General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Allied Pharmacy Aston, 82 Worksop Road, Swallownest, Sheffield, South Yorkshire, S26 4WD

Pharmacy reference: 9012361

Type of pharmacy: Community

Date of inspection: 21/10/2024

Pharmacy context

The pharmacy is next to a health and community service centre in a village around four miles south of Rotherham in South Yorkshire. It moved to its current premises in March 2024. The pharmacy's main services include dispensing NHS prescriptions and selling over-the-counter medicines. It provides a good range of NHS consultation services including Pharmacy First, the New Medicine Service (NMS), contraception, blood pressure checks and vaccinations. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine 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

Overall, the pharmacy appropriately identifies and manages the risks for its services. It keeps people's confidential information secure, and it generally keeps its records as required by law. Its team members are confident in responding to feedback. They know how to recognise and raise concerns to help keep vulnerable people safe from harm. And they engage in some conversations to share learning following the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support it in operating safely and effectively. These had last been updated in April 2024. It held its current SOPs electronically and team members could readily access these. But team members had not completed training records for the recently updated SOPs to confirm they had read and understood them. Most team members had completed learning records for the previous version of the SOPs. They demonstrated how they followed the SOPs when working. For example, by applying their dispensing signatures to medicine labels when assembling medicines and by checking people's addresses when handing out bags of assembled medicines. A team member discussed the tasks that could not take place should the responsible pharmacist (RP) take absence from the pharmacy. The pharmacy's manager was a pharmacy technician, working in an accuracy checking role (ACPT). They demonstrated how pharmacists marked prescriptions to show they had conducted a clinical check of them. They had worked with pharmacists to identify medicines which would always be accuracy checked by a pharmacist. These medicines included controlled drugs (CDs) and medicines requiring ongoing monitoring and counselling checks. The ACPT felt confident in referring any queries during the checking process to the RP.

The pharmacy had copies of risk assessments and guidance introduced by its head office team to support it in managing its services safely. The risk assessments were readily available for team members to refer to. Guidance included processes for managing people's confidential information. And observations showed team members taking care to protect people's personal information from unauthorised view. For example, a team member physically covered an appointment list on the medicines counter for the morning's vaccination clinic between checking people in for their appointments. The pharmacy held personal identifiable information in staff-only areas of the pharmacy. And team members followed secure arrangements for disposing of confidential waste.

The pharmacy had processes for managing mistakes its team members made and identified during the dispensing process, known as near misses. Team members were often asked to check their work again to help them identify their own mistake as part of the learning process. And they worked to correct their own mistakes. Team members demonstrated actions they took to reduce risk, such as separating similar sounding medicines. And holding some stock medicines in baskets to reduce the risk of them becoming mixed up with other medicines on the dispensary shelves. Team members recorded some of the near misses they made, but they explained that when workload pressure rose in the dispensary mistakes would be corrected but not always recorded. The RP and manager demonstrated the records they would complete should a mistake be identified following the supply of a medicine, known as a dispensing incident. This process included identifying and reporting mistakes involving CDs through a national NHS reporting tool. The manager discussed a recent dispensing incident and changes to

practice the team had applied following the mistake being investigated. But they had not yet formally reported the mistake. They explained this was due to workload recently increasing as the pharmacy was providing the COVID-19 vaccination service for the first time. A discussion highlighted the importance of timely reporting, and the team was referred to some tools published by the GPhC to support it in understanding the importance of acting openly and honestly and sharing learning following mistakes.

The pharmacy had a complaints procedure. But it did not advertise how people could make comments or raise concerns about its services. A team member discussed how they would manage feedback and escalate any concerns in the first instance to the attention of the manager. And team members knew to provide contact information to people if they wished to escalate their concern to the pharmacy's head office. Team members explained that the most common topic of feedback was around the availability of medicines. In response to this feedback, they regularly communicated with GP surgery teams when medicines were not available to seek prescriptions for alternative medicines. Pharmacy team members completed safeguarding learning and they knew how to recognise and report concerns about potentially vulnerable people. A team member confidently explained the steps they would take to support people requesting access to a safe space.

The pharmacy had current professional indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. The RP record was generally completed in full. But some pharmacists did not always sign out of the register when ceasing their role as required. A sample of the private prescription register found team members did not always enter accurate prescribing dates or details of the prescriber when making records. The pharmacy held records of the unlicensed medicines it supplied with full audit trails of who they had supplied the medicine to. The pharmacy kept its CD register electronically. Entries generally complied with legal requirements. But the team did not always record the address of the wholesaler when entering the receipt of stock into the register. The team completed regular balance checks of physical stock against the CD register. A random check of the physical stock matched the balances recorded in the register. The pharmacy held a record of the patient-returned CDs it received, and it made entries in the record at the point it received returns.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the appropriate knowledge and skills. It provides its team members with regular training opportunities to support their ongoing learning and development. Pharmacy team members work enthusiastically within their roles, and they are supportive of each other. They engage in regular conversations to support them in working efficiently and managing risk. And they know how to provide feedback or raise a concern at work.

Inspector's evidence

The RP was a company-employed pharmacist who worked at the pharmacy two days each week. Also on duty was the pharmacy manager, three qualified dispensers and a trainee dispenser. Two other company-employed pharmacists covered the remainder of the working week with locum pharmacist cover arranged to cover leave and days off. The pharmacy also employed three more dispensers and a pre-registration pharmacy technician. A company-employed delivery driver provided the medicine delivery service. Team members generally worked flexibly to help cover each other's leave and support was available from a relief dispensing team. The manager provided examples of recent opportunities where relief dispensers had supported the team. The team was up to date with its workload.

Pharmacy team members felt there were ongoing opportunities to engage in learning relevant to their role and to support the delivery of pharmacy services. For example, three team members had recently completed vaccination training. Trainee team members received protected time to complete their learning. The trainee on duty was confident in asking questions relevant to their learning and would be signposted to reference resources and procedures to support them in obtaining the answers. They knew how to raise and escalate any concerns with their training arrangements. The pharmacy had some targets for the services it provided. Both the manager and RP discussed a flexible approach to achieving targets and explained there was no penalty for not meeting these. They felt the team focussed well on identifying and delivering services that were beneficial to people.

The pharmacy team engaged in some discussions about patient safety, learning and workload management. But it did not routinely record details of the discussions. This meant there may be some missed opportunities to share learning with team members not on duty, and to help measure the effectiveness of any actions taken forward from the discussions. The pharmacy had a whistleblowing policy. Its team members understood how to raise and escalate a concern at work. And they were confident at putting forward ideas designed to improve workflow.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, clean, and well maintained. People using the pharmacy can speak with a member of the pharmacy team in a private consultation room.

Inspector's evidence

The pharmacy was secure, and it was well maintained. Team members knew to report maintenance concerns to their area manager in the first instance. Floor spaces remained free of trip hazards. Sinks were equipped with antibacterial soap and paper towels and there was hand sanitiser available for use. Lighting was bright throughout the premises and air conditioning helped to control the temperature within the pharmacy all year round.

The public area was fitted with aisles and led to the medicine counter. This area was particularly busy throughout the inspection due to people waiting for vaccination appointments. A few seats were provided for people wishing to sit whilst waiting. Two good-size consultation rooms led off the public area. The rooms were professional in appearance and offered suitable spaces for holding private conversations with people. The dispensary was a good size for the level of activity taking place and workflow was efficient. A separate dispensary was used to manage tasks for the multi-compartment compliance pack service. Both the ACPT and RP had protected space for completing the accuracy check of medicines in the main dispensary. Staff break and toilet facilities were available onsite in rooms leading off the main dispensary.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It provides its services safely and it supplies people with relevant information to help them in taking their medicines correctly. The pharmacy obtains its medicines from licensed sources. And it generally stores its medicines appropriately and conducts checks to ensure medicines are safe to supply to people.

Inspector's evidence

People accessed the pharmacy up a small step from street level. The team had considered the need for people to navigate this step and explained the owners were considering a ramp at the entrance to improve access. The pharmacy advertised its opening hours, information about its services and it displayed a poster published by the GPhC informing people of the standards they could expect from the pharmacy. The pharmacy stored its Pharmacy (P) medicines behind plastic screens in its public area. Signage on the screens informed people they needed to see assistance from team members when wishing to purchase these medicines. A team member explained the checks they would make when managing requests for P medicines and they had a good awareness of the need to manage repeat requests of higher-risk P medicines subject to misuse to the RP. They provided examples of declining repeat requests for medicines only licensed for short-term use, and signposting people to see their GP when a request was declined.

The pharmacy had a range of information available to support its team members in delivering its services safely. This information included training records for team members providing the service, service specifications, national protocols, and patient group directions (PGDs) for administering and supplying medicines. The dispenser administering flu and COVID-19 vaccinations discussed their role when working under the national protocol and had a clear understanding of when to refer to the RP. They discussed positive feedback they had received about the accessibility of the service from people living locally.

There was a range of tools available to support counselling when supplying higher-risk medicines to people. The RP discussed how they would counsel people on the safe use of their medicines and the importance of regular monitoring checks for some medicines. The team understood the requirements of medicine related pregnancy prevention programmes (PPPs). The RP discussed how a recent update to the valproate PPP required them to provide counselling to men taking the medicine. But the team did not often take the opportunity to record these types of interventions on people‘s medication records to support continual care.

Pharmacy team members signed the ‘dispensed-by’ boxes and ‘checked-by’ boxes on medicine labels to identify who had been involved in the dispensing process. They used baskets throughout the dispensing process to help keep all items for each prescription together and to help inform workload priority. The team used barcode technology to scan bags of assembled medicines to shelf locations. This prompted text messages to be sent to people informing them their medicines were ready. The delivery driver used the same technology when delivering medicines to people’s homes. The pharmacy team could access real-time updates through the delivery application to support them in answering any queries about the status of a delivery. The pharmacy retained prescriptions for the medicines it owed to

people. And it used these prescriptions when dispensing owed medicines.

The pharmacy used the patient medication record (PMR) system to support it in managing the supply of medicines in multi-compartment compliance packs. The team wrote information on a board in the compliance pack dispensary to support them in keeping up to date with dispensing tasks. The team documented the checks they made to confirm changes to people's medicine regimens. A sample of assembled compliance packs did not always include important safety information for some of the medicines assembled inside them. The team acted swiftly to seek support from a member of the pharmacy's senior management team and identified a setting on the PMR to ensure this safety information was printed on backing sheets attached to all compliance packs moving forward. The pharmacy supplied patient information leaflets when supplying medicines in this way.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It generally stored medicines in their original packaging. But some amber bottles containing medicines in the compliance pack dispensary were not appropriately labelled with full details of the medicine inside, batch number, expiry date and assembly date available to ensure the medicine inside remained safe to use. The team confirmed it would dispose of these medicines. The pharmacy had two fridges for storing medicines requiring cold storage. The team kept a record of the operating temperature range of its fridges. But there were some minor gaps in this record. The record showed the fridges were working within the required temperature range of two and eight degrees Celsius. The pharmacy stored its CDs safely in secure cabinets with out-of-date and patient-returned CDs clearly labelled and stored away from stock medicines within a cabinet.

Pharmacy team members explained they undertook regular stock management tasks, such as checking the expiry date of medicines. It had records of these checks for retail stock, but not for stock held in the dispensaries. A random check of stock found short-dated medicines to be highlighted clearly with stickers. But the team had not acted to remove several of these medicines from stock when they had expired. Both the ACPT and RP were observed checking expiry dates of medicines when completing accuracy checks. This helped to reduce the risk of an out-of-date medicine being supplied. Team members annotated opening dates on liquid medicines to help them make checks that any medicine remaining in the bottle was safe to supply. The pharmacy had an appropriate supply of medicine waste and clinical waste receptacles, and these were collected regularly by a waste contractor. It had CD denaturing kits available for the secure destruction of CDs. The team received details of medicine recalls and drug alerts through email. The manager explained how these alerts were checked and information about the alert was retained.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it requires to support the delivery of its services. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members had access to up-to-date digital reference resources to support them in resolving queries and obtaining up-to-date information. They used password protected computers and NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicines in a designated holding area behind the medicine counter. Information on personal information on bag labels and prescription forms were not visible from the public area.

Pharmacy team members used a range of standardised counting and measuring equipment when dispensing medicines. This included clean, crown stamped glass measures for measuring liquid medicines. The pharmacy stored equipment designated for use when measuring and counting higher-risk medicines separately to prevent any risk of cross-contamination. Equipment used to provide consultation services was from recognised manufacturers. It was stored safely and checked regularly to ensure it remained safe to use. The dispenser providing the vaccination clinic had set the consultation room up effectively for the safe management of the clinic with equipment readily available to hand, adrenaline supplies were available within the room to support the service.

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.