General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: UK Pharmacy Ltd, 286 Abbeydale Road, SHEFFIELD, S7 1FL

Pharmacy reference: 1124666

Type of pharmacy: Internet / distance selling

Date of inspection: 27/04/2021

Pharmacy context

This is an internet community pharmacy in the city of Sheffield, Yorkshire. It is on a busy main road alongside other local retail businesses. In addition to the internet pharmacy, there is a healthy living store at the front of the premises which focusses on selling health and beauty items to people. It operates from the website www.ukpharmacyltd.co.uk. The pharmacy dispenses NHS prescriptions. And it delivers people's medicines to their homes. The pharmacy dispenses medicines for some people in multi-compartment compliance packs. The inspection was completed during the Covid-19 pandemic.

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

The pharmacy effectively identifies and manages risks with its services. It maintains the records it needs to by law and keeps people's information secure. The pharmacists record details of any mistakes they make while dispensing and learn from these to help prevent similar mistakes from happening again.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). They covered tasks such as dispensing, responsible pharmacist requirements and controlled drug (CD) management. There was an index available to help find an SOP easily. The SOPs had been implemented in 2014 and last reviewed in October 2017. There was no future review date scheduled, but the pharmacy's superintendent pharmacist (SI) planned to complete a review over the next few months. The pharmacy delivered all the medicines it dispensed to people's homes. And there was an SOP for the process. But the pharmacy's delivery driver had not signed the SOP and so there was a risk that the delivery driver may not fully understand how to carry out their role. The NHS SOP for the Covid-19 pandemic was in place. It set out general principles for the delivery of services during the pandemic. Each team member had signed the SOP.

The SI and a second pharmacist worked at the pharmacy, and each completed both the dispensing process and the final check of the medicines they dispensed. There was a paper near miss log in place which the pharmacists used to record and near miss errors that they may have made. The SI demonstrated how he had affixed 'warning' stickers next to medicines that had similar names, such as amlodipine and amitriptyline. The purpose of the stickers was to remind the pharmacists to select these medicines carefully and make sure they hadn't selected the incorrect medicine in error. They recorded details of any dispensing errors that had reached a person. The details recorded included the reason why the error may have happened. The two pharmacists discussed any such incident with each other and considered how they could prevent a similar error happening again. For example, they had decided to use 'master sheets' for people who received their medicines in a multi-compartment compliance pack. These sheets detailed the person's current medication details and time to be taken. The master sheets helped reduce the number of errors made when dispensing of the packs.

The pharmacy had a concerns and complaints procedure in place, but it was available for people to see on the pharmacy's website. Any complaints or concerns were required to be raised verbally with a team member. The pharmacy completed an annual patient satisfaction survey each year. The results for the 2020 survey were displayed on the pharmacy's website. The results showed that 96% of participants were satisfied with the service they received from the pharmacy.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist (RP) notice displayed the name and registration number of the RP on duty. Entries in the RP record complied with legal requirements. The pharmacy kept up-to-date and accurate records of private prescriptions. It kept CD registers and records of CDs returned by people to the pharmacy. The CD registers were audited against when the pharmacy dispensed or received medicines.

Confidential waste was placed into a separate basket to avoid a mix up with general waste. The waste was periodically destroyed using a shredder. The SI understood the importance of keeping people's

private information secure. The pharmacists and the delivery driver had completed information governance training as part of their employment induction process, and they had all signed confidentiality agreements.

Both pharmacists had completed level 2 training on safeguarding vulnerable adults and children via the Centre of Pharmacy Postgraduate Education. The delivery driver had not completed any formal training but had received some informal verbal training from the SI. The SI explained he was confident that the delivery driver would immediately raise any safeguarding concerns he had with the pharmacist on duty. The SI was aware of when and how he could escalate any concerns to the local safeguarding team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a small team of pharmacists with the necessary skills to provide its services. And they keep their professional knowledge up to date. The pharmacists manage the workload well and communicate regularly.

Inspector's evidence

At the time of the inspection, only the SI was working. The SI was also a company director. He alternated between working four days a week and two days a week. The days that the SI didn't work were covered by the pharmacy's second pharmacist who was also a company director. The pharmacy didn't employ any dispensers. It employed one part-time delivery driver. The SI was observed to be working well during the inspection and was not seen dispensing prescriptions under any significant time pressures.

The pharmacy didn't have a formal training programme in place, but the pharmacists took time to ensure they were kept up to date with the latest pharmacy news and regularly accessed the Pharmaceutical Services Negotiating Committee (PSNC) and GPhC websites. They also ensured they were up to date with their continuing professional development as required as part of their GPhC registration.

The delivery driver could raise any professional concerns by contacting one of the pharmacists either in person or via telephone. All decisions relating to the running of the pharmacy were made together by both pharmacists during regular informal meetings outside of working hours. There were no specific targets for the pharmacists to achieve.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy keeps its premises clean, secure and well maintained. The premises are suitable for the services it provides.

Inspector's evidence

The pharmacy was clean and well maintained. It had separate sinks available for hand washing and for the preparation of medicines. The pharmacy was cleaned regularly to reduce the risk of spreading infection. The pharmacy dispensary was kept tidy and well organised throughout the inspection. Floor spaces were kept clear to prevent the risk of a trip or a fall. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room had been rarely used during the pandemic. As the pharmacy only allowed one person in the premises at a time, the consultation room door could be kept open during a consultation to allow for appropriate social distancing. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy makes its services accessible to people. It manages these services with effective processes. And it supports people to take their medicines correctly. The pharmacy appropriately sources, stores and manages its medicines,

Inspector's evidence

People couldn't access the pharmacy for its essential pharmacy services. There was stepped access to the entrance door for people to use if they wished to purchase any health and beauty items or use the consultation room. The pharmacy's services contact details and opening hours were displayed on the pharmacy's website. People contacted the pharmacy via telephone or email to ask them to collect a prescription on their behalf. The SI demonstrated how he would signpost people for services that the pharmacy didn't provide. During the inspection, the SI was observed signposting a person to another local pharmacy that offered Covid-19 travel certificates. The pharmacy served a large South Asian community and both pharmacists could communicate with people who didn't speak English in both Urdu and Punjabi.

The pharmacists used various stickers and annotated bags containing people's dispensed medicines to use as an alert before they delivered medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a CD that needed handing out at the same time. They signed the dispensing labels to keep an audit trail of the dispensing and final check parts of the dispensing process. The SI explained that prescriptions that were not urgent or due on the same day, were dispensed by one of the pharmacists and then would be checked and bagged by the other pharmacist. On occasions when one pharmacist both dispensed and checked a prescription, they took a mental break between the two processes to reduce the risk of errors happening. They used dispensing baskets to hold prescriptions and medicines together which reduced the risk of them being mixed up. The pharmacy had owing slips, but the pharmacists did not always use them. And so, there was a risk that the pharmacy's dispensing records were not accurate. The inspector reminded the SI of the importance of using owing slips during the dispensing process. Due to the pandemic, the delivery driver didn't ask people to sign for receipt of their medication. The driver left the medicines on the person's doorstep before moving away and waiting to watch them pick up the medicines. The SI was aware of the Pregnancy Prevention Programme for people in the at-risk group who were prescribed valproate, and of the associated risks. The SI demonstrated the advice he would give in a hypothetical situation.

The pharmacy supplied medicines in multi-compartment compliance packs to several people. The packs were provided either weekly or every four weeks. To help manage the workload evenly, the dispensing of the packs was divided across a four-week cycle. The pharmacists used master sheets which contained a list of the person's current medication and dose times. Prescriptions were checked against the master sheets for accuracy before the dispensing process started. Any queries were discussed with the relevant prescriber. Any details of any changes such as dosage increases or decreases, were recorded on the person's master sheet. The packs were supplied with patient information leaflets and descriptions of the medicines to help people identify them. For example, 'orange, round, capsule'.

The pharmacy didn't have a formal process to check the expiry dates of its medicinal stock. The SI said

that he checked medicines around 2-3 times per year to ensure no out of date stock was kept in the dispensary. The pharmacy didn't have a process to highlight short-dated stock. No out of date medicines were found after a random check of around 20 randomly selected medicines. The date of opening was recorded on medicines that had a short shelf life once they had been opened. The pharmacy had medical waste bins, sharps bins and CD denaturing kits available to support the team in managing pharmaceutical waste. The pharmacy had a fridge which was used to store medicines that required cold storage. The fridge temperature ranges were checked and recorded daily.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for its services. And it uses its equipment appropriately to protect people's confidentiality.

Inspector's evidence

Team members had access to up-to-date reference sources. The pharmacy used a range of CE quality marked measuring cylinders. The computers were password protected to prevent any unauthorised access. The pharmacists had access to personal protective equipment including face masks, visors, aprons and gloves.

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.