General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Well, The Whitehouse Surgery, 1 Fairfax Rise, SHEFFIELD, S2 1SL

Pharmacy reference: 1123625

Type of pharmacy: Community

Date of inspection: 27/02/2020

Pharmacy context

This is a community pharmacy inside a medical centre in the city of 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 (NMS) and medicines use reviews (MURs). The pharmacy supplies medicines in multi-compartment compliance packs to some 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 has an up-to-date set of procedures to help identify and manage risks to its services. The pharmacy's team members follow them to make sure they work safely and effectively. The pharmacy keeps most of the records it must have by law. And it keeps people's private information secure. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children. The team members record and discuss any mistakes that happen within the dispensing process. They take some steps to learn from their mistakes to reduce the risk of mistakes happening again.

Inspector's evidence

The pharmacy had an open plan retail area and dispensary. The dispensary was located behind the pharmacy counter. The pharmacy counter acted as a barrier between the retail area and the dispensary to prevent any unauthorised access. 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 the bench closest to the retail area to complete final checks on prescriptions. And so, she could listen in to conversations the pharmacy's team members were having with people.

The pharmacy had a set of up-to-date electronic standard operating instructions (SOPs) in place. The superintendent pharmacist's office reviewed the procedure every two years on a monthly rolling cycle. It sent new and updated procedures to pharmacy team members via the eExpert online training system approximately each month. Once the team members had read the contents of the SOP, they needed to complete a short quiz to test their understanding. They had to pass the quiz to be signed off as having read and understood the SOP. A pharmacy assistant demonstrated that she had completed 100% of the SOPs that were relevant to her role. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team.

The pharmacy had a procedure to record any near miss errors made while dispensing. The pharmacist who identified the near miss error and the dispenser had a brief discussion about the error immediately after it was identified. The team members recorded the details of the near miss errors onto a paper near miss log. They recorded the date, time and a brief description of the near miss error. But they didn't record the reason why the near miss error might have happened. So, they may have missed out on the opportunity to make specific changes to the way they work to reduce the risk of similar mistakes happening again. They were required to transfer the details onto the pharmacy's online reporting system called Datix. But the team members explained they did not always have the time to do this. They had recently talked about how they could reduce the number of times they selected the wrong form of ramipril. For example, the capsules instead of the tablets. They decided to separate the capsules and tablets away from each other. The pharmacy had a process for dealing with dispensing errors that had been given out to people. It recorded incidents on the Datix system. And kept a paper copy in the pharmacy for future reference and learning. The records included details of the action taken to reduce the risk of a similar error happening again. For example, the need to take more care and complete additional checks when dispensing medicines that sounded or looked alike, known as LASA medicines.

The pharmacy was displaying the correct responsible pharmacist notice at the time of the inspection. 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. And it was on display in the retail area 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's team. The pharmacy collected feedback each year through questionnaires that were placed on the pharmacy counter for people to self-select and complete. And the results were published for people who used the pharmacy to see.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept records of private prescriptions and emergency supplies. But the last three entries of private prescription supplies did not include the date of dispensing or the date when the prescription was issued. The last two entries of emergency supplies did not include the reason the supply was made. The pharmacy 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 week. 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). And they had completed training each year via the eExpert online training system. 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. The confidential waste was periodically collected by a third-party contractor and securely destroyed.

The responsible pharmacist had completed training on safeguarding vulnerable adults and children through the Centre for Pharmacy Postgraduate Education (CPPE). Other team members had not completed any formal training. 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. If the team members needed further guidance, they explained they would contact the pharmacy's superintendent pharmacist's office for support.

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. The pharmacy team members complete 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 if necessary.

Inspector's evidence

The responsible pharmacist at the time of the inspection was the pharmacy's temporary manager. And she worked full-time. The pharmacist had been employed at the pharmacy for around a month after the pharmacy's previous manager had left the business. The pharmacist was supported by two part-time qualified pharmacy assistants, a part-time trainee pharmacy assistant and a part-time trainee counter assistant. Another qualified pharmacy assistant was absent during the inspection. The pharmacist explained although she had not been working at the pharmacy for very long, she felt it had enough staff to manage the dispensing workload. The team members explained they were almost always ahead of their workload and didn't feel the need to dispense medicines in a rush or under pressure. The team members often worked additional hours to cover absences and holidays. The team was seen managing the workload well and dispensing prescriptions in a timely manner. The team members supported each other and were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various e-learning modules through the eExpert online system. The modules covered various topics including health and safety, new and revised SOPs and health conditions such as pain relief. Some modules were mandatory and others 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. But they were not always able to take the time because of the dispensing workload. The team members received a performance appraisal every six months. The team members were asked to assess their own performance and were given the opportunity to discuss any personal goals they wanted to achieve and give feedback on ways to improve the pharmacy's services. A team member was given some one-to-one training on a new dispensing software system.

The team members felt comfortable to raise professional concerns with pharmacist or the pharmacy's regional development manager. The pharmacy had a whistleblowing policy. So, the team members could raise concerns anonymously. They were encouraged to give feedback to improve the pharmacy's services. The pharmacy set the team 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 clean, hygienic and properly maintained. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak privately to 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 a separate sink for 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 with the team member to have a private conversation. 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 provides some medicines in multi-compartment compliance packs to help people take them correctly. And it suitably manages the risks associated with the service. The pharmacy's team members identify people taking high-risk medicines. And they support these people to take their medicines safely. The pharmacy sources its medicines from licenced suppliers. And it mostly stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had level access from the health centre car park. So, people with wheelchairs or prams could easily access the premises. There was a hearing loop induction kit available to help people who had hearing aids. The pharmacy could provide people with large print dispensing labels to help if they had a visual impairment. The pharmacy advertised its services and opening hours in main window. And there were several healthcare related leaflets available for people to select and take away with them. There was a healthy living zone in the retail area. The zone displayed information on various healthcare related topics. At the time of the inspection, there was a poster promoting the Sheffield services for cancer patients.

The team members regularly used various stickers that they could 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 controlled drug that needed handing out at the same time. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. Baskets were available to hold prescriptions and medicines to help manage the workflow efficiently. The team had a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. The team members gave people owing slips when the they could not supply the full prescribed quantity. One slip was given to the person. And one kept with the original prescription for reference when the remaining quantity was dispensed and checked. The team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy 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 had recently introduced a new system for dispensing many of the prescriptions it received, at the company's offsite dispensing hub. The system was designed to reduce the team's dispensing workload and allow the team members more time to offer services. But team members couldn't evidence how they obtained people's consent to dispense their medicines offsite. The importance of consent was discussed. Each team member had received comprehensive training before the process went live. The team firstly assessed whether a prescription was suitable to be dispensed at the hub. Any prescriptions that were for CDs or fridge items were not sent. The team also avoided sending prescriptions for more urgent items such as antibiotics. Once it was established that a prescription was suitable to be sent to the hub, the data was entered. And then the pharmacist completed an accuracy and clinical check. Only the pharmacist, using their personal smart card and password, was able to perform the clinical and accuracy check and release prescriptions to the hub. The details of the prescription were then sent electronically to the hub. And the prescription was assembled

using automation. It took around three days for prescriptions to be processed and the medicines to be received from the hub. The team marked all prescriptions that were sent to the hub and stored them in a separate box to prevent them being mixed up with other prescriptions. The pharmacy received the medicines that had been dispensed at the hub in sealed bags. The bags were then coupled with the relevant prescription. And then scanned on the shelves in the prescription retrieval area, ready for collection. Each day the pharmacist opened two randomly selected bag that had been dispensed at the hub and completed another accuracy check. This was to ensure the pharmacy completed a regular quality check.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The workload was managed 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 dispensed the packs on a separate bench. The team members used master sheets for each person who was supplied a pack. The master sheets had information of which medicines should be dispensed in the packs and at which dosage times. For example, morning or evening. The packs were supplied with backing sheets which listed the medicines in the packs and the directions. And the team supplied patient information leaflets for each medicine. But the packs were not supplied with information to help people visually identify the medicines.

The pharmacy dispensed high-risk medicines for people such as warfarin. The team members used alert stickers attached to people's medication bags to remind the person handing out that the bag contained a high-risk medicine. They used 'antibiotic' stickers. These stickers reminded the team to ask people collecting antibiotics if they had any allergies and to remember to complete the full course. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. There was an information document about dispensing valproate available in the dispensary for the team members to read. They demonstrated the advice they would give people in a hypothetical situation. The team had access to literature that they could provide to people to help them take their medicines safely and understand the risks. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements. One person had been identified. The person was given advice about the risks of becoming pregnant while taking valproate. The pharmacy dispensed fridge and CD items in clear bags. Which allowed the team members to complete a final visual check of the medicine before they handed them out to people.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The medicines in the dispensary were tidily stored. Every three months, the team members checked the expiry dates of its medicines to make sure none had expired. And the team was up to date with the process. No out-of-date medicines were found following a check of some randomly selected 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 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 received some training on how to follow the directive. The team members were unsure of when they were to start following the directive. 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. But the team members did not do this every

day. The temperatures had not been checked or recorded on the two days before the inspection. The fridge temperature was checked during the inspection. But it was not within the correct range. The inspector discussed this with the team. The pharmacist explained she would monitor the fridge temperatures during the day and report any issues to the pharmacy's superintendent pharmacist's office. The CD cabinet was secured and of an appropriate size. The medicines inside the fridge and CD cabinet 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 reference sources available, including 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 medicines into multi-compartment compliance packs. The fridges used to store medicines were of an appropriate size. A Methameasure pump was used to dispense methadone to a small number of people. It was cleaned and calibrated each day.

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.