General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Whitworth Chemists Ltd, Queens Road Medical Centre, Queens Road, Beighton, SHEFFIELD, S20 1BJ

Pharmacy reference: 1111466

Type of pharmacy: Community

Date of inspection: 13/02/2020

Pharmacy context

This is a community pharmacy inside a former medical centre in the village of Beigton in 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, medicines use reviews. It also provides private services such as travel vaccinations through Citydoc. 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: 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 up-to-date written procedures for the team members to follow. The pharmacy keeps the records it must have by law. And it mostly keeps people's private information secure. The team members know when to raise a concern to safeguard the welfare of vulnerable adults and children. The team members openly discuss mistakes that they make when dispensing. And they make some changes to their ways of working to reduce the risk of mistakes happening again.

Inspector's evidence

The pharmacy had a small dispensary which was behind the pharmacy counter. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. But it was possible for people to lean over the counter and see some activities in the dispensary. The pharmacist used a bench close to the pharmacy counter. This allowed her to oversee sales of pharmacy medicines.

The pharmacy had a set of standard operating procedures (SOPs). They were held both electronically and in paper form. The pharmacy's superintendent pharmacist's team reviewed the SOPs every two years. They were last reviewed in October 2019 and were due to be reviewed again in October 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 read and signed each SOP that was relevant to their role.

There was a process in place to highlight near miss errors made by the team when dispensing. The details of each near miss error were entered onto on electronic reporting system. Each team member had their own username and password to log into the system. And so, they were given the responsibility of entering their own errors onto the system. This helped with their learning. The team members recorded the time, date and type of error. As well as the reasons why the error might have happened. The near miss errors were analysed each month for any trends and patterns. The findings were discussed with the team members. And a report was made. The report was kept in the dispensary for future reference and to help the team members' learning. The team members thought the main cause of error was the lack of space in the pharmacy to dispense. The team had been unable to improve this much, as the dispensary was small, and the benches were often full. The pharmacy had a process to record dispensing errors that had been given out to people. And copies of the reports were kept in the pharmacy for future reference. The report included details of who was involved, what happened and what actions they pharmacy completed to prevent a similar error from happening again. The most recent report detailed an occasion where the pharmacy had delivered a person with another person's bag of medicines. The team discussed the incident and implemented a system for the delivery driver to complete double check of the address labels before leaving the pharmacy to start the deliveries.

The pharmacy displayed the correct responsible pharmacist notice. And it was easy to see from the retail area. 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 in place. And it was available for people to see via a poster in the retail area. The pharmacy collected feedback through an annual patient satisfaction survey. The team members discussed the findings of the survey with each other. The findings were generally positive. But the team couldn't provide any examples of any improvement measures following the feedback.

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. The pharmacy kept CD registers. And they were completed correctly. The pharmacy team checked the running balances against physical stock every week. A physical balance check of a randomly selected CD 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 members were aware of the need to keep people's personal information confidential. They had all undertaken General Data Protection Regulation (GDPR) training. And there was guidance in an information governance booklet kept in the dispensary for the team members to access if they needed any further information. 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 using a shredder.

The responsible pharmacist and the full-time resident pharmacist had completed training on safeguarding vulnerable adults and children via the Centre for Pharmacy Postgraduate Education (CPPE). And when asked about safeguarding, the team members gave several examples of the symptoms that would raise their concerns in both children and vulnerable adults. Two team members explained how they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage or report a concern and the contact details of the local support teams. But the team couldn't locate it during the inspection.

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 they feel comfortable to raise professional concerns when necessary. The pharmacy supports its team members to complete training to help them keep their knowledge and skills refreshed and up to date.

Inspector's evidence

At the time of the inspection, the responsible pharmacist was a locum pharmacist. Two full-time pharmacy assistants and a full-time trainee pharmacy assistant supported her. The full-time resident pharmacist was not present on the day of the inspection. The pharmacy also employed a part-time delivery driver who collected prescriptions from local surgeries and delivered medicines to people's homes. The team members felt they had enough support to ensure the pharmacy provided a high quality of service. They could speak to the pharmacy's area manager if they felt they needed additional staffing support. And there had been occasions when staff from other Whitworth pharmacies had worked in the pharmacy. The team members often worked additional hours to cover absences and holidays. The team made sure that no more than two team members were absent at any one time. And they did not take time off in the run up to Christmas as this was the busiest time of the year for the pharmacy. The team members were observed managing the workload well and had a manageable workflow. They 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 pharmacy provided the team members with a structured training programme. The programme involved team members completing various e-learning modules through an online system called Virtual Outcomes. The modules were based on 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. But they were not always able to take the time if the pharmacy was busy. 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. One team member had recently discussed wanting to be enrolled on an accuracy checking training course. Another team member explained they wanted some additional training to help them understand the ways in which people could treat the symptoms of chickenpox. The team member received one-to-one training with the resident pharmacist to help them achieve their goal. They could also take the opportunity in appraisals to give feedback to improve the services the pharmacy offered.

The team members felt comfortable to raise professional concerns with resident 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, hygienic and well maintained. It has a sound-proofed room where people can have private conversations with the pharmacy's team members. The dispensary is small for the volume of prescriptions the pharmacy dispenses. So, the team members' work often clutters the benches. They adequately manage the space. But there is an increased risk of errors happening.

Inspector's evidence

The pharmacy was clean and highly professional in appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was small, and the benches were cluttered with baskets of medicines and prescriptions awaiting a final check. The baskets were stacked on top of each other and there was a risk of medicines falling into the wrong baskets. The floor spaces were mostly clear to minimise the risk of trips and falls. The retail area was small. People using the pharmacy were seen leaning over the pharmacy counter to speak with the team members working in the dispensary. And it was possible for them to see some prescriptions and a computer screen from the pharmacy counter. Following a discussion with the inspector, the team members said they would ensure the computer screen was rotated to face away from the pharmacy counter and prescriptions were kept out of sight.

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. But it was not clearly signposted. And so, people may not have been aware it was available for use. 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 provides several private services using up-to-date protocols. And it supports some people to take their medicines at the right time by providing them with medicines in multi-compartment compliance packs. It suitably manages the risks associated with these services. The pharmacy sources its medicines from licenced suppliers. And it appropriately stores and manages its medicines.

Inspector's evidence

The pharmacy had level access to an automatic door from the car park. So, people with wheelchairs and prams could easily access the pharmacy. It 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. And they were of different colours to help the team manage the workload efficiently. The team members used 'CD' stickers to attach to the dispensed medicines bags. 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 some 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 second or third week of the cycle. Which gave the team members enough time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. 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 backing sheets 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. A copy of the label was also affixed to the shelf where valproate was stored. The label reminded the team to give people information about the programme and the risks of using valproate in pregnancy.

The pharmacy provided various private services through a collaboration with Citydoc. The services included vaccinations for yellow fever, malaria prophylaxis and typhoid. And blood tests for potential sexually transmitted infections and hepatitis. The pharmacy had up-to-date patient group directions. The resident pharmacist and a dispenser demonstrated the training they had completed with Citydoc to provide the services. The pharmacy provided the services on an appointment basis on Mondays, Tuesdays and Wednesdays. People completed a short online questionnaire on the Citydoc website to check if they were suitable for the service they wanted. People were required to bring proof of identity and information about their medical history. The team members gave an example of how the pharmacist had refused a yellow fever vaccination for a person. The person had already had the vaccination and was not aware that they didn't need another one. The pharmacy had access to summary care records (SCR) and the team members explained how the records were used when immediate access to people medical information was needed.

The pharmacy stored pharmacy medicines (P) in clear, locked cabinets next to the pharmacy counter to prevent people self-selecting them. The pharmacy stored its medicines in the dispensary tidily and the team members checked the expiry dates of each medicine every three months. And they kept a record of the medicines that were expiring over the next six months. They also highlighted these medicines using alert stickers. At the beginning of each month the team members checked the records and removed of the medicines that were expiring in that month. No out-of-date medicines were found after a check of around ten randomly selected medicines. 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. But the pharmacy did not keep any records of the action the team members had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinet was 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 fridges used to store medicines were of an appropriate size. The team members had access to adrenaline, sharps bins, and disposable gloves to assist them in providing the services via Citydoc.

Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. 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.