General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sheffield Late Night Pharmacy, 277 Fulwood Road, SHEFFIELD, S10 3BD

Pharmacy reference: 1117446

Type of pharmacy: Community

Date of inspection: 27/05/2021

Pharmacy context

This is a community pharmacy in the city of Sheffield, Yorkshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. And it delivers medicines for some people to their homes. The pharmacy dispenses medicines in multi-compartment compliance packs to some people living in their own homes and some local care homes. The inspection was completed during the Covid-19 pandemic.

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 risks with its services. And it effectively manages the risks with infection control during the pandemic to help keep members of the public and team members safe. It maintains most of the records it needs to by law and mostly keeps people's private information secure. Its team members record details of any mistakes they make while dispensing and learn from these to help prevent similar mistakes from happening again.

Inspector's evidence

The pharmacy had several procedures in place to help manage the risks of the services it offered and help prevent the spread of coronavirus. These included posters on the entrance door and in the retail area, reminding people visiting the pharmacy to wear a face covering as required by law. There was a large plastic screen placed at the pharmacy counter which acted as a protective barrier between team members and members of the public. There were markings on the floor of the retail area which helped people socially distance. Several of the pharmacy's team members wore masks throughout the inspection. The main part of the dispensary was small and so it was not always possible for team members to socially distance from each other while they worked.

The pharmacy had a set of standard operating procedures (SOPs). They covered tasks such as dispensing, responsible pharmacist requirements and controlled drug (CD) management. There wasn’t an index available to help find an SOP easily. Several SOPs were prepared in January 2021 and they were all scheduled to be reviewed every two years. Each team member had signed a record sheet to confirm they had read and understood the contents of the SOPs that were relevant to their role.

The pharmacy had a process to record and report near miss errors made by its team members during the dispensing process. The team member who completed the final check informed the dispenser of the error and asked them to rectify the mistake. A record of the error was made in a near miss log. Details recorded included the identity of the team member who made the error, the time and date of the error and a reason why the error may have happened. In a sample seen during the inspection several team members had recorded errors happening due to ‘being hungry’. The responsible pharmacist (RP) during the inspection explained that to reduce the risk of similar errors happening, he had increased the number of breaks the team members could take. He also made sure the team members were aware that they should let the RP know immediately if they felt they needed a break. The pharmacy kept records of any dispensing errors that had reached people. But no examples were available to inspect.

The pharmacy had a concerns and complaints procedure, but it was not clearly outlined for people to see. People could raise any complaints or concerns verbally with a team member. If the matter was not resolved by the team member, they would escalate the matter to one of the pharmacy's directors. The pharmacy had up-to-date professional indemnity insurance. The RP notice displayed the name and registration number of the RP on duty. Entries in the RP record mostly complied with legal requirements, but there were several occasions where the RP hadn't recorded the time their duties ended. The pharmacy kept up-to-date and accurate records of private prescriptions. It kept CD registers and records of CDs returned by people to the pharmacy. The CD registers were audited against physical stock at least every three months.

The team held records containing personal identifiable information in areas of the pharmacy that generally only team members could access. The consultation room was located at the back of the dispensary. To access the room, people had to walk through the dispensary and by bags and baskets that contained people's prescriptions and medicines. So, there was a risk that people could see other people's confidential information. Confidential waste was placed into a separate bag to avoid a mix up with general waste. The waste was periodically destroyed using a shredder. Team members had completed information governance training as part of their employment induction process. The RP had completed level 2 training on safeguarding vulnerable adults and children via the Centre of Pharmacy Postgraduate Education. Other team members had not completed any formal training but were aware of their responsibilities and when they should escalate any concerns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the necessary qualifications and skills to provide the pharmacy's services. They manage the workload well and support each other as they work. They feel comfortable raising concerns, giving feedback and suggesting improvements to provide a more effective service.

Inspector's evidence

At the time of the inspection, the RP was the pharmacy's resident pharmacist who had been working at the pharmacy for approximately seven years. He was supported by two provisionally registered pharmacists, a pre-registration pharmacy graduate and three full-time qualified pharmacy assistants. The RP worked around 45 hours a week. Another resident pharmacist worked the remainder of the time the pharmacy was open. Team members who were not present during the inspection included a part-time pharmacy technician, two delivery drivers and three university students. The university students worked weekends and completed basic tasks such as cashing up, serving customers and ensuring the premises were tidy. The team was observed to be working well and were not seen dispensing prescriptions under any significant time pressures. Team members explained the Covid-19 pandemic had been a challenging time, but they had coped well to make sure they continued to offer an efficient service to people who used the pharmacy.

Team members were given the opportunity to complete ongoing training during their working hours to improve their knowledge and skills. They were not provided with a structured training programme, but they could choose healthcare topics to learn about or use their time to learn new skills to help them perform better in their roles. The pre-registration pharmacy undergraduate attended various training days as part of his training course. Team members mostly improved their ability to carry out tasks by shadowing other team members who were more experienced. For example, a team member described how she helped others manage the process of ordering prescriptions for people who had their medicines dispensed in a multi-compartment compliance packs. As a result, more team members could complete this task which helped make the process more efficient.

The team could raise concerns with either of the two resident pharmacists. The RP explained that the team members worked with an open and honest dialogue and he encouraged them to provide feedback on ways the pharmacy could improve its services. Several team members explained they were comfortable raising concerns and giving feedback to the two resident pharmacists and were confident that the concerns would be acted upon. The pharmacy didn't have a whistleblowing policy in place, and so team members couldn't report any concerns anonymously. There were no targets set for the team to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises clean, secure and well maintained. 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 well maintained. It had separate sinks available for hand washing and for the preparation of medicines. The team cleaned the pharmacy regularly to reduce the risk of spreading infection. They paid attention to areas of the pharmacy that were touched regularly such as benches and door handles. The pharmacy dispensary was kept tidy and well organised throughout the inspection. Floor spaces were mostly kept clear to prevent the risk of a trip or a fall. The pharmacy had a sound-proofed consultation room. But during the inspection it was used as a storeroom to hold several miscellaneous items. The RP explained that during the pandemic the room was generally not used for holding private conversations with people, but the team could empty the room quickly should it be needed to be used at short notice. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which supports people's needs and it makes these services easily accessible for people. The pharmacy manages its services well to ensure people receive their medicines safely. It sources, stores and manages its medicines correctly so they are fit for purpose.

Inspector's evidence

People had level access into the pharmacy. The pharmacy advertised its services and opening hours in the main window. There was a seat available in the retail area for people to use while they waited for their prescriptions to be dispensed. The team provided large-print labels on request to help people with a visual impairment. Team members had access to the internet which they used to signpost people requiring services that the pharmacy did not offer. The RP spoke Punjabi and Urdu, and one of the provisionally registered pharmacists spoke Arabic. They had recently helped people with their care speaking these languages.

Team members used various stickers and they annotated bags containing people's dispensed medicines to 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 CD that needed handing out at the same time. Team members signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. The baskets were of different colours, for example, the team used grey baskets for more urgent prescriptions and red baskets to indicate people's medicines needed delivering to their homes. Team members gave owing slips to people on occasions when the pharmacy could not supply the full quantity prescribed. They gave one slip to the person and kept one with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. Due to the pandemic, the delivery driver didn't ask people to sign for receipt of their medication. The driver left the medicines on the person's doorstep before moving away and waiting to watch them pick up the medicines. Team members knew about the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They knew to provide these people with patient information cards and to check they were taking appropriate contraception.

The pharmacy supplied medicines in multi-compartment compliance packs to several people living in their own homes and to some local care homes. The team dispensed the packs at the rear of the dispensary to ensure minimum distraction. The area was small, but the team made sure it was kept tidy to reduce the risks of mistakes being made. The team provided the packs either weekly or every four weeks and divided the workload evenly across a four-week cycle. Team members used master sheets which contained a list of the person's current medication and dose times. The pharmacist checked prescriptions against the master sheets for accuracy before the dispensing process started. Different team members labelled the prescriptions and picked the medicines. A team member explained this helped reduce the number of errors being made as the team found that more errors were made when the same team member completed the labelling and medicine selection process. People received their packs with patient information leaflets but the pharmacy did not add the descriptions of the medicines to help people identify them. The inspector discussed the importance of this.

Pharmacy (P) medicines were stored behind the pharmacy counter and people were not able to self-select them. The pharmacy had a process to check the expiry dates of its medicines every three months. The team was up to date with the process. No out-of-date medicines were found after a random check of around 20 randomly selected medicines. The pharmacy highlighted medicines that were expiring in the next three months. The date of opening was recorded on medicines that had a short shelf life once they had been opened. The pharmacy had two fridges to store medicines that required cold storage. The team tidily stored medicines inside the fridges and they kept daily records of the fridge temperature ranges. A sample seen were within the correct ranges. Team members knew what to do if the fridge was operating outside of the correct ranges.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses its equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources. The pharmacy used a range of CE quality marked measuring cylinders. It positioned the computer screens so unauthorised people did not see any confidential information. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so that team members could have conversations with people in private. It had a wireless card terminal for contactless transactions and reduce the use of cash during the pandemic. Team members had access to personal protective equipment including face masks, visors, aprons and gloves.

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.