General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: J Swire & Son, 210-212 King Cross Road, HALIFAX, West Yorkshire, HX1 3JP

Pharmacy reference: 1039549

Type of pharmacy: Community

Date of inspection: 25/11/2019

Pharmacy context

The pharmacy is on a high street in the suburbs of Halifax. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). And, they supply medicines to people in multi-compartment compliance packs. The pharmacy provides a substance misuse service.

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 not all met	1.1	Standard not met	Pharmacy team members don’t always identify and manage the risks with the pharmacy’s services. For example, they don’t appropriately manage the risks when dispensing liquid medicines and for items stored in the fridge. The team doesn’t always follow the pharmacy's documented procedures. And, the pharmacy doesn't have robust processes to manage the risks of providing medicines in multi-compartment compliance packs.
		1.2	Standard not met	The pharmacy doesn’t keep regular records of near miss errors. The last record is from February 2019. And it only keeps records of some dispensing incidents. There is little evidence that pharmacy team members learn from the mistakes or make changes to stop similar errors in the future.
		1.4	Standard not met	The pharmacy does not adequately respond to feedback. It has not maintained the changes following feedback from the inspector in the previous inspection in 2017.
		1.6	Standard not met	The pharmacy, over a prolonged time, does not keep all the necessary legal records. And, it does not adequately maintain other records necessary to help manage the delivery of safe and effective services. This is a continuing issue
		1.7	Standard not met	The pharmacy does not adequately manage the disposal of confidential waste. And, it does not have processes in place to properly restrict access to NHS electronic systems.
2. Staff	Standards not all met	2.2	Standard not met	Pharmacy team members do not have the right qualifications for their roles and the services they provide. And, they are not enrolled on appropriate training courses.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines	Standards not all met	4.2	Standard not met	The pharmacy cannot evidence, that during dispensing, it takes appropriate steps to make sure some liquid medicines are

Principle	Principle finding	Exception standard reference	Notable practice	Why
management				supplied accurately and safely to people. The pharmacy does not have a robust process to adequately manage the risks when providing medicines in multi-compartment compliance packs.
		4.3	Standard not met	Pharmacy team members do not regularly monitor the temperature of the medical fridge storing medicines. They don't take any action when the temperature is out of range. And they don't ever monitor the temperature of the fridge storing people's medicines waiting to be collected. So, there is a risk medicines are not safe to supply to people. Pharmacy team members do not monitor the temperatures in the medicine fridges. So, there is a risk the medicines are not safe to supply to people. And, they do not provide medicines information leaflets to people receiving their medciens in multi-compartment complaince packs. Or, provide descriptions of the medicines in the packs, so people can identify what they look like.
5. Equipment and facilities	Standards not all met	5.1	Standard not met	The pharmacy does not have the necessary range of equipment available to accurately and safely measure and dispense liquid medicines.

Principle 1 - Governance **Standards not all met**

Summary findings

The pharmacy doesn't always identify and manage all the risks with its services. The pharmacy has a written procedure to support pharmacy team members to record mistakes that happen. But there is little evidence they record their mistakes. It is difficult for them to evidence any learning from these mistakes. And how they make effective changes to stop similar mistakes happening in the future. The pharmacy does not always keep the records it must by law. This is seen over a prolonged period. And it doesn't always maintain other records necessary to help manage safe and effective services. Pharmacy team members understand the importance of keeping people's private information safe. But they don't always dispose of people's private information appropriately. The pharmacy does not always adequately respond to feedback over the longer term. It has not maintained the changes following feedback from the inspector in the previous inspection. Pharmacy team members know what to do to protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. And, the pharmacy owner said he reviewed them every two years. The sample checked were last reviewed in April 2018. But, these did not show the date of the next review. Pharmacy team members had read and signed the SOPs. Some pharmacy team members had done so since the last review because they were new to the pharmacy team. Other team members that had worked at the pharmacy for longer had not read the procedures since they were last reviewed. One example was a team member that had last read and signed the procedures in 2017. Pharmacy team members did not always follow the documented procedures. One example was the process for handling near miss errors. The pharmacy defined the roles of the pharmacy team members each SOP. Pharmacy team members said the pharmacy owner usually defined their daily tasks verbally.

The pharmacy did not record near-miss errors made by pharmacy team members when dispensing. The pharmacy owner said they had started recording near miss errors after the last inspection in 2017. But, they had not made any records of near-miss errors since February 2019. And, the records available from before that were infrequent. A pharmacy team member gave an example of a recent near-miss error where prochlorperazine had been dispensed instead of prednisolone. She explained that the pharmacist had told them the error had happened. And, had asked them to be more careful. But they had not had any discussion about why the mistake had been made. Or, made any changes to help prevent the mistake happening again. The owner said he did not analyse the errors for patterns of occurrence. The SOP in place for handling near-miss errors instructed pharmacy team members to record and discuss all errors. And, to analyse the data collected for patterns to help inform changes to reduce risks. The procedure for recording and analysing near miss errors was not being followed. The pharmacy had a procedure for dealing with dispensing errors that had been given out to people. But, the procedure was not being followed. The pharmacy did not record dispensing errors that happened. Pharmacy team members explained that when an error was identified, the pharmacy owner told them to be more careful. They could not give any examples of any changes they had made to help prevent dispensing errors happening again. The pharmacy owner said he did not record dispensing errors unless someone asked to make a complaint. And, two examples of complaints records were available. One was from November 2019. And, the other from March 2018. The information recorded included details of the nature of the complaint. But, there was no explanation about how and why the mistakes could have

happened. And no detail of any changes the pharmacy had made to reduce risks. The GPhC had also recently received a complaint highlighting four dispensing errors since the beginning of 2018 that the pharmacy had been made aware of. And, none of these had been recorded. The team acknowledged that little had been done in response to errors made in the pharmacy. This had been discussed but little had changed.

At the last inspection in 2017, the pharmacy had received feedback about the standards in the pharmacy. And the report had highlighted where standards needed improvement. After that inspection, the pharmacy owner gave assurances that the issues identified had been resolved. The changes made at this time had not all been sustained. The pharmacy had a procedure to deal with complaints handling and reporting. It had a poster available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. But pharmacy team members were not aware of any feedback received. And, they could not give any examples of any changes made in response to feedback to improve services.

The pharmacy had up-to-date professional indemnity insurance in place. It had a certificate of insurance displayed. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. But, pharmacy team members did not regularly audit these against the physical stock quantity, including methadone. The pharmacy owner said stock audits were carried out in most registers approximately every six weeks. But there was no evidence of the checks recorded. The pharmacy kept register of CDs returned by people for destruction. But the pharmacy did not keep a record in the register of who had destroyed the CDs or who had witnessed the destruction. The pharmacy maintained a responsible pharmacist record electronically. But, the record had frequent gaps in the sign-out time of the responsible pharmacist. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures in the fridge in the main dispensary. But, they did not monitor the temperature frequently. For example, the records available for October 2019 showed four entries. And, the record for November 2019 showed five entries. The pharmacy had a second fridge, which pharmacy team members used to store bags of dispensed medicines. Temperatures in the second fridge were not monitored or recorded. They kept private prescription records in a paper register. Some records recorded the necessary information. But some records did not accurately record the date of the prescription or the date when the supply had been made. The pharmacy recorded emergency supplies of medicines electronically. And, in the samples seen, it frequently did not document a reason for making an emergency supply. Some of these issues had been raised with the pharmacy at their last inspection in 2017.

The pharmacy kept sensitive information and materials in restricted areas. Pharmacy team members were asked where they placed confidential waste ready for destruction. They pointed to a dedicated bin under the dispensary bench. And, they said that when the bags were full, they were marked as confidential waste and the owner took them home to burn. The pharmacy had another bin in a room it used to store dispensed multi-compartment compliance packs. Pharmacy team members said the bin was used for general household waste. But the inspector found several pieces of confidential waste in the bin, primarily discarded bag labels. This issue was raised during the pharmacy's last inspection in 2017. And, at the time, the pharmacy owner gave his assurance that confidential waste would be handled, stored and destroyed securely. This was discussed. And, the pharmacy owner could not explain why confidential items had been found in the same bin again. Throughout the inspection, pharmacy team members were seen accessing the NHS electronic prescriptions system using NHS smart cards that belonged to someone else. For example, the smart card in use at the main dispensing computer belonged to a pharmacy team member who was not present during the inspection. And, they had written their PIN on the back of the card for others to use. Another card in use belonged to the pharmacy owner, although he was not using the computer. Three pharmacy team members present

explained they did not have their own smart cards. So, they had no choice but to use cards that belonged to others. And the pharmacy had not made attempts to resolve this. Pharmacy team members were generally clear about how to protect people's confidentiality in the pharmacy. For example, by using the consultation room to have discreet discussions. And, by making sure confidential items were not left on the pharmacy counter.

When asked about safeguarding, a dispenser gave some examples of symptoms that would raise her concerns in both children and adults. She explained she would refer to the pharmacist. And, with the patient's GP or substance misuse service if necessary. The pharmacy owner said he would assess the concern. And, would refer to local safeguarding teams. He said he had completed training via the Centre for Pharmacy Postgraduate Education (CPPE) but could not remember when. Other staff had not been provided with any training. There was a procedure in place instructing pharmacy team members about what to do if they had a concern.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy team has the experience required to provide the pharmacy's services. But the pharmacy team members do not have the right qualifications for their roles and the services they provide. And, the pharmacy has not enrolled them on the appropriate training courses. The pharmacy provides little support to help pharmacy team members learn and develop. The pharmacy team members discuss together the work they need to complete. They feel comfortable raising concerns. And, making suggestions to help improve pharmacy services. But, changes they make are not always maintained and do not always improve the way they work.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a pharmacist and four pharmacy team members. None of the four team members were qualified or enrolled in training for the activities they were performing. And, all were employed as dispensers. Each of the team members had been in their current roles for more than three months. The longest serving member had been in position approximately ten years. She explained that she had been enrolled in training approximately two years ago. She had not been given opportunities to complete her training at work. And she had fallen behind with completing the course. So, the training course had expired before she could complete her training. The newest pharmacy team member had started in February 2019. Pharmacy team members completed training ad-hoc by reading various trade press materials. And by having discussions with the pharmacist and each other. They said this did not happen often. The pharmacy did not have an appraisal or performance review process.

The pharmacy team members felt they were not working efficiently. And they felt there was lots of jobs to try and complete at the same time. They had created a staff rota some time ago to address the issues. But they had not been able to concentrate on their allocated tasks on the rota. And so, the changes to their ways of working hadn't been maintained. They acknowledged that the pharmacy team as a whole didn't take time to record and discuss learning from mistakes made during dispensing.

Pharmacy team members communicated with an open working dialogue during the inspection. The said they felt comfortable raising issues and sharing ideas to improve pharmacy services. But they felt the issues were not always resolved. One suggestion had been to implement the staff rota to help make sure pharmacy team members were in key areas of the business at the right time. But, the implementation of the rota had not been maintained. The pharmacy did not have a whistleblowing procedure. So, pharmacy team members may find it difficult to raise concerns anonymously if necessary. The pharmacy owner did not ask the team to achieve any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. And, it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. The pharmacy had clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy also had a cellar. The cellar was used for storage. And it was kept tidy and organised. The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink which provided hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

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

Summary findings

The pharmacy doesn’t always manage its services safely and effectively. It doesn’t always take appropriate steps to make sure it measures liquid medicines accurately. Pharmacy team members do not monitor the temperatures in the medicine fridges appropriately. So, there is a risk the medicines may not be safe to supply to people. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. But they don’t have a robust process to adequately manage the risks to make sure people receive their medicines correctly. The team members take steps to identify people taking some high-risk medicines. And they provide people with advice and support. The pharmacy's services are generally accessible to people. The pharmacy sources its medicines from reputable suppliers.

Inspector's evidence

The pharmacy was accessed via a step from the street. It did not have a ramp available to help people using wheelchairs to access the pharmacy. And, there was no signage available telling people how to attract attention if they needed help from the pharmacy team. Pharmacy team members explained they usually saw someone who needed help and went to assist them. And, they explained that some people had telephoned the pharmacy from outside to ask for help. Pharmacy team members explained they would use written communication and lip-reading with someone with a hearing impairment. And, they could provide large print labels and instruction sheets for people with a visual impairment.

A pharmacy team member was seen reconstituting a bottle of amoxicillin suspension for a child during the inspection. The amoxicillin required 82ml of water to be added to reconstitute it properly. But, the smallest available measure in the pharmacy was 50ml. And, this had 5ml graduations marked. The pharmacy did not have a measure available to measure 1ml graduations. It was suggested that the pharmacy team member could estimate the 2ml volume. But after a discussion with the inspector, a 5ml oral syringe was used. Pharmacy team members explained that the pharmacy’s 5ml glass measure had been broken approximately two months ago. And, this had been raised with the pharmacy owner. But to date, the measure hadn’t been replaced which meant the team couldn’t make accurate measurements of small volumes of liquids.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacy owner provided women receiving prescriptions for valproate with the necessary counselling and advice. But the pharmacy did not have any printed materials to give to people, as they are required to do, to help them understand the risks of taking valproate during pregnancy.

The pharmacy supplied medicines to people in multi-compartment compliance packs when requested. It attached labels to the pack, so people had written instructions of how to take the medicines. These did not include descriptions of what the medicines looked like, so they couldn't be easily identified in the pack. Pharmacy team members did not regularly provide people with patient information leaflets about their medicines. The pharmacy used the patient's master record sheet to record changes made to peoples medication received in packs. But this process wasn't robust. Pharmacy team members were usually informed of changes via a fax from the patient's GP. If they were informed of a change by

another means, such as a phone call, there was no record kept of the information received. So, people may receive medicines that had been stopped. Or, they may not receive new medicines. The pharmacy delivered medicines to people. It kept records of the deliveries made. But it did not ask people to sign for receipt of their deliveries. So, there was no reliable audit trail of the delivery service. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy to arrange a re-delivery.

The pharmacy obtained medicines from several licensed wholesalers via buying group. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. Pharmacy team members checked medicine expiry dates at least every 12 weeks. But they did not keep records of their checks. They highlighted any short-dated items with a sticker on the pack up to six months in advance of its expiry. And they removed expiring items in the month before their expiry. This required a pharmacy team member to go around the shelves and look for items with an expiry sticker attached. After a search of shelves, the inspector did not find any out-of-date medicines. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. Pharmacy team members did not record any action taken. The pharmacy owner was aware of the requirements of the Falsified Medicines Directive (FMD). But, the pharmacy did not have the necessary equipment, software or procedures to comply with the requirements. And, pharmacy team members had not been trained. The pharmacy owner said he was currently in talks with his computer system supplier to arrange installation of the necessary equipment.

The pharmacy had two fridges which they used to store medicines. Pharmacy team members kept the contents of the pharmacy fridges tidy and well organised. They sometimes monitored minimum and maximum temperatures in the fridge in the main dispensary. For example, four entries had been made in the record in October 2019. And, five entries were made in November 2019. Records were available from before October 2019. And, these showed temperatures in the fridge regularly exceeding the permitted 8 degrees Celsius. So, the team couldn’t be sure the medicines in the fridge at that point had remained in the correct temperature range. The temperature of the fridge during the inspection was within acceptable limits. This was discussed with the pharmacy owner. And, he said nothing had been done at this time to address the temperature readings that were outside the permitted range. The pharmacy had a second fridge in a store room. Pharmacy team members used the fridge to store bags of dispensed medicines waiting for collection. They did not monitor or record temperatures in the fridge. The temperature in the fridge during the inspection was 8.2 degrees Celsius. The pharmacy owner was asked to remove the items and place them in the other fridge until he could determine whether it was safe to store medicines in the store room fridge. And to ascertain if the medicines were safe to supply to people.

Principle 5 - Equipment and facilities **Standards not all met**

Summary findings

The pharmacy mostly has the necessary equipment available, which it properly maintains. But, it does not have the proper range of equipment available to measure liquids accurately. Pharmacy team members share their personal access cards to people's records, which means people's private information may not be adequately protected.

Inspector's evidence

The pharmacy had some equipment it needed to provide the services offered. The pharmacy had resources that included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy had some clean, well maintained measures available for medicines preparation. But, it did not have a measure available to measure quantities of less than 5ml. So, it couldn't accurately measure small volumes. The pharmacy positioned computer terminals away from public view. And these were password protected. But, pharmacy team members were using other people's smart cards to access NHS systems. And, this was because they did not have their own. The pharmacy had two fridges used to store medicines. Pharmacy team members didn't record the temperature in one of the fridges. And they rarely recorded the temperature in the other. So, the couldn't establish whether the fridges were working properly.

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.