General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Sky Pharmacy, 35 Harehills Road, LEEDS, West Yorkshire, LS8 5HR

Pharmacy reference: 1039726

Type of pharmacy: Community

Date of inspection: 14/11/2019

Pharmacy context

This community pharmacy is in a large suburb close to Leeds City Centre. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides a supervised methadone consumption service and the flu vaccination service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	Not all pharmacy team members are enrolled on qualification training suitable for their role and in accordance with GPhC minimum training requirements.
3. Premises	Standards not all met	3.1	Standard not met	The method the pharmacy uses to destroy some confidential waste creates a potential health and safety risk for the team.
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 identifies and manages most of the risks associated with its services. The team members have training, guidance and experience to respond well to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and they act to prevent future mistakes. The pharmacy has up-to-date written procedures that the team follows. And it keeps most of the records it needs to by law. The pharmacy has suitable arrangements to protect people's private information. But the method for destroying dispensing labels containing confidential information is not safe.

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 SOPs signature sheets to show they understood and would follow them. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacist discussed with the person involved why they thought they had made the error. The pharmacy kept records of these near miss errors. A sample of the error records looked at found that the team rarely recorded the details of what had been prescribed and dispensed to spot patterns. The team members usually recorded what caused the error and actions they had taken to prevent the error happening again. Several entries in the near miss records from recent months gave the same reason for the error which was staff shortages. So, this did not reflect what the team member involved had identified as their own reason for the error. The Superintendent Pharmacist reviewed these records each month to spot patterns and make changes to processes. And shared the results of the review with the team. Following a review, the team had separated medicines that looked and sounded alike (LASA) including amitriptyline and atenolol. The pharmacy team recorded dispensing incidents. The Superintendent Pharmacist stated there had not been any dispensing incidents for some time.

The pharmacy completed an annual patient safety report. The 2018 report highlighted that several errors were made in the evening. So, the team members were asked, when working the evening shift, to take a 10-minute break to refresh and ensure they remained alert. The report stated the team members were asked to not rush when the pharmacy was busy. So, they could maintain their methodical approach to dispensing, And where possible one dispenser labelled the prescription and another dispenser picked and dispensed the medicine. The pharmacy had a leaflet and a poster providing people with information on how to raise a concern. The pharmacy used surveys to find out what people thought about the pharmacy. And it published comments from people on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that several registers did not have the header completed. The pharmacy used coloured tags on registers for CD currently in stock. So, the pharmacist knew registers without the tag were for zero stock. The pharmacist also wrote 'zero stock'

in the register. The pharmacy regularly checked CD stock against the balance in the register. This helped to spot errors such as missed entries. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist (RP) records looked at found that some entries did not record when the RP finished their shift. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they did not meet the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The team had received training from the Superintendent Pharmacist on the General Data Protection Regulations (GDPR). The pharmacy displayed details on the confidential data kept and it displayed a privacy notice in line with the requirements of the GDPR. The team separated confidential waste and shredded most of the confidential waste onsite. But the pharmacy owner burnt dispensing labels in a metal bin in a room behind the dispensary. The Superintendent Pharmacist had raised this as a concern with the pharmacy owner and alternate arrangements for disposing of dispensing labels had been discussed.

The pharmacy team members had access to contact numbers for local safeguarding teams. The pharmacists had completed level 2 training in 2019 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training in 2017. The team responded well when safeguarding concerns arose. The team reported concerns such as people not collecting their medicines to the person's GP. The Superintendent Pharmacist asked the team members to inform the pharmacist on duty when they found two or more uncollected prescriptions for the same person. The delivery driver reported concerns they had about people they delivered medicines to back to the pharmacy team.

Principle 2 - Staffing **Standards not all met**

Summary findings

Most of the pharmacy team members have the qualifications and skills to provide the pharmacy's services. But the pharmacy hasn't enrolled one of its team members, who has been working for over a year, on any recommended qualification training for their role. The team members support each other in their day-to-day work. And they share information and learning particularly from errors when dispensing. The pharmacy provides the team with some opportunities to complete ongoing training. And it gives team members feedback on their performance. So, they have opportunities to improve and identify new roles to help the safe and effective delivery of services.

Inspector's evidence

The Superintendent Pharmacist covered most of the opening hours. And regular locum pharmacists provided support. The pharmacy team consisted of two full-time level three National Vocational Qualification (NVQ) qualified dispensers who were not registered as pharmacy technicians so could not use the term, a part-time trainee dispenser, a full-time trainee medicines counter assistant (MCA), a new part-time member of the team who had been in post for one month, a part-time delivery driver and a part-time team member had worked at the pharmacy for a year but had was not trained. This team member worked on the pharmacy counter and had read and signed the SOPS. One of the NVQ3 dispensers was the pharmacy manager. At the time of the inspection the Superintendent Pharmacist, one of the regular locum pharmacists, the pharmacy manager, the NVQ3 dispenser and the trainee MCA were on duty.

The pharmacy provided extra training through learning modules provided by the National Pharmaceutical Association (NPA) and the Chemist and Druggist journal. The Superintendent Pharmacist also provided the team with information from online training modules provided by an external company. The team members had some protected time to complete the training. The pharmacy held morning team meetings. And it provided annual 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 pharmacy had targets for services such as Medicine Use Reviews (MURs). And the team felt the targets were achievable. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises **Standards not all met**

Summary findings

The pharmacy is clean, tidy and secure. The pharmacy premises are small and suitable for the service provided. But the method it uses to destroy some confidential waste creates a potential health and safety risk for the team. The pharmacy has good arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy was clean and hygienic. It had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and the pharmacy had liquid gel for hand cleansing. The dispensary was very small. The team managed this by limiting the amount of clutter in the dispensing areas. The Superintendent Pharmacist had spoken to the pharmacy owners about converting an upstairs room for the team to use when dispensing the multi-compartment compliance packs. So, the team would have space to safely dispense the packs. And team members would be away the distractions of the retail area. The Superintendent Pharmacist was awaiting a response.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. And when delivering services such as the flu vaccination service. 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.

The premises were secure. And the pharmacy owners have acted to improve the security of the premises. The pharmacy had restricted access to the dispensary during the opening hours. The pharmacy manager who was also the pharmacy owner burnt dispensing labels in a metal bin in a room behind the dispensary. The Superintendent Pharmacist had raised this as a concern with the pharmacy manager and alternate arrangements for disposing of dispensing labels had been discussed.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that support people's health needs. And it manages its services well. The pharmacy obtains its medicines from reputable sources. And it generally stores and manages medicines appropriately. The pharmacy team members keep records of prescription requests and deliveries they make to people. So, they can deal with any queries effectively. The team members carry out checks with people taking high risk medicines. To ensure the person understands what dose to take. And to confirm they have regular blood tests. These checks help ensure people can take their medicines safely.

Inspector's evidence

People accessed the pharmacy via several steps. An entrance used by the pharmacy team was available for people who had difficulty accessing the pharmacy through the normal entrance. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy provided services such as the flu vaccination service against up-to-date patient group directions (PGDs). These provided the pharmacist with the legal authority to administer the flu vaccination. People liked the flu vaccination service. The team received positive comments such as the gentle technique used by the pharmacist when administering the vaccine.

The pharmacy provided multi-compartment compliance packs to help around 70 people take their medicines. The team members mostly provided weekly supplies of packs to people. So, they could manage any changes to people’s medicines. To help with the workload the team divided the preparation of the packs across the month. The pharmacy received most prescriptions in the repeat dispensing format. The team usually ordered repeat prescriptions one week before supply. This allowed time to deal with issues such as missing items. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list. And queried any changes with the GP team. The dispensary was small with limited dispensing bench space. So, the team members prepared most packs over the weekend when they were less busy with other activities. The team recorded the descriptions of the products within the packs. And supplied the manufacturer’s patient information leaflets. The pharmacy received copies of hospital discharge summaries via the NHS communication system, PharmOutcomes. The team checked the discharge summary for changes or new items.

The pharmacy supplied methadone as supervised and unsupervised doses. The team prepared the methadone doses using a MethaMeasure electronic pump. The pump was linked to a laptop that the team updated with the methadone doses on receipt of a new prescription. When the person presented at the pharmacy the pharmacist selected the person's records from the laptop. And labelled the daily dose. This sent the dose to the pump to pour in to a container for the person to take. The pharmacist asked the person to confirm their date of birth before supplying the methadone. This acted as a check that the pharmacist had selected the correct person. The pharmacist also asked the person how they were feeling before handing over the dose. This helped to identify anyone who may need to delay taking their dose. The pharmacy had a dedicated folder holding the prescriptions in clear wallets to separate people’s prescriptions. People presenting for their methadone doses were offered the choice

of receiving their dose in the retail area or in private in the consultation room. The person's choice was recorded with their prescription. When the person chose the consultation room the pharmacist took the measured dose from the dispensary to the room, which was some distance from the dispensary, in a bag with the prescription.

The team members provided a repeat prescription ordering service. They used an electronic system as an audit trail to track the requests. The team usually ordered the prescriptions a week before supply. This gave time to chase up missing prescriptions, order stock and dispense the prescription. The team regularly checked the system to identify missing prescriptions and chase them up with the GP teams. 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 team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And had used the electronic patient medication record (PMR) to record conversations the team had with people prescribed valproate products. The pharmacy had the PPP pack to provide people with information when required. The pharmacist used the PMR to record conversations with people on other high-risk medicines such as methotrexate. The information included the latest blood tests and the dose of the medicines.

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 include 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 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. 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 pharmacy kept a record of the delivery of medicines to people. This included signature from the person receiving the medication.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was recorded in October 2019. The team highlighted medicines with a short expiry date. And it kept a list of products due to expire each month. No out-of-date stock was found. 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. The team recorded fridge temperatures each day for one of the two fridges in the pharmacy. The fridge in the consultation room contained one flu vaccine. But there were no fridge temperatures recorded for this. A sample of fridge temperature records looked at found they were within the correct range. 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 Superintendent Pharmacist was reviewing the layout and electrical points in the dispensary to accommodate the FMD equipment along with other equipment such as the MethaMeasure. 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 printed off the alert, actioned it 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 the team mostly uses the pharmacy's facilities and equipment in a way to protects 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 that was not measured using the MethaMeasure electronic pump. The team regularly checked the pump to make sure it measured accurate doses. The pharmacy had a separate, marked counting triangle for cytotoxic medicines such as methotrexate. The pharmacy had two fridges to store medicines kept at these temperatures.

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 held most private information in the dispensary and rear areas, which had restricted access. But the team stored several completed multi-compartment compliance packs and the medication list that went with the packs on open display in the consultation room. The packs and the medication list contained people’s confidential information. The door into the consultation room was locked with a Digilock. The team locked the screen on the computer in the consultation room when it was not in use. And it 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.