General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: SKF LO (CHEMIST) LTD, The Hollies Medical Centre, 20 St. Andrews Road, Sheffield, South Yorkshire, S11 9AL

Pharmacy reference: 9010026

Type of pharmacy: Community

Date of inspection: 15/05/2019

Pharmacy context

The pharmacy is in a suburb of Sheffield and next door to a medical centre. It dispenses NHS and private prescriptions. It supplies medicines in multi-compartmental compliance packs to help people take their medication. And it delivers medication to people's homes. The pharmacy provides a blood pressure checking 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	2.2	Good practice	The pharmacy team members get feedback on their performance. And they have opportunities to complete more training and share best practice with others. So, they can keep their skills and knowledge up-to-date.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.1	Good practice	The pharmacy team works with community groups to identify and actively promote the health and wellbeing of the local population.
		4.2	Good practice	The pharmacy has robust processes to ensure its services are effectively managed and provided safely.
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 its services. And it keeps most of the records it needs to by law. The pharmacy has written procedures that the team follows. And it has adequate arrangements to protect people's private information. The pharmacy team members respond well when errors happen. They discuss what happened and they make changes to prevent future mistakes. People using the pharmacy can raise concerns and provide feedback. The team members respond to this feedback to improve the delivery of pharmacy services. The pharmacy team has training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a range of up to date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read the SOPs and signed the SOP signature sheet to show they understood and would follow them. The pharmacy had up to date indemnity insurance.

The pharmacist when checking prescriptions and spotting an error told the team member involved of the mistake rather than getting them to identify their own error. The pharmacist spoke to the team member involved asking them what had caused the mistake. And then recorded the error on to a paper log. A sample of logs looked at showed details about the prescription and dispensed item. This helped to spot patterns. The log recorded the team members learning and the actions they took to prevent similar errors. For example, one entry on the log involved picking the wrong strength of a product. The entry stated that the pharmacist and team member involved had discussed self-checking their work by placing a tick against the strength. The pharmacist reviewed the logs each month and discussed the outcome with the team. The pharmacist summarised the findings from the review on to a sheet listing the key focus points. And displayed it in the dispensary for the team to read. The April 2019 review highlighted the common causes of error as formulations, tiredness and distractions. The current focus for the team included the use of appropriate questions when selling medicines and date checking.

The pharmacy recorded dispensing incidents electronically. And printed them off for reference. The report detailed what had been prescribed and dispensed. Along with the reason for the error and the actions taken to prevent it happening again. The pharmacy completed monthly and annual patient safety reports. A recent report recognised the importance of recording errors to help the team learn and work methodically. The team members separated any items that looked or sounded alike (LASA). As these products were at greater risk of errors. The team shared information sent from the Superintendent Pharmacist. This included common errors reported across the company and how to prevent them. The team members had identified frequent errors with Symbicort inhalers. So, they had placed a large notice on the shelves holding these products to prompt them to check what they had picked. Following a dispensing error with gabapentin strengths the pharmacist asked the team to triple check the strength and quantity they had selected. The pharmacist attached a note to the shelves to

remind the team to do this. And had updated the computer so that a flash note appeared when the team selected this medication. The note reminded the team members to check what they had picked.

The pharmacy had a SOP and a leaflet providing people with information on how to make a complaint. It also had a suggestions box on the pharmacy counter. The team had responded to a request to have alcohol gel available for people to use by placing a container on the pharmacy counter. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy checked CD stock after receiving items or supplying to the patient. The team recorded patient returned CDs. A sample of Responsible Pharmacist records looked at found they mostly met legal requirements. But the time the pharmacist signed out as Responsible Pharmacist was not always recorded. Details of private prescription supplies met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The pharmacy provided people with information on how it protected their private information. And it displayed a privacy notice in line with General Data Protection Regulation (GDPR) requirements. The team had completed GDPR training. The team members separated confidential waste for shredding offsite.

The pharmacy had procedures informing the team of the steps to take if concerned about vulnerable people. The team had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training on 23 January 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The delivery driver reported to the team any concerns they had about people they delivered medication to. The team shared the concerns with the person's GP who usually visited the same day.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has team members with the qualifications and skills to support the pharmacy's services. It offers team members opportunities to complete more training and they share best practice with others. The pharmacy provides feedback to team members on their performance. And they share information and learning particularly from errors when dispensing. So, they can improve their practice and knowledge. The team members discuss how they can make improvements. And they agree new processes to support the safe and efficient delivery of the pharmacy services.

Inspector's evidence

The pharmacist manager with locum pharmacist support covered the opening hours. The pharmacy team consisted of a level 3 national vocational qualification (NVQ) trainee, one qualified dispenser and a trainee dispenser. There were two delivery drivers. On the day of the inspection the pharmacist manager, the level 3 NVQ trainee and the qualified dispenser were on duty. The team had a daily task sheet and rota to ensure the completion of key tasks. This also helped to maintain team members skills and knowledge. The pharmacist manager spent time at other pharmacies in the company to see how they operated and share good practice. The pharmacist had suggested that the team would also benefit from this. But, this had not yet happened.

The pharmacy provided access to extra training through online modules and reading materials. The pharmacy team had protected time to complete the training. The pharmacy kept a record of when the team members had completed the training. The record also captured if the team member needed more training. For example, dispensing medication into multi-compartmental compliance packs. The pharmacist had discussed with the team the legal changes to pregabalin and gabapentin. And attached a note to the dispensary wall explaining this.

The pharmacy team members received annual performance reviews. The reviews gave them a chance to receive feedback and discuss development needs. One of the dispensers had taken the opportunity to ask about the NVQ3 training. The team members held regular meetings to discuss matters such as dispensing errors and information received from head office. All the team contributed to the focus points on the monthly safe practice list. Team members could suggest changes to processes or new ideas of working. The NVQ3 trainee had used their experience from working in other pharmacies to suggest changing the layout of stock. The team agreed to this and found the new layout easier to work with.

The pharmacist was set targets for services such as medicine use reviews (MURs). The pharmacist was not under pressure to meet the targets and performed the services when appropriate for the patient’s needs.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. And it displayed notices providing information on correct methods for hand washing. The team kept floor spaces clear to reduce the risk of trip hazards. The pharmacy had enough storage space for stock, assembled medicines and medical devices.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. And they used cordless telephones to make sure telephone conversations were held in private.

The premises were secure. The pharmacy had restricted access to the dispensary when it was open. The team had asked head office to fit a barrier across the pharmacy counter to prevent people attempting to get medicines from behind the counter. This had been fitted. The team had also put a notice on the shelves informing people that the medicines were not for self-selection. And to ask a member of the team for assistance.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team works with community groups to identify and actively promote the health and wellbeing of the local population. The pharmacy creates attractive themed displays to improve people's awareness about healthy living. And it regularly changes the healthy living topic to support the needs of a wide range of people. The pharmacy has robust processes to ensure its services are effectively managed and provided safely. The team regularly carries out audits of people prescribed higher risk medicines. And it responds to information from these audits to help people take their medicines safely. The pharmacy team members follow organised processes for dispensing into multi-compartmental compliance aids. This ensures people receive their medicines on time and helps them use them safely. The team members review their processes and they make changes to improve the safe delivery of this service. The pharmacy obtains its medicines from reputable sources. And it has processes to help ensure medicines are safe and fit for purpose.

Inspector's evidence

People accessed the pharmacy via an automatic door. The pharmacy had a practice information leaflet providing people with details of the services it offered and the pharmacy contact details. It also had a large range of health information leaflets for people to take away. Team members wore name badges detailing their roles.

The team was actively involved in promoting healthy living. The current focus was oral health. The team had created an eye-catching display. This included information on the type of toothpaste to use and how much sugar the average child consumed. It also included details on a range of dental products. The pharmacy team worked with community groups to identify and actively promote the health and well being of the local population. The alcohol awareness campaign included the team asking people to use water to measure out what they thought one unit of alcohol looked like. The group were working on the June initiative focusing on childhood obesity. And they were liaising with local schools and scout groups to promote this. The pharmacy had trained the team members to take people’s blood pressure readings. The team's training included when it was necessary to refer the person to their GP.

The pharmacy used laminate cards to highlight prescriptions with high-risk medication such as warfarin to prompt the pharmacist to speak to the person. The pharmacy team recorded information such as blood tests for people on high-risk medication. The team had completed an audit of people prescribed anti-inflammatory products that were not taking medication to protect their stomach. In response to this the team members introduced a laminate card to prompt them to check that people were prescribed stomach protection medication. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found people within the category had spoken to their GP and were prescribed contraceptives. The pharmacy had the PPP information cards and leaflets to pass on to patients.

The pharmacy provided multi-compartmental compliance packs to help people take their medicines. The team usually ordered prescriptions two weeks in advance of supply. This allowed time to deal with

issues such as missing items. And the dispensing of the medication in to the packs. Some prescriptions came as repeat dispensing. The pharmacist manager worked with the pharmacist at the GP surgery to move more prescriptions to repeat dispensing. As this helped to make sure prescriptions arrived at the pharmacy in plenty of time. The team kept a list of people using this service and whether they received monthly or weekly packs. The team also had a chart showing when to order the prescriptions and dispense the medication in to the pack. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list. This helped identify missing items or changes. The pharmacy had a notice in the area where the team dispensed medication in to the packs. The notice asked the team to not disturb the team member whilst they were dispensing the packs. The pharmacist used the medication list to highlight the form, such as capsules or tablets. The pharmacist did this to reduce errors involving the team putting the wrong formulation in to the packs. The team member ticked the drug name listed on the pack when placing it in to the packs. They had introduced this to ensure medication was not missing from the packs. The team triple checked packs containing many white tablets. The team wrote the descriptions of the products on the sheet sent with the packs. So, that people could identify their medication. The pharmacy supplied the manufacturer's patient information leaflets. Copies of hospital discharge summaries were usually sent via the Pharmacist at the GP surgery. The pharmacist checked the discharge summary for changes or new items. And then asked for prescriptions to send new packs when required.

The team provided a repeat prescription ordering service. The pharmacy kept a record to help identify missing prescriptions. The team passed information from the GP team on to the person such as the need to attend the surgery for medication reviews or blood tests. The pharmacy kept prescriptions from the repeat dispensing service in dedicated folders that detailed when the person had received their medication. And the questions the team asked the person to make sure the supply was safe to make. The pharmacy provided separate areas for the labelling, dispensing and checking of prescriptions. The team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items or stock for one prescription mixing in with another. The team members referred to the prescription when selecting an item from the shelves. To help ensure they picked the correct product. The pharmacy used clear bags to hold dispensed controlled drugs (CDs) and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to add these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy printed off the manufacturers' patient information leaflets for products that came in bulk containers. The team did this as a limited number of leaflets came with the container. And it helped to ensure that people received this information. The pharmacy had checked by/dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team used the boxes. When the pharmacy didn't have enough stock of someone's medicine, they provided a printed slip detailing what was owed. And it kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The team separated prescriptions that had recent owings from ones with long term supply problems. And prioritised the owings when the stock arrived from the wholesaler. So, the prescription was complete when the person came to collect it. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The team used a large red sticker with the expiry date written on to highlight medicines with a short expiry date. For example, Duloxetine 40mg with an expiry date of July 2019 had such a sticker attached. The team members usually recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of cetirizine oral solution with six months use once opened had a date of opening of 15 May 2019 recorded. The

team recorded fridge temperatures each day. A sample looked at found they were within the correct range.

The pharmacy had appropriate medicinal waste bins for out of date stock and medication returned by people. The pharmacy provided clear instructions on how to handle returned medication. The team asked the person returning the medicines to place them in to a large basket. And asked the person if there were needles amongst the returned items. The team used gloves when handling the returned medication. The team separated out of date and patient returned CDs from in date stock in a CD cabinet that met with legal requirements. The team members labelled the shelves in the CD cabinet to show the stock held and this helped when selecting the product. And they used denaturing kits for CD destruction.

The pharmacy had 2D scanners and head office was arranging for a computer update to meet the requirements of the Falsified Medicines Directive (FMD) that came out on 9 February 2019. The pharmacy had procedures covering FMD and the team had completed training on the subject. The pharmacist manager had produced two workflow charts about the verification and decommissioning elements of FMD. The pharmacist displayed these in the dispensary for the team to refer to. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team actioned the alert and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and protect people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up to date clinical information.

The pharmacy used a range of CE quality marked measuring cylinders to accurately measure liquid medication. The pharmacy had two fridges to store medicines kept at these temperatures. It used one fridge for stock and the other for completed prescriptions awaiting supply. The pharmacy completed annual safety checks on the fridges. The pharmacy had a basket holding equipment for the team to use when handling cytotoxic medication.

The computers were password protected and access to patients' records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held most of its private information in the dispensary and rear areas, which had restricted access. But the team kept a box file with consent forms completed by people on open display in the consultation room. This meant that people in the room could look in to the box file and see other people's information.

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.