General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Seven Hills Pharmacy, 78 Wincobank Avenue, Sheffield, South Yorkshire, S5 6AZ

**Pharmacy reference:** 9010122

**Type of pharmacy:** Community

**Date of inspection:** 29/01/2020

## Pharmacy context

This community pharmacy is opposite a large medical centre in a suburb of Sheffield. The pharmacy dispenses NHS and private prescriptions. And it delivers medication to people's homes. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines. The pharmacy provides the methadone consumption service.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

Follow this link to find out what the inspections possible outcomes mean

## 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 team generally identifies and manages the risks associated with its services. People using the pharmacy can raise concerns and provide feedback. The team members respond to this feedback. And they use it to improve the efficient delivery of pharmacy services. The team members have training and guidance to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members generally respond appropriately when errors happen. They discuss the errors and they take the action needed to help prevent similar errors happening again. But they don't always record their errors. So, the team may miss opportunities to help identify patterns and reduce mistakes.

### 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. Some team members had signed the SOPs signature sheets to show they had read, understood and would follow the SOPs. The team members worked within their competences and knew when to refer to the pharmacist. The medicines counter assistant gave clear instructions to a new member of the team on how to perform certain tasks in the retail area. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist and the accuracy checking technician when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy had a record to capture these near miss errors. But the team did not always record the near miss errors. The record had three entries in January 2020, four in December 2019, two in November 2019, and no records between June 2019 and November 2019. The pharmacist manager was new to post and aware of this. And had spoken to the team. A sample of the error records looked at found that for the records they did make the team recorded details of what had been prescribed and dispensed to spot patterns. But team members did not always record what caused the error, their learning from it and actions they had taken to prevent the error happening again. The pharmacy had a system to record dispensing incidents electronically. These were errors identified after the person had received their medicines. The pharmacist manager stated they had not had the occasion to report a dispensing incident. The pharmacy did not review the error records to spot patterns and make changes to processes. The previous pharmacy manager had completed an annual patient safety report covering the period July 2018 to December 2018. This report stated that the team had moved medicines that looked alike and sounded alike (LASA). The new pharmacist manager had introduced a three-way step to the dispensing process. This involved one dispenser picking the medicine stock and a different dispenser attaching the label, before the pharmacist or ACT completed their checks. The pharmacist manager introduced this to provide more opportunities for errors to be spotted and corrected before the person received the supply.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And it displayed information in the retail area providing people with details on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website. And on the wall by the entrance in to the dispensary from the retail area. So, the results were out of sight. Positive comments included providing advice and having

somewhere to speak to the team in private. The team responded to feedback provided by people. This included when the team made changes to the process for dispensing repeat prescriptions after a few people complained about the service.

A sample of controlled drugs (CD) registers looked at found that they mostly met legal requirements. A few CD registers were missing the headers. The pharmacy did not regularly check CD stock against the balance in the register. So, may miss spotting errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist (RP) records looked at found several entries did not have the time the pharmacist stopped being the RP. Records 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 team had received training on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. The pharmacy had an information governance (IG) folder containing several IG documents for the team to refer to. The team separated confidential waste for shredding offsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. Some team members had completed Dementia Friends. The delivery driver reported to the team concerns they had about people they delivered to. For example, if a person was showing signs of confusion.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has a team with the qualifications and skills to support the pharmacy's services. And it reviews its staffing and skill mix when the workload increases. The team members support each other in their day-to-day work. And they discuss and share ideas so they can introduce new processes to improve the delivery of pharmacy services. The pharmacy gives team members regular feedback on their performance. So, they can keep their skills up to date. But it provides the team members with limited opportunities to complete ongoing training. So, they may find it difficult to keep their knowledge up to date.

### Inspector's evidence

A full-time pharmacist manager covered most of the opening hours. Locum pharmacists provided support when required. The pharmacist manager had been in post for three months. But had worked at the pharmacy as a locum pharmacist so knew the systems and procedures. The pharmacy team consisted of an accuracy checking technician (ACT), two full-time qualified dispensers, two full-time trainee dispensers, a part-time trainee dispenser, a full-time pharmacy apprentice, a part-time medicines counter assistant (MCA) and a part-time delivery driver. The pharmacy had recently recruited team members including the ACT to support the growing business. At the time of the inspection the pharmacist manager, the ACT, one of the qualified dispensers, two trainee dispensers and the MCA were on duty. The pharmacy did not provide the trainee dispensers with protected time to complete the training.

The pharmacy held weekly team meetings that were usually in response to the weekly communications from head office. The pharmacist manager had used the weekly meetings to plan with the team the recent refit. And to discuss the impact on the team's workload from the increase in business. The pharmacy provided some extra training opportunities for the team. But it was limited to information from manufacturers of new products. The team had asked the representative from a company launching new types of inhalers to provide training. The pharmacist supported this training by speaking one-to-one with team members to ensure they understood the information provided by the company representative. And to see if they needed more training about the new inhalers.

The pharmacy provided performance reviews for the team. So, they had a chance to receive feedback and discuss development needs. Team members could suggest changes to processes or new ideas of working. The team had introduced a system to improve the management of the repeat prescription service. The pharmacy had a whistleblowing policy. The pharmacy did not have targets for the services provided. The pharmacist offered the services when they would benefit people.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has good facilities to meet the needs of people requiring privacy when using the pharmacy services.

### Inspector's evidence

The pharmacy premises had recently had a refit resulting in an extension to the dispensary. This provided the team with more dispensing space and storage space. The pharmacy was clean, tidy and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The team kept floor spaces clear to reduce the risk of trip hazards.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy team provides services that support people's health needs. The team members manage the pharmacy services well. They identify issues that affect the safe delivery of services. And they act to address them. The pharmacy team members keep records of prescription requests and deliveries they make to people. So, they can deal with any queries effectively. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines adequately.

### Inspector's evidence

People accessed the pharmacy through a step-free entrance. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team used a notice board in the retail area to display health information such as NHS leaflets on the medical conditions linked to long-term symptoms of a cough. The pharmacy also displayed information from the Mental Health Foundation. The team had access to the internet to direct people to other healthcare services.

The pharmacy provided multi-compartment compliance packs to help around 200 people take their medicines. One of the trainee dispensers was responsible for ordering the prescriptions. And another trainee dispenser organised the dispensing of the medicines in to the packs. Other members of the dispensary team supported the service by helping with the dispensing of the medicines in to the packs. People received monthly or weekly supplies depending on their needs. To manage the workload the team divided the preparation of the packs across the month. The team usually ordered prescriptions two weeks before supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication, dosage and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The team used a section to the rear of the dispensary to dispense the medication in to the packs. This was away from the distraction of the retail area. One of the dispensers picked the stock and placed the medicines in to a basket with the prescription and backing sheet supplied with the pack. A different dispenser dispensed the medicines in to the packs. The pharmacist manager had introduced this to provide opportunities for the team to spot errors before the packs reached the pharmacist or ACT for the final check. The team used dedicated shelves to hold baskets for packs awaiting medicine stock from the wholesaler. And the team placed notes in the baskets indicating the missing medicines. The team recorded the descriptions of the products within the packs. And it supplied the manufacturer’s patient information leaflets. The ACT checked most of the packs. The team bagged the weekly packs separately and stored them on shelves labelled with the person’s name. The pharmacy received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. The team requested prescriptions when changes were made to the medicines sent to the person. So, the team could provide the person with a new set of compliance packs and retrieve the old packs back from the person for destruction.

The team members provided a repeat prescription ordering service. The team kept the repeat prescription order slips in a dedicated folder and usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team kept a record of the request and regularly checked the record to identify missing prescriptions to chase them up with the GP teams. The team passed on information to people from their GP such as the need to attend the surgery for a medication review. The team recorded this information on the

person's electronic medication record (PMR). So, all the team was aware of this information when the person presented at the pharmacy to collect their prescription. The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had completed checks to see if anyone prescribed valproate met the criteria. And found that none of the people supplied valproate met the PPP criteria. The pharmacy had a text messaging service to inform people when their prescriptions were ready to collect. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication.

Several people had complained that their repeat prescriptions were incomplete. And other people had complained about receiving several text messages for the same repeat prescription because the team had not supplied all the medicines in one go. The team discussed how to manage this to prevent further complaints. As a result, the team introduced a system where baskets held prescriptions that were waiting stock or other prescriptions. These baskets were kept in a separate part of the dispensary. And every afternoon two team members went through the baskets adding any medicines that arrived from the wholesaler so the prescription could be completed, re-ordering medicines that had not arrived from the wholesaler or contacting the wholesaler to find out why the medicines had not been sent. The two team members also contacted the GP teams to chase up any missing prescriptions. The pharmacist manager went through the baskets each day to ensure stock was ordered and missing prescriptions identified and chased up with the GP teams. The team found this system had reduced the risk of supplying incomplete prescriptions.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The team members referred to the prescription when selecting medication from the storage shelves. The team members used this as a prompt to check what they had picked. The pharmacy used clear bags to hold dispensed controlled drugs (CDs). 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 include these items. And to provide relevant advice. 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 had checked by and 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 completed the boxes. The pharmacist initialled the prescription to show the prescription had been clinically checked. So, the ACT could do the accuracy check. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The team separated prescriptions with owings into ones with stock due from the wholesaler and ones with long term supply issues.

The pharmacy team checked the expiry dates on stock. The team members had checked the expiry dates as they returned the stock to the shelves after the recent refit. The pharmacy had a template to record when the team checked the expiry dates on medicines. But the team had not completed it. The team placed a yellow sticker or used a coloured dot on to the packaging to highlight medicines with a short expiry date. The team members 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 Oramorph oral solution with three months use once opened had a date of opening of 09 January 2020 recorded. The team used the computer to record fridge temperatures each day. But only two readings had been recorded in the last seven days. These two readings were within the correct range. The fridge temperatures were within the correct range at the time of the inspection. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it

stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). The pharmacist manager did not know when the pharmacy would have the FMD equipment. 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. A pop-up message on the main computer screen alerted the team to a new email. The team printed off the alert, actioned it and occasionally kept a record.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide safe services. And it mostly uses its facilities to 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 equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. The fridge had a glass door. This enabled the team to view the stock inside the fridge without prolong opening of the door.

The computers were password protected and access to people's 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 mostly held private information in the dispensary and rear areas, which had restricted access. But completed consent forms containing people's private information were found in the consultation room. The team used cordless telephones to make sure telephone conversations were held 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. |