

# Registered pharmacy inspection report

**Pharmacy Name:** Swift Pharmacy, 108 Broom Valley Road,  
ROTHERHAM, South Yorkshire, S60 2QY

**Pharmacy reference:** 1039198

**Type of pharmacy:** Community

**Date of inspection:** 21/08/2024

## Pharmacy context

This community pharmacy is in a parade of shops in a residential area of Rotherham in South Yorkshire. It has recently changed ownership. The pharmacy's main services are dispensing prescriptions and selling over-the-counter medicines. It dispenses some medicines in multi-compartment compliance packs to support people in taking their medicine safely. And it offers a medicine delivery service to people.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy identifies and manages the risks for its services appropriately. It keeps people's confidential information secure. And it uses the feedback it receives to help inform the way it provides its services. The pharmacy mostly keeps its records as required by law. Its team members know how to recognise and respond to safeguarding concerns. And they engage in some learning following the mistakes they make during the dispensing process.

### Inspector's evidence

The pharmacy changed ownership in June 2024 and the team was currently in the process of embedding changes. This included a significant increase in dispensing activity in July 2024 due to the company preparing to close its distance selling pharmacy within the town. Most team members had moved across from the distance selling pharmacy to the new pharmacy around a month ago to support the change in workload. The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. A sample of SOPs showed they had been reviewed by the superintendent pharmacist (SI) in 2023. Team members were familiar with the SOPs and discussed the differences between providing services in a community pharmacy and a distance selling pharmacy, such as preparing more liquid medicines and selling general sales list (GSL) and pharmacy (P) medicines to people. But they had not completed training records to show they had read and understood the SOPs. A team member discussed the tasks that they could not complete if the responsible pharmacist (RP) took absence from the pharmacy.

The team used the functions of its patient medication record (PMR) system to support a series of checks throughout the dispensing process. This relied on barcode technology to complete checks during the assembly process and the final accuracy check of the medicine. The RP undertook clinical checks of all prescriptions and recorded these on the PMR before dispensing activity began. A team member demonstrated how the PMR flagged mistakes made during the dispensing process, known as near misses. The PMR did not produce dispensing labels until a near miss was rectified. A team member explained how they would seek support from the RP when they needed more information to help them understand why the medicine they had picked was not correct. The team also referred queries, including any medicines that did not scan and those not dispensed in the manufacturer's original packaging to the RP for a manual accuracy check. Team members discussed their near misses and demonstrated how they adapted their practice to help reduce risk. For example, by paying particular care to the quantities they were dispensing. The RP explained the team had developed a near miss record to capture the mistakes picked up by manual accuracy checks following an inspection of its distance selling pharmacy in March 2024. But it had not embedded the same record at this new pharmacy. The pharmacy had a procedure for reporting and investigating mistakes made following the supply of a medicine to a person, known as a dispensing error. The RP was the pharmacy manager and a director of the company, they explained they were not aware of any dispensing errors that had occurred since the change in ownership.

The pharmacy had a complaints procedure, but this was not advertised to people visiting the pharmacy. A team member explained how they would manage feedback and escalate a concern to the RP. The pharmacy used feedback from people to help inform how it provided its services. For example, it had

recently invested in an additional barcode scanning handset to allow it to gather real time information about the medicine delivery service. The RP explained how this change would allow team members to check real-time information for people if a query arose. Pharmacy team members completed mandatory information governance learning. The pharmacy kept personal-identifiable information within the staff-only area of the pharmacy. The pharmacy segregated its confidential waste and it disposed of this securely.

The pharmacy had current professional indemnity insurance arrangements. The RP notice on display contained the correct details of the RP on duty. And the RP register was completed in full. The private prescription register was held in accordance with legal requirements. The pharmacy mostly held its controlled drug (CD) register in accordance with legal requirements. It had completed physical checks of CDs against running balances in the register upon transferring ownership. But there were a few incomplete page headers found in the register and the pharmacy did not routinely record the address of the wholesaler when entering the receipt of a CD into the register. Pharmacists signed against the running balances in the register when entering receipt and supply of a CD. Random balance checks of CDs completed during the inspection identified a balance discrepancy This was investigated and immediately resolved. It was caused by a missed entry on 5 July 2024. Several receipts and supplies of the CD involved had been made and initialled by pharmacists since this date. The RP stated they would inform locums of the need to physically check stock when entering the receipt and supply of CDs before initialling the register. The pharmacy had a register to records its patient-returned CDs, but it did not record returns upon receipt. A discussion took place about the need to record patient-returned CDs at the point of receipt and the RP acted to do this immediately.

Pharmacy team members had completed some learning to support them in identifying potential safeguarding concerns. A team member provided examples of hypothetical scenarios which they would report on to the RP to help ensure people were kept safe from harm. Team members had acted to report a number of concerns to people's own GPs when they had identified compliance issues with medicine regimens. This had led to changes in the way the pharmacy dispensed some medicines to people to help keep them safe from harm. The pharmacy advertised its consultation room as a safe space and it promoted the 'Ask for ANI' safety initiative, designed to support people experiencing domestic violence in accessing a safe space. The RP was aware of the initiative, but a discussion highlighted the need to share learning with all team members to support them in managing a request from a person to use pharmacy's safe space.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy employs a committed team of people who work together well. Team members complete ongoing learning to support them in delivering the pharmacy's services safely and effectively. They regularly share learning with each other and are confident in providing feedback at work.

### Inspector's evidence

The RP was supported by two qualified dispensers, a trainee pharmacy technician, and an apprentice throughout the inspection. The pharmacy also employed a delivery driver and a qualified dispenser. Team members worked flexibly to cover both planned and unplanned leave. Regular locum pharmacists covered the RP's days off. The team was up to date with its workload, and it managed its planned workload, such as the supply of medicines in multi-compartment compliance packs effectively to ensure these were ready for collection or delivery when they were due.

The trainee pharmacy technician had completed their learning and was waiting to register with the GPhC. The apprentice received regular learning time at work and stated they were progressing well on their course. They felt able to ask the RP or other experienced team members for support with their learning when needed. Recent learning for all members of the team had included refreshing their knowledge and skills when selling P medicines.

Pharmacy team members were observed working well together. They enjoyed their roles and were confident in providing feedback at work. Several team members had taken the opportunity to look round the pharmacy before the change of ownership in order to share their thoughts about how the team could use the space effectively. The pharmacy had a whistle blowing policy and team members knew how to raise and escalate concerns at work. Pharmacy team members engaged in regular informal conversations about workload and safety. And they communicated regularly with each other through a secure messaging application. But the team did not keep records of any meetings it had to help it review the effectiveness of any shared learning or risk reduction actions it applied. The pharmacy did not have specific targets for the services it delivered. The RP explained that the directors regularly shared information with each other about the services each of their pharmacies were providing.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean, secure, and suitably maintained. It offers a professional image to people visiting the pharmacy. People using the pharmacy are able to speak to a member of the pharmacy team in a private consultation room.

### Inspector's evidence

The pharmacy was secure and adequately maintained. The premises were dated, and the new owners were conducting a programme of improvement works to modernise them. Works conducted to date included refitting the public area of the pharmacy. This area presented a modern, clean, and welcoming environment for people accessing the pharmacy. The owners had also invested in air conditioning to help regulate the temperature inside the pharmacy year-round. Lighting was sufficient and the premises were generally clean and organised. There was some minor debris on the carpet in the dispensary and in a hand washing sink due to current building works. Work benches were clear of unnecessary clutter and floor spaces were free of trip hazards. Team members had access to sinks equipped with antibacterial hand wash. The dispensary sink provided access to fresh drinking water and was used by team members preparing liquid medicines.

The public area was open plan and led to the medicine counter. People could not see directly into the dispensary from the medicine counter. The pharmacy's consultation room offered a good, protected space for people to have confidential discussions with team members. Team members could access the room from the staff-only area, and they invited people into the room via a public facing door which was kept locked between use. The dispensary was an adequate size for the activities observed. Team members used the space effectively to help manage risk. For example, higher risk activities such as assembling medicines in multi-compartment compliance packs and measuring higher-risk liquid medicines were completed in an area of the dispensary which was distraction free. The team had access to staff break and toilet facilities onsite.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy's services are accessible to people. The pharmacy obtains its stock from reputable sources and its team members apply checks to help ensure medicines are safe to supply. Pharmacy team members use a range of audit trails to support them in answering queries which may arise when supplying medicines. But they do not always provide information leaflets when supplying medicines to help people take their medicines safely.

### Inspector's evidence

People used either a slope or steps from street level to access the pharmacy. The pharmacy displayed details of its opening times but some leaflets within its consultation room referred to services provided by the previous owner. A discussion highlighted the need to remove any information which was not current to avoid the risk of confusing people about what services were provided. The RP explained the current focus was on providing NHS essential services, they were planning to introduce new services once the team had adapted to its new surroundings and the changes to the way the pharmacy delivered its services. Team members had appropriate knowledge of the local area and signposted people to other pharmacies or healthcare providers if the pharmacy could not provide a service. Many team members spoke at least one other language and the RP provided examples of how they used their language skills to communicate with people visiting the pharmacy.

Pharmacy team members understood the importance of asking people questions about their symptoms and medication history when managing requests for P medicines. And team members had knowledge of the types of P medicines that were liable to abuse. The RP had positioned their checking station out-of-sight of but close to the medicine counter. This arrangement allowed them to listen to conversations taking place at the medicine counter and intervene when required. Pharmacy team members discussed how they managed risk when dispensing medicines. For example, the RP used information available from manufacturers to help inform whether it was safe to supply a medicine in a multi-compartment compliance pack.

Pharmacy team members had an awareness of the requirements of medicines subject to pregnancy prevention programmes (PPPs). And the pharmacy had completed individual risk assessments for exceptional circumstances when it dispensed valproate outside of the manufacturer's original packaging. The RP counselled people about the safe use of their medicines. But they did not routinely seek confirmation of ongoing monitoring checks taking place for people taking higher-risk medicines. And they did not generally record the interventions they made on people's medication records to support them in providing continual care. Pharmacy team members had received recent training to support them in dispensing prescriptions for opioid treatment programmes safely. They demonstrated how they effectively monitored the supply of these medicines and communicated with prescribers and people's key workers when needed.

The pharmacy used audit trails to support it in managing its services. For example, pharmacy team members personally signed into the PMR system when completing dispensing tasks. And they applied their dispensing signatures to backing sheets attached to multi-compartment compliance packs. This helped to identify who had assembled and checked medicines in the event a query arose. The team

used baskets throughout the dispensing process. This helped to organise workload and reduced the risk of mixing up medicines. The pharmacy kept a record of the deliveries it made to people's homes. It kept details of the medicines it owed to people and of the checks it made with wholesalers to obtain these medicines. The pharmacy supplied some medicines to people residing in a care home. It provided medication administration records (MARs) for all the medicines it supplied to the care home. The pharmacy used a range of monitoring tools to support it in dispensing medicines in multi-compartment compliance packs. These included checks to ensure people were collecting their compliance packs and recording changes to people's medication regimens on their PMR. A sample of assembled compliance packs contained clear directions to help people take their medicines. But the pharmacy did not always provide descriptions of the medicines inside the packs or supply a patient information leaflet for each medicine it dispensed. This meant people may not have all the information available to them about the medicines they are taking.

The pharmacy sourced medicines from licensed wholesalers. Medicine storage in the dispensary was orderly with most medicines stored in their original boxes, one loose blister strip containing two tablets was found on the dispensary shelves. This was brought to the attention of the RP and removed from stock. It stored medicines subject to cold chain requirements in two fridges. The team generally recorded the operating temperature range of each fridge. But there were some recent gaps in these monitoring records. The minimum and maximum temperatures of both fridges had remained within the required range between these gaps. The pharmacy held its CD stock in secure cabinets. And storage arrangements within the cabinets was orderly.

The team discussed the checks of medicine stock it had applied when moving to the pharmacy. This had included checking expiry dates of medicines at the time of the change of ownership and again when the team had moved some stock across from its other premises. A random check of dispensary stock found no out-of-date medicines. The pharmacy had medicine waste receptacles available to support the team in managing pharmaceutical waste. It received details of drug alerts and recalls by email, and it kept an audit trail of the checks it made for these alerts.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide its services. And its team members team members use the equipment in a way which protects people's confidentiality.

### Inspector's evidence

Pharmacy team members accessed reference resources digitally, such as the British National Formulary. They used the internet to help resolve queries and to obtain up-to-date information. Team members used passwords and NHS smart cards to access people's medication records. They used a cordless telephone which allowed them to move to a quiet area of the dispensary when discussing confidential information. The pharmacy stored bags of assembled medicines in drawers behind its medicine counter and on some shelves to the side of its medicine counter. Information on bag labels could not be read from the public area.

The team used a range of equipment to support it in delivering the pharmacy's services. For example, standardised measuring cylinders for measuring liquid medicine with separate measures identified for use only with a higher-risk liquid medicine. The equipment used for the multi-compartment compliance pack service included single-use compliance packs. The RP was in the process of removing some equipment left by the previous owners as it was no longer required, such as equipment used to provide blood testing services.

### 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.