General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Skye Pharmacy, Dovercourt Centre, Skye Edge Avenue, SHEFFIELD, South Yorkshire, S2 5FY

Pharmacy reference: 1093157

Type of pharmacy: Community

Date of inspection: 18/06/2019

Pharmacy context

The pharmacy is in a large medical centre close to Sheffield City Centre. It dispenses NHS and private prescriptions. The pharmacy supplies medicines in multi-compartmental compliance packs to help people take their medication. And it delivers medication to people's homes. The pharmacy supplies medication to people via a minor ailments scheme.

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 met	N/A	N/A	N/A
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.3	Standard not met	The pharmacy team members don’t follow procedures and check that medicines stored in the fridge are kept at the correct temperature. They don't identify when the equipment doesn't work correctly or take the appropriate action. So, there is a risk that the pharmacy may supply medicines that are not fit for purpose.
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. But not all the team members have signed to say they have read the procedures. This means there is a risk they may not understand or follow correct procedures. The pharmacy has adequate arrangements to protect people's private information. The pharmacy team members respond appropriately when errors happen, and they act to prevent future mistakes. But they don't record all errors or review them regularly. This means the team may miss opportunities to identify patterns and reduce mistakes. People using the pharmacy have some opportunities to raise concerns and provide feedback. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had up to date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOP folder had an index to help locate the relevant SOP. Most of the team had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. The new dispenser and delivery driver had not signed the SOPs. The pharmacy had up to indemnity insurance with an expiry date of 30/09/19.

The pharmacist when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy usually kept records of these errors. But there were no records for the months of February 2019 and March 2019. Other months had few entries. A sample of the error records looked at found the team did not capture details of what had been prescribed and dispensed to spot patterns. For example, one entry listed co-codamol with the code 'D' for wrong drug. But the team member completing the record didn't capture any other information such as the item prescribed. Team members did not always record what caused the error, their learning from it and actions they had taken to prevent the mistake happening again. Most records had the same learning point recorded, namely to double check. The team recorded most actions taken as 'corrected'. This meant that team members were not using the opportunity to reflect on why they had made the error. And what they were doing individually to prevent similar mistakes. The pharmacy team recorded dispensing incidents. The team discussed dispensing incidents and how to prevent them. But didn't always record this information. The pharmacy only reviewed all the error records to spot patterns and make changes as part of an annual review. The last review highlighted that the team members were to slow down and concentrate more. And the team had moved medicines that looked and sounded alike away from each other. The team members were checking prescriptions after labelling to make sure all were for the same person. And that all the labels matched the prescription. The team members asked the pharmacist to check the insulin product they had selected before they dispensed the prescription.

The pharmacy didn't have a SOP for handling complaints raised by people using the pharmacy. And it didn't have any information such as a poster or leaflet to provide 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.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy recorded CDs returned by people. A sample of Responsible Pharmacist records looked at found that they met legal requirements. Records of private prescription supplies looked at found that the date of supply and the prescription date were often missing or only recorded as the month and year, i.e. Dec 18. The team had not entered several private prescriptions dated from March 2019. 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 had a folder containing several documents related to the General Data Protection Regulations (GDPR). A note at the front of the folder asked the team to read the privacy policy inside the folder. There was no evidence, such as a signature sheet, to show that the team had read the documents. The pharmacy had a privacy notice in line with the requirements of GDPR but didn't display it for people to see. The team separated confidential waste and sent it to another pharmacy in the company for shredding.

The pharmacy had safeguarding procedures and team members had access to contact numbers for local safeguarding teams. The pharmacist had completed level 2 training in 2017 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. Most of the team had completed Dementia Friends training. The pharmacy driver reported to the team concerns they had about the people they delivered to such as signs of neglect. Or if a person was not taking their medication.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the qualifications and skills to support the pharmacy's services. The team members discuss how they can make improvements. And they act to support the safe and efficient delivery of these services. The pharmacy team members have few opportunities to complete more training. So, they may miss the opportunity to progress in their role to help the safe and effective delivery of services.

Inspector's evidence

Regular locum pharmacists covered the opening hours. The pharmacy team consisted of a registered pharmacy technician who was also an accuracy checking technician (ACT), two qualified dispensers, a trainee dispenser, a medicines counter assistant (MCA) and a delivery driver. One of the dispensers was also an accuracy checker. The MCA had received additional training to help the team put stock away. The pharmacy had advertised for a part time dispenser. At the time of the inspection one of the regular locum pharmacists, two qualified dispensers and the medicine counter assistant were on duty. The ACT was the pharmacy manager and an area manager but was regularly at another branch for a few days providing managerial support. The team were working increased hours to cover the ACTs absence. The pharmacy displayed some of the team’s training certificates for people to see.

The pharmacy provided the team with limited training such as children’s oral health from the Centre for Pharmacy Postgraduate Education (CPPE) The team members used their initiative to identify training events. Two of the team had attended a local training event on Mental Health. Following this one of the dispensers had asked for funding to do the Mental Health first aid course. The dispenser was keen to complete this training and was looking at funding it herself. The pharmacy recently introduced performance reviews for the team. But they were yet to take place. One of the dispensers had asked about technician training with the aim to be an ACT. The dispenser was offered the accuracy checker training to support the ACT.

Team members could suggest changes to processes or new ideas of working. The team had rearranged the storage of incomplete prescriptions. This helped to easily locate and prioritise the prescriptions when the stock arrived.

The pharmacy set targets for services such as Medicine Use Reviews (MURs). The pharmacist was under some pressure to achieve them. The pharmacist offered the services when they benefited people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and suitable for the services provided. And it has adequate 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. 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 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 pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy provides services that support people's health needs. And it manages its services well. It keeps records of the medicines people have supplied in multi-compartmental compliance packs and it has records of the deliveries it makes to people at home. So, it can deal with any queries effectively. The pharmacy obtains its medicines from reputable sources. And it stores them correctly. But the pharmacy team members don’t follow procedures and make the necessary checks of medicines requiring refrigeration. They can't identify when the temperature is out of the required range. So, there is a risk that the pharmacy may supply medicines that are not fit for purpose.

Inspector's evidence

People accessed the pharmacy via an automatic door. The window displays detailed the opening times and the services offered. The pharmacy didn’t have a leaflet containing information such as contact details for people to take away. The team had access to the internet to direct people to other healthcare services. The pharmacy kept a range of healthcare information leaflets for people to read or take away. The minor ailments scheme was popular. People obtained advice on symptoms and received certain medicines such as paracetamol liquid if needed. This was instead of a visit to the GP and having to get a prescription. The medicines counter assistant was responsible for managing this service. And regularly checked that there was enough stock of the medicines allowed under the scheme.

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 didn’t know if checks had been done to identify people that met the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy had the PPP pack containing information to hand over to people. The pharmacy team asked people taking high risk medicines such as methotrexate for information about blood tests and doses. But didn't record this information when it was given.

The pharmacy provided multi-compartmental compliance packs to help around 100 people take their medicines correctly. People received monthly or weekly supplies depending on their needs. One of the qualified dispensers managed the service. And received support from others in the team. To manage the workload the team worked a week in advance of supply. This allowed time to deal with issues such as prescriptions with missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list and the backing sheet supplied with the packs. And queried any changes with the GP team. The team used a section of the dispensary to dispense the medication. The dispenser labelled the prescriptions and picked the medicine to put in to the packs. The dispenser put the labels and selected stock into baskets and stored them on dedicated shelves waiting for dispensing. This meant other dispensers could see packs awaiting dispensing and complete this task. The dispenser used separate baskets with labels attached to show prescriptions awaiting stock. The team recorded the descriptions

of the products within the packs to help people identify their medicines. And supplied the manufacturer's patient information leaflets. The pharmacy occasionally received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. And shared it with the person's GP. The team kept the discharge summary for reference. The GP team sent the pharmacy team a sheet highlighting medication changes. This included the date of the change and who had requested it. The pharmacy team recorded who had actioned the change and when. The team asked the GP if the change could wait until the team sent the next set of packs.

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. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. 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 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 team members were reminded to not sign the dispensing labels before attaching them to the container so that a second check could take place before they signed the box. The accuracy checker asked the pharmacist to complete a clinical check of the prescription. But there was no record to evidence that this had happened. So, it would be difficult to identify who had completed the check in response to a query or mistake. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication. The pharmacy obtained separate signatures for CD deliveries.

The pharmacy team checked the expiry dates on stock. But didn't always keep a record of this. The last date check record was on 03/05/18. The team marked expiry dates with a highlighter pen. And attached post-it notes with the expiry date written to medicines with a short expiry date. 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. For example, an opened bottle of Oramorph oral solution three month use once opened had a date of opening of 12/06/19 recorded. 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 team used disposable gloves when handling medicines returned by people. The team members used the gloves as sometimes they had found items other than the medicines, such as false teeth.

The pharmacy had a record sheet to capture daily fridge temperatures and when starting the computer each day a prompt flashed up. The team had not recorded any readings since February 2019. And the thermometer at the time of the inspection was showing maximum readings outside the range of 8 degrees, for example 14 degrees. The pharmacy had no evidence that the medication in the fridge could still be supplied and used safely or when the issue started. The pharmacy team and Superintendent Pharmacist were alerted to investigate.

The pharmacy had installed scanners to meet the requirements of the Falsified Medicines Directive (FMD). But the team had to return them as they were not working. The pharmacy didn't have any FMD procedures and the team hadn't received any FMD training. The pharmacy obtained medication from several reputable sources including IPS Specials for unlicensed products. 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 and actioned it.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services and the team mostly 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. But it didn't make sure the equipment was working properly. It completed safety checks on its electrical equipment.

The computers were password protected and access to peoples' 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 private information in the dispensary and rear areas, which had restricted access. 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 the folder holding completed consent forms for pharmacy services containing people's confidential information in baskets in the consultation room. This meant that people in the room could see other people's information. 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.