General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Weldricks Pharmacy, 1 Moorthorpe Bank, Off Moorthorpe Way, Owlthorpe, SHEFFIELD, South Yorkshire, S20 6PD

Pharmacy reference: 1087941

Type of pharmacy: Community

Date of inspection: 13/02/2020

Pharmacy context

This is a community pharmacy next to a GP surgery in the village of Owlthorpe, 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, flu vaccinations and medicines use reviews. It supplies some medicines in multi-compartment compliance packs to people living in their own homes. And it provides a home delivery service.

Overall inspection outcome

✔ **Standards 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	1.2	Good practice	The team members are good at regularly discussing and recording any mistakes that they make when dispensing. So, they can learn from each other. They talk about why the mistakes may have happened, how they can improve, and they make changes to minimise the risk of similar mistakes happening in the future.
2. Staff	Standards met	2.2	Good practice	The pharmacy encourages and supports its team members to complete regular training to help them keep their knowledge and skills refreshed and up to date. It achieves this by providing its team members with protected training time and regular performance appraisals.
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 up-to-date written procedures for the team members to follow. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The team members are good at regularly discussing and recording any mistakes they make when dispensing. So, they can learn from each other. They talk about why the mistakes may have happened, how they can improve, and they make 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 a retail area which led to the dispensary at the rear. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. The retail area and the dispensary were open plan which allowed the team members to easily see into the retail area from the dispensary. 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 a bench closest to the pharmacy counter to complete final checks on prescriptions. And this allowed her to easily oversee any sales of medicines and listen to any advice the team members were giving to people.

The pharmacy had a set of up-to-date electronic and written standard operating instructions (SOPs) in place. The SOPs included processes such as dispensing and responsible pharmacist regulations. There was an index available. And so, it was easy to find a specific SOP. They were prepared in July 2019 and were due to be reviewed in July 2021. 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 highlighted any near miss errors made by the team when dispensing. There was a paper near miss error log that the team used to record the details of near miss errors. They recorded the time and date the near miss error happened. And any factors that may have contributed to the error. The near miss errors were analysed for any trends or patterns. And the findings were documented for future reference and learning. Each team member signed the analysis to confirm they had read and understood the contents. The team had recently had a focus on reducing the number of near miss errors involving medicines that looked or sounded alike (LASAs). The team members demonstrated several steps they had taken to reduce the risk of near miss errors involving LASAs. These included relocating amlodipine away from other ‘A’ medicines. And putting up a shelf edge alert next to gabapentin. The alert read ‘Gabapentin not Pregabalin’. They also put an alert next to hydroxyzine tablets. The alert read ‘hydroxyzine tablets. Double check you are picking the correct item’. The team members said the alerts had raised awareness of the potential for error with the medicines and they had helped to reduce the number of near misses that occurred. The pharmacy had a 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.

The pharmacy had a formal complaints procedure. But it was not available in the pharmacy 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. The completed questionnaires were sent to the pharmacy's head office for analysis and the results were displayed on a poster in the retail area. 23% of participants of the latest survey indicated they did not know about the prescription ordering service. The team talked about how they could improve. And they decided they would speak to each person who was eligible for the service and explain its benefits.

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 completed a full balance check of the CDs every month. 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). 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. A third-party contractor periodically destroyed the confidential waste.

The pharmacist on duty and the resident 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, at the earliest opportunity. There was written 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 to ensure people receive a high-quality service. And they feel comfortable to raise professional concerns when necessary. The pharmacy encourages and supports its team members to complete regular training to help them keep their knowledge and skills refreshed and up to date. It achieves this by providing its team members with protected training time and regular performance appraisals.

Inspector's evidence

The responsible pharmacist at the time of the inspection was a locum pharmacist who worked at the pharmacy every Thursday. A full-time pharmacy technician and a full-time pharmacy assistant supported her. The resident pharmacist, the pharmacy's supervisor, a part-time pharmacy assistant, a pre-registration pharmacy graduate and two delivery drivers were not present during the inspection. The team members said they felt they had enough staff to manage the workload. They were observed managing the workload well and had a manageable workflow. The team members were seen asking 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 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 often worked additional hours to cover absences and holidays. If they were unable to do this, they could ask for addition support from a pool of relief dispensers. 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. 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 dementia. The team members received a performance appraisal each year. The appraisals were an opportunity for the team member to discuss which aspects of their roles they enjoyed and where they wanted to improve. A team member had recently been given additional training on using the pharmacy's dispensing software.

The team held meetings each month. They were an opportunity for the team members to discuss ways they could improve their services. They had recently talked about the pharmacy's new app. The team were unclear about the functions and benefits of the app. They found out that people could order their prescriptions and book services such as flu vaccinations through the app. They were observed telling people about the app and encouraging them to download it to their smart phones.

The team members felt comfortable to raise professional concerns with pharmacist or the pharmacy's area manager. 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 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 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 for private conversations with the team member. 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. It supports some people to take their medicines at the right time by providing them with medicines in multi-compartment compliance packs. And it suitably manages the risks associated with this service. The pharmacy sources its medicines from licenced suppliers. And it appropriately stores and manages its medicines.

Inspector's evidence

The pharmacy had level access from the surgery car park to the main entrance door. So, people with wheelchairs and prams could easily access the pharmacy. And there was a bell next to the entrance door for people to use if they required any help. The pharmacy stocked a wide range of healthcare related leaflets in the retail area, which people could select and take away with them. And it used a small section of the retail area to promote healthy living advice. The team had access to the internet to direct people to other healthcare services. The pharmacy could supply people with large print dispensing labels if needed.

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. The team members wrote 'CD' onto prescriptions for CDs. 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. 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 supplied medicines in multi-compartment compliance packs for a small number of people living in their own homes. The pharmacy managed the workload for dispensing the packs 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 did not order any medicines that were not able to be dispensed in the packs. For example, any creams or eye drops. The responsibility of ordering these types of medicines was left with the person. The team members explained this helped them reduce medicinal wastage. They dispensed the packs at the rear of the dispensary. This was to minimise distractions. They used master sheets which detailed the person's current medication and times of administration. The team members used these to check off prescriptions and confirm they were accurate. The team members kept records of conversations that they had with people’s GPs. For example, if they were told about a change in directions or if a treatment was to be stopped. They supplied the packs with dispensing labels 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. They also routinely provided patient information leaflets with the packs.

The pharmacy dispensed high-risk medicines for people such as warfarin. But there wasn't a system to highlight people who were prescribed any high-risk medicines. And so, the team could have missed the opportunity to give people advice on how to take their medicines safely and effectively. The team members explained they would tell the pharmacist if they felt the person collecting the medicine would benefit from any additional advice or if any checks needed to be done. Such as checking if the person was having regular blood tests, or if their INR ranges needed checking if they were supplied with 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 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 met the requirements of the programme. No one had been identified. The team demonstrated a warning label that was printed each time valproate was dispensed. The label reminded the team to give people information about the programme and the risks of using valproate in pregnancy. The pharmacy dispensed insulin in clear bags. This helped the team members and the person collecting the insulin to complete a final visual check.

The pharmacy stored pharmacy medicines (P) in clear cabinets in the retail area. There were notices around the cabinets which outlined that the medicines in the cabinets were only to be sold under the supervision of a pharmacist. And people should ask for assistance if they needed help selecting a medicine. The pharmacy counter was manned throughout the inspection. And so, a team member could easily see if a person needed help selecting a P medicine from the cabinets. 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 of twenty medicines. The team members used alert stickers to help identify medicines that were expiring within the next six 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 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. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. But the folder could not be located during the inspection. 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 fridge 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.