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: 04/03/2020

Pharmacy context

The pharmacy is in a large medical centre in a suburb of Sheffield. The pharmacy dispenses NHS and private prescriptions. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy provides the supervised methadone consumption service. And the Community Pharmacist Consultation Service (CPCS).

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 generally identifies and manages the risks associated with its services. The pharmacy has some ways to obtain feedback from people using the pharmacy. And the team members respond to feedback they receive. The pharmacy has procedures to protect people's confidential information. And it keeps most of the records it needs to by law. Most team members have training to respond to safeguarding concerns. So, they can help protect the welfare of children and vulnerable adults. The pharmacy team members respond appropriately when errors happen. They discuss what happened and they take appropriate action to prevent future mistakes. But sometimes they don’t record enough detail of why the error happened. This means the team may miss opportunities to learn.

Inspector's evidence

The pharmacy had a range of recently updated 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 SOPs described the roles and responsibilities of the team. Most team members had read the SOPs and signed the SOPs signature sheets to show they understood and would follow the SOPs. Other team members were in the process of reading and signing the updated SOPs. The team demonstrated a clear understanding of their roles. And knew when to refer to the pharmacist. The pharmacy had up-to-date indemnity insurance.

On some occasions the pharmacist and the accuracy checking technician (ACT) when checking prescriptions and spotting an error asked the team member involved to find and correct the mistake. The pharmacy kept records of these near miss errors. A sample of the error records looked at found that the team recorded details of what had been prescribed and dispensed to spot patterns. The team members usually recorded their learning from the error and actions they had taken to prevent the error happening again. But many records had the same reason. Such as to double check the strength and quantity picked. So, there was little evidence of individual reflection. A few records did have specific details. One entry stated that the team member was to be more careful when checking owings from prescriptions. The regular pharmacist and the ACT identified patterns and discussed them with the team members. But the pharmacy did not keep records of this review of the near miss errors. The pharmacy had a procedure to record dispensing incidents. But there were no records of dispensing incidents available to evidence this. And the team could not recall any recent dispensing incidents. The team had rearranged medicine stock to reduce picking errors when certain medicines were often involved with picking errors. The team responded to an incident when a person who had two prescriptions only received the medicines from one prescription. The team identified that the two prescriptions were not kept together in the box holding completed prescriptions. So, rearranged the prescriptions waiting to be collected in alphabetical order. So, when there was more than one prescription for a person the team could see all the prescriptions. The team asked the person collecting the prescription to confirm the number of items they were expecting. So, if the dispensed items were less than the quantity the person was expecting the team could check if there were other prescriptions for the person.

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. In response to complaints about waiting times the team provided people with an idea of how long the prescription was taking, especially when the pharmacy team were busy. So, the person could decide to wait or call back. The medicines counter assistants asked the team how long a prescription would take when there were several items on the prescription. So, this could be passed on to the person.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. 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 several entries did not have the time the pharmacist stopped being the RP. The team members knew what activities could and could not take place in the absence of the RP. A sample of records of private prescription supplies found that some did not have the prescription date recorded. Records of emergency supply requests 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 had a folder containing several documents related to the General Data Protection Regulations (GDPR). Some team members had signed the documents to show they had read the information. The pharmacy did not display a privacy notice or other information about how it protected people's confidential information. The pharmacy had safeguarding procedures and team members had access to contact numbers for local safeguarding teams. The pharmacist and ACT had recently completed level 2 training 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 has a team with the qualifications and skills to support the pharmacy's services. The team members support each other in their day-to-day work. They discuss and share ideas and they introduce processes to improve their efficiency and safety in the way they work. The pharmacy provides the team members with opportunities to develop their knowledge. But team members don't receive formal feedback on their performance. So, they may miss the opportunity to reflect and identify training needs to help the safe and effective delivery of services.

Inspector's evidence

A full-time locum pharmacist covered most of the opening hours. Other locum pharmacists provided support when required. The pharmacy team consisted of a part-time accuracy checking technician (ACT), three part-time qualified dispensers, a part-time trainee dispenser, a part-time medicines counter assistant (MCA), a part-time trainee MCA and a delivery driver. At the time of the inspection the full-time locum pharmacist, the ACT, one of the qualified dispensers, the trainee dispenser and the trainee MCA were on duty. A dispenser from another pharmacy in the company was helping the team with the dispensing of multi-compartment compliance packs. The trainee MCA had protected time to complete their training. The regular locum pharmacist developed a rota of key tasks for the team to complete. This helped to ensure the tasks were completed. And provided the team members with a range of skills to support the pharmacy services especially in times of absence.

The pharmacy provided extra training for the team through e-learning modules. The area manager informed the team when new training modules were released. The current training module was about Sepsis. The company used a WhatsApp group to share information from the company and to celebrate success. The pharmacy did not provide performance reviews for the team. So, they did not have a chance to receive feedback and discuss development needs. Team members could suggest changes to processes or new ideas of working. The ACT had introduced a process where team members counted out the medicines for each compliance pack before placing the medicine in to the packs. So, if medicine was left over after the packs had been filled or there was not enough medicine to fill the packs the team member checked the contents of the packs. The pharmacy did not set targets for services such as the New Medicines Service (NMS). 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 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 consultation room contained a sink and alcohol gel for hand cleansing. The pharmacy had notices next to the sinks describing effective hand washing techniques. 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. But the team also used the room as an office for storing several box files of paperwork and cardboard boxes. This gave the room a slightly untidy appearance. 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 obtains its medicines from reputable sources. And it mostly stores them correctly. But the pharmacy team members don't follow procedures and make the necessary regular checks of medicines requiring refrigeration. They can't identify when the temperature is out of the required range. So, there is a risk that they may supply medicines that are not fit for purpose. The pharmacy provides services that support people's health needs and it manages its services appropriately. The pharmacy team takes care when dispensing medicines in to multi-compartment compliance packs to help people take their medication. And it keeps records of the deliveries it makes to people at home. So, this enables the team to deal with any queries effectively.

Inspector's evidence

People accessed the pharmacy via an automatic door. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The team had access to the internet to direct people to other healthcare services. The pharmacy displayed a GPhC poster explaining what people could expect from the pharmacy. The poster included a code for people to scan using their telephone to take them to the GPhC inspections website. At the time of the inspection the pharmacy had not received the latest HM Government and NHS Coronavirus posters. The pharmacy technician had received an email from the GPhC providing up-to-date information on the Coronavirus and links to advice from organisations such as the NHS. The team members were aware of information about Coronavirus released by the NHS. The pharmacy team had completed checks to identify patients that met the criteria of the valproate Pregnancy Prevention Programme (PPP). And found no-one who met the criteria.

The pharmacy provided multi-compartment compliance packs to help around 117 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. The regular locum pharmacist had met with the GP team to ask for prescriptions to be sent earlier. This had been agreed so the team had more time to prepare the packs. 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 team used a section of the dispensary to dispense the medication. One of the dispensers picked the medicine to put in to the packs. And asked another dispenser to check the items picked before dispensing them in to the packs. So, any picking errors could be identified before the medicines were removed from the original packaging. The team recorded the descriptions of the products within the packs to help people identify their medicines. And it supplied the manufacturer's patient information leaflets. The team stored completed prescriptions on dedicated shelves with the person's name on the spine of the pack and the due date written on the pack. The pharmacy occasionally received copies of hospital discharge summaries. The team checked the discharge summary for changes or new items. And shared the discharge summary with the person's GP. 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 team kept the medication list and other documents such as the hospital discharge summary for reference.

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 pharmacy used clear bags to hold dispensed 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 pharmacist initialled the prescription to indicate a clinical check had been completed. So, the accuracy checking technician could do their check. 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 team members checked the expiry dates on stock. But they didn't always keep a record of this. The team marked expiry dates with coloured dots. 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 cetirizine oral solution with six months use once opened had a date of opening of 28 February 2020 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 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 did not regularly record fridge temperatures. When the team started the computer each day a prompt flashed up. But the team had only recorded the fridge temperatures on 15 occasions since January 2020. The thermometer at the time of the inspection was showing readings in Fahrenheit but the readings on the computer were in Celsius. The pharmacist adjusted the thermometer to the Celsius readings. This showed readings outside the normal range of between two and eight degrees Celsius. The probe for the thermometer was inside of the door of the fridge so was moved during the inspection further in to the fridge for better readings. The pharmacist used another thermometer to take the fridge temperatures during the inspection and the readings were within the range. The recording of fridge temperatures was a standard not met at the last inspection on 18 June 2019.

The pharmacy had recently had equipment installed to meet the requirements of the Falsified Medicines Directive (FMD). The team members were not scanning FMD compliant packs as they were waiting for training from the company. The regular locum pharmacist had received some training from the person who installed the equipment. And planned to share this with the team. The ACT had worked with FMD equipment at another pharmacy. So, could help the team with the training and use of the 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. The team actioned it and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services and the team mostly 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. The pharmacy had a fridge to store medicines kept at these temperatures. But didn't make sure the equipment was working properly.

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 team used cordless telephones to make sure telephone conversations were held in private. 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 folders holding completed consent forms for pharmacy services that contained people's confidential information in the consultation room.

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.