considered separating some medicines from each other to prevent incorrect selection. But this action had not been successful in the past. The pharmacy used a similar system to record details of dispensing incidents that had reached the patient. These types of incidents were documented and reported to the National Reporting and Learning System (NRLS). Which is a system to allow healthcare professionals to share and learn from incidents. The most recent incident involved the pharmacy supplying a person with the incorrect medicine. The pharmacist held a team meeting to discuss the incident and ensure all team members were aware of what had happened and to consider what they could do to prevent a similar error happening again. The team members attached alert stickers next to the medicine involved in the error to remind them to take extra care when dispensing.

The pharmacy had a formal complaints procedure. It was available in the retail area for people who used the pharmacy to see. And there was a complaints guidance document kept in the dispensary for the team to use. A team member explained she would always try to resolve any complaints informally but would escalate any complaints that were not successfully resolved to the pharmacist. The pharmacy asked people for feedback on the pharmacy's performance through an annual customer satisfaction survey. It had recently started collecting completed questionnaires for this most current survey. It kept a copy of the results of the last survey in the retail area. So, people could read it if they wished to do so. An example of an area of the pharmacy that required improvement was the time the team took to acknowledge people who were waiting to be served. The team explained that often they were busy dispensing prescriptions and did not notice that people were waiting in the retail area. To improve, the pharmacy had a bell installed on the retail counter, which people who were waiting could use to attract the attention of the team.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the name and registration number of the responsible pharmacist on duty. But the size of the font on the display was small and it was difficult to see the details of the responsible pharmacist from the retail area. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock at least every month. A physical balance check of Elvanse 30mg matched the balance in the register. 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 team was aware of the need to keep people's personal information confidential. And they had all undertaken General Data Protection Regulation (GDPR) training and signed a confidentiality agreement. And they were seen offering the use of the consultation room to people to discuss their health. 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 via a third-party contractor.

The pharmacist and two other team members had completed training on safeguarding vulnerable adults and children via the Centre for Pharmacy Postgraduate Education. All other team members had completed training via the Virtual Outcomes training programme. They gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. The pharmacy assistant explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance that the team could refer to, on how to manage or report a concern and the contact details of the local safeguarding team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely. They work well together to manage their workload and to ensure people receive a high-quality service. The pharmacy team members complete regular 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 when necessary.

Inspector's evidence

At the time of the inspection, the responsible pharmacist was the pharmacy's superintendent pharmacist who had been working at the pharmacy for over ten years. He was supported by two full-time accuracy checking technicians (ACTs), a full-time pharmacy assistant and a part-time pharmacy assistant. The team members who were not present during the inspection were four part-time pharmacy assistants, two part-time counter assistants and two delivery drivers. The pharmacist organised the team rotas in advance to ensure enough support was available during the pharmacy's busiest times. The team members were observed managing the workload well and were not seen to be working under pressure. A team member was seen asking the pharmacist for support, when she was presented with a difficult query about a person's medicines. Another team member was seen helping a person select a suitable product for a young child who presented with a chesty cough. And one of the ACTs was seen calling other pharmacies in the area to find out if they had a medicine that the pharmacy did not have in stock. They mostly acknowledged people as soon as they arrived at the retail counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. The team members felt they had enough staff to manage the workload efficiently, especially when all the team members were available to work. They said they could speak to the pharmacy's owner if they needed extra support and they often received additional support if they felt they were falling behind with their workload. And to make sure they provided the high quality of service they aimed to achieve. The team members often worked additional hours to cover absences and holidays. They 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.

Each team member was enrolled onto the Virtual Outcomes training programme. The programme had various modules for the team members could work through. And they were required to pass a short quiz to confirm they had read and understood the module. Some of the modules were mandatory to complete and the pharmacist asked the team to complete an average of one module per month. The team members were also able to choose a module to complete voluntarily. For example, if they had an interest in a particular subject. The team had recently completed training on safeguarding. The team used a small office to train when they had time to do so. So, they could train without distractions. The pharmacy encouraged the team members to attend external training events if they wished to do so. A team member had recently attended a training event on dementia as she had a family member who was suffering from dementia and wanted to use the training to help her and people who used the pharmacy.

The team attended ad-hoc, informal meetings and discussed topics such as company news, targets and patient safety, when the pharmacy was quiet. The team members felt comfortable to give feedback or

raise concerns with the pharmacist or the company's human resources team, to help improve the pharmacy's services. The pharmacy had a whistleblowing policy. And so, the team members could raise concerns anonymously. The team was set various targets to achieve. These included the number of prescription items they dispensed and the number of services they 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 kept secure and is 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 not particularly tidy at the start of the inspection. As there were several baskets containing prescriptions and medicines awaiting a final check stacked on top of each other. But this improved as the inspection progressed. 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 WC which had a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had two sound-proofed consultation rooms. One of the rooms was a secondary room and was generally now used as an office. The main consultation room was not well signposted and could have been tidier. It contained two seats and a sink. 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. It engages with people using the pharmacy to help them improve their health. The pharmacy provides medicines to some people in multi-compartmental compliance packs to help them take them correctly. And it suitably manages the risks associated with this service. It delivers medicines to people's homes. But doesn't ask people to sign for receipt of their medicines. So, it may be difficult to resolve any queries and mistakes. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had level access from the street to the entrance door. Which allowed people with prams and wheelchairs to enter the pharmacy unaided. The pharmacy could supply people with large print dispensing labels if needed. The pharmacy advertised its services and opening hours in the main window. 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 sleeping disorders, indigestion and acne. The pharmacy had an eye-catching display of information about stopping smoking and taking antibiotics safely. The team members described how several people had engaged with the display. And how they then had an opportunity to speak to people about their health and give healthy living advice.

The team members regularly used various stickers during dispensing 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. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people’s prescriptions from getting mixed up. The baskets were of different colours to help the team identify prescriptions that were for delivery, for people who were calling back or for people who were waiting in the pharmacy. They used CD alert stickers to attach to medication bags. This system helped the team members check the dates and helped prevent them 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 include a signature of receipt. So, there wasn’t 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 supplied medicines in multi-compartmental compliance packs for around 120 people living in their own homes. And 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 a week 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 medication on a bench furthest away from the retail area. This was to minimise distractions. The pharmacy managed the workload

across four weeks to help them spread the workload evenly. And it kept all documents related to each person on the service in separate wallets. The documents included master sheets which the team members used to check off prescriptions and confirm they were accurate. They also kept details of any changes in people's medicines. And they kept records of who had authorised the change, for example, the person's GP. The packs were supplied with information 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. It also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used alert stickers or annotated the bag label attached to people's medication bags to remind them that the bag contained a high-risk medicine. They then brought the bag to the attention of the pharmacist. The pharmacist then asked the person various questions to make sure they were taking their medicines safely. For example, if they had been having regular blood tests and if they understood their dosage. 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 had access to literature about the programme that they could provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And it identified several people. It contacted the surgery of each person to confirm they had received the appropriate advice. And they were on a pregnancy prevention programme.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy stored its medicines in the dispensary tidily. Every three 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 random check. And the team members used alert stickers to help identify medicines that were expiring within the next 12 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 were 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 not received training on how to follow the directive. But had the correct type of scanners and software installed. The pharmacist had no immediate plans to ensure the pharmacy was FMD compliant. 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. It had one CD cabinet in place. And it was secured and of an appropriate size. The medicines inside 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-compartmental compliance packs. The fridge used to store medicines was of an appropriate size. And the medicines inside were organised in an orderly manner. 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 telephones, so the team members could have conversations with people in private. The pharmacy's electrical equipment was clean. Wires and plugs were visibly free from wear and tear.

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.