General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Swanland Pharmacy, 16 West End, Swanland, NORTH FERRIBY, North Humberside, HU14 3PE

Pharmacy reference: 1032132

Type of pharmacy: Community

Date of inspection: 06/06/2023

Pharmacy context

This community pharmacy is in the large village of Swanland near Hull. It dispenses NHS prescriptions and supplies some people with their medicines in multi-compartment compliance packs to help them take their medicines properly. And it delivers medicines to several people's homes. The pharmacy offers NHS services including the NHS Community Pharmacist Consultation Service. And it has a private travel clinic, where it provides travel advice and administration of vaccines.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 suitably identifies and manages the risks associated with all its services. It has up-to-date written procedures that the pharmacy team follows. It completes the records it needs to by law and it protects people's private information properly. Pharmacy team members respond correctly when errors occur. And they take appropriate action to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of its services. Team members had read the SOPs and signed the SOPs signature sheets to show they understood and would follow them. They demonstrated a clear understanding of their roles and worked within the scope of their role. And they referred queries to the pharmacist when necessary. A risk assessment for the travel clinic was in place, this had been reviewed in 2020 when the pharmacy relocated to its current premises and again in June 2023. The RA included details of the training required for the pharmacist vaccinator and for the team supporting the service.

The pharmacist and accuracy checking technician (ACT) when checking prescriptions and spotting an error asked the team member involved to identify and correct the error. This helped the team member reflect on why the error occurred. The pharmacy kept records of these errors, known as near misses, which the ACT regularly reviewed to identify patterns. The near miss records captured the learning points from the error such as the need for additional checks on the strengths of medicines to reduce errors. Recent reviews identified incorrect quantities being dispensed particularly when the same medicine came in different pack sizes. These where highlighted to team members so they were aware. The team had also separated on the shelves medicines that looked and sounded alike to reduce picking errors.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. The team had received concerns from several people that their prescriptions were not ready to collect from the pharmacy after they were notified by the GP team or NHS App that it was ready. In response, the Superintendent Pharmacist (SI) developed a letter advising people to manage expectations. This included allowing five working days from ordering their prescriptions and two working days after receipt of the message before presenting at the pharmacy. This information was also on a notice displayed in the retail area.

The pharmacy had current indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The correct RP notice was displayed. The pharmacy kept detailed records of each consultation with people attending for the travel clinic. These records were kept securely on a dedicated platform and on the pharmacy's secure electronic patient medication record (PMR). The records detailed where the person was travelling to, the date the vaccine was administered and details of the vaccine administered including the batch number. When a course of vaccinations was required each separate date of administration was captured.

Team members had recently completed training on the General Data Protection Regulations (GDPR)

and they knew how to manage people's confidential information. They separated confidential waste for shredding offsite. The pharmacy did not have a safeguarding procedure for the team to follow. But team members had completed safeguarding training appropriate to the role. This included training about the safe space initiative which helps people experiencing domestic abuse. Team members had access to contact numbers for local safeguarding teams. The delivery drivers reported concerns back to the team who took appropriate action such as contacting the person's GP

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of experience and skills to safely provide its services. Team members work well together, and they are good at supporting each other in their day-to-day work. And they discuss ideas to enhance the safe delivery of the pharmacy's services. Team members have opportunities to receive feedback and complete some training so they can suitably develop their skills and knowledge.

Inspector's evidence

The SI worked full time at the pharmacy with locum pharmacists cover when required. The pharmacy team consisted of one full-time ACT, two full-time dispensers, one part-time dispenser, one part-time trainee dispenser and three part-time delivery drivers. At the time of the inspection the SI, the ACT, and two dispensers were on duty. Team members worked well together particularly to ensure people presenting at the pharmacy counter were not kept waiting.

Trainees were given protected time at work to complete their training. There were some opportunities for team members to complete additional training. The SI provided the travel clinic service and completed annual training to ensure his knowledge and skills, such as vaccination techniques, were up to date.

Weekly team meetings took place when a range of matters were discussed including the outcomes from error reviews and plans to manage the team's workload. A recent meeting discussed the importance of team members re-starting a task such as dispensing if they were disturbed before completing the task. Team members received informal feedback on their performance. But they didn't have the opportunity to formally reflect on their performance and identify opportunities to progress and develop their skills.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy premises were tidy and hygienic. There were separate sinks for the preparation of medicines and hand washing, with hot and cold water available along with hand sanitising gel. Team members kept the work benches clean and they kept the floor spaces clear to reduce the risk of trip hazards. There was sufficient storage space for stock, assembled medicines and medical devices.

The pharmacy had a defined professional area and items for sale in this area were healthcare related. There was a soundproof consultation room for the team to have private conversations with people and when providing services such as the travel clinic. It was a suitable size for the services provided and was appropriately equipped. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which are easily accessible and help people to meet their healthcare needs. Team members manage the pharmacy services well to help make sure people receive medicines when they need them. They store medicines properly and they mostly complete regular checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a small step with handrails either side of the door. Team members provided people with information on how to access other healthcare services when required. They gave people clear advice on how to use their medicines and they asked appropriate questions when people requested to buy over-the-counter products.

The travel clinic service was supported by up-to-date patient group directions (PGDs) supplied by a specialist company. These gave the SI the legal authority to administer the vaccines. The SI had provided this service for many years and used his experience to evaluate the risk of providing the service in this way. He had undertaken governance checks on the company providing the PGDs before starting the service. The SI worked within guidance and up-to-date information issued by the National Travel Health Network and Centre (NaTHNaC). Appointments for the travel clinic were limited to four a day to help manage the other pharmacy services. People generally contacted the team by telephone to arrange an appointment. The SI had developed a letter template to send to the person's GP to advise of the vaccinations administered. The letter had previously been emailed to the GP but several people reported to the SI that the GP hadn't received it. In response the SI printed out the letter for the person to the take to the GP. People were provided with information about the vaccination for them to take away and read. And if they required proof of administration such as for the yellow fever vaccine they were given a certificate. In-date adrenaline injections were available in the consultation room in case of an anaphylactic reaction to the vaccine.

The pharmacy supported people to take their medication by offering larger print labels and providing medicines in multi-compartment compliance packs, depending on the person's needs. A record detailed when each person was due to receive their medicines so team members could prepare the packs in advance. Prescriptions were usually ordered one week before supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication and dose times. The team checked people's prescriptions against the list and queried any changes with the GP team. Team members did not always record the descriptions on the packs of what the medicines looked like to help people identify the medicines in the packs. They supplied the manufacturer's patient information leaflet, so people had information about their medicines. The pharmacy occasionally received copies of hospital discharge summaries which the team checked for changes or new items.

Team members provided people with clear advice on how to use their medicines. They were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to provide to people when required. A recent audit led to the pharmacist having a conversation with a small number of people to confirm they were aware of the risks and the PPP requirements. The PMR was updated with details of the conversation for the team to refer to when required.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. Different coloured baskets were used depending on whether the person collected their medication, or it was delivered, to help organise workload. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription and a sample looked at found the team completed both boxes. The ACT accuracy checked the prescriptions after the pharmacist had marked the prescription to indicate a clinical check had been completed. The pharmacy used fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. Completed prescriptions awaiting delivery were stored in a dedicated area so they were readily available for the driver. And for team members to find if the person presented to collect their medication. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose.

The pharmacy obtained medication from several reputable sources. Team members checked the expiry dates on stock and marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening. This meant the team could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day for the one holding stock but not the one holding completed prescriptions. A sample of these records looked at found they were within the correct range. The fridge holding completed prescriptions was showing the correct temperatures at the time of the inspection. And after the issue was highlighted the SI created a separate record on the PMR for this fridge. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and 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 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 it uses its facilities to suitably protect people's private information.

Inspector's evidence

The pharmacy had reference sources and access to the internet to provide the team with up-to-date information. It had equipment available for the services provided including a range of CE equipment to accurately measure liquid medication. And two fridges for holding medicines requiring storage at this temperature. Appropriate waste facilities were in place for the safe disposal of syringes and needles used when administering the travel vaccinations.

The pharmacy 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 and it stored completed prescriptions away from public view. The pharmacy held private information in the dispensary and rear areas, which had restricted public access.

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.