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: 28/09/2022

Pharmacy context

This is a community pharmacy in the city of Sheffield, Yorkshire. The pharmacy sells over-the-counter medicines, dispenses NHS prescriptions and provides a substance misuse service. 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.

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 has up-to-date processes in place to help the pharmacy team effectively and safely manage the risks to the services it provides to people. Team members keep the records they need to, and they generally keep people's private information safe. The team has the knowledge to help protect vulnerable people who use the pharmacy. Team members discuss the mistakes they make while dispensing.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs). These provided information to help team members carry out various tasks, including dispensing and record keeping. Team members described their roles within the pharmacy and the processes they were involved in. They had read and understood the SOPs relevant to their roles. They signed a document to confirm they had read and understood an SOP. They did this within the first few weeks of starting their employment with the pharmacy. The SOPs were reviewed every two years. This was to make sure they were up to date and accurately reflected the pharmacy's current practices. Team members were only required to reread the SOPs if there were any changes following a review.

The pharmacy had a process to report mistakes made by team members during the dispensing process. These were known as near misses. Each near miss was immediately brought to the dispenser's attention, and all team members present discussed why the mistake might have happened. And they discussed how they could make changes to the way they worked to improve patient safety. A dispenser explained he had recently made some errors by selecting the incorrect pack size of medicines. For example, a pack of 60 tablets when the prescription called for a pack of 30 tablets. To improve, the dispenser worked with a pharmacist to help him recognise medicines that were produced in different pack sizes. The pharmacy had a near miss log which was used to record details of near misses such as the time the mistake happened, what action was taken and what the reason for the mistake might have been. The team had not used the log for several months. And so, there was a risk the team may have missed the chance to identify any common trends or patterns. 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 the process 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 responsible pharmacist (RP) notice displayed the name and registration number of the RP on duty. Entries in the RP record complied with legal requirements. The pharmacy kept up-to-date and accurate records of private prescriptions. It kept controlled drug (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. During the inspection, the balance of three randomly selected CDs were checked against the physical stock and the balances were correct. The pharmacy kept up-to-date records of the destruction of out-of-date CDs and CDs that had been returned to the pharmacy by people.

The team held records containing personal identifiable information in areas of the pharmacy that generally only team members could access. 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 team members have the skills to effectively provide the pharmacy's services. The pharmacy supports them to make changes to improve the way the pharmacy operates. Team members feel comfortable in raising professional concerns and giving feedback.

Inspector's evidence

The pharmacy employed several team members. At the time of the inspection the RP was one of the pharmacy's resident pharmacists. He was being supported by another full-time pharmacist, two trainee pharmacists, a full-time trainee pharmacy technician, a full-time trained dispenser and a trainee medicines counter assistant. Team members that were not present during the inspection were four trained dispensers, two pharmacy university undergraduates, another full-time pharmacist, a delivery driver, and the pharmacy's superintendent pharmacist (SI). The trainee pharmacy technician was enrolled onto a GPhC approved training course. The university students worked weekends and completed basic tasks such as cashing up, serving customers, and ensuring the premises were tidy. Team members were observed working well together and supported each other in managing the workload.

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 trainee pharmacists were scheduled to attend various training days as part of their training programme. Team members mostly improved their ability to carry out tasks by shadowing other team members who were more experienced. For example, one of the trainee pharmacists worked with his designated tutor to understand how to complete CD register balance checks.

The team could raise concerns with either of the RP or the SI. 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 SI or the RP and they were confident that the concerns would be acted upon. The pharmacy didn't have a whistleblowing policy in place, and this could make it harder for team members to report 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. The premises are small and so the pharmacy has limited space to store its medicines.

Inspector's evidence

The pharmacy was clean, well maintained, and overall professional in appearance. 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. Over the past 12 months, the pharmacy had significantly increased the number of prescriptions it was dispensing. As a result, there was a shortage of space in the dispensary. During the inspection, benches in the dispensary were full of medicines and prescriptions stored in baskets awaiting a final check. Some medicinal stock and dispensed medicines ready for delivery were stored on the floor of the dispensary and this created some risk of a trip or a fall. The potential risk was discussed with the RP during the inspection. The RP explained the pharmacy had increased the number of hours the pharmacy was operating with two pharmacists working at the same time to help reduce the time for medicines to be checked. The pharmacy used drawers and shelves to store most of its medicines. But due to a lack of space some medicines were stored in the pharmacy’s consultation room. Team members explained they could move the medicines out of the room at short notice to create space if people wished to have a private conversation with them. The room was small but was appropriately soundproofed.

There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. However, the toilet was used to store several containers filled with medicines that had been returned by people. Team members controlled public access to restricted areas of the pharmacy. Throughout the inspection, the temperature was comfortable. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team manages and delivers the pharmacy's services well. And it makes its services easily accessible to people. The pharmacy sources its medicines from recognised suppliers, and it completes regular checks of its medicines to make sure they are suitable to supply.

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 another team member spoke Arabic. They had recently helped people speaking these languages with their care. Team members were aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. They demonstrated the advice they would give in a hypothetical situation, including checking people were enrolled on a Pregnancy Prevention Programme if they fit the inclusion criteria. And ensuring such people used appropriate contraception.

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 generally signed the dispensing labels to keep an audit trail of which team member had dispensed and completed a final check of the medicines. But on some occasions the process had not been followed. Team members 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, they used grey baskets for more urgent prescriptions and red baskets to indicate people's medicines needed delivering to their homes. Team members didn't give owing slips to people on occasions when the pharmacy could not supply the full quantity prescribed. And so, people were not provided with a record of the medicines they were outstanding. The pharmacy kept a record of the delivery of medicines to people. It provided a substance misuse service. The team dispensed instalments weekly and stored them tidily in a CD cabinet.

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 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 the packs to help people identify them.

Pharmacy (P) medicines were stored behind the pharmacy counter and people were not able to self-

select them. Some medicines were stored on shelves in the retail area. But these were kept on upper shelves and so they were out of reach of members of the public. 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 and records were seen confirming this. 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 had not been recorded on three medicines that had a short shelf life once they had been opened. And so, there was a risk that these medicines may not be suitable to be supplied to people. 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. The inspector checked the temperature ranges of one of the fridges. The fridge was operating outside of the correct range. This was brought to the attention of the RP who provided assurances the issue would be actioned immediately.

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 suitably positioned computer screens to ensure people couldn’t 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 a private area. Team members had access to personal protective equipment including face masks 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.