General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Swillington Pharmacy, Church Lane, Swillington, LEEDS, West Yorkshire, LS26 8DY

Pharmacy reference: 1039696

Type of pharmacy: Community

Date of inspection: 09/05/2019

Pharmacy context

The pharmacy is in the village of Swillington that is between Leeds and Wakefield. The pharmacy dispenses NHS and private prescriptions. It provides multi-compartmental compliance packs to help people take their medication. And it delivers medication to people's homes. The pharmacy provides flu vaccinations. And it supplies medicines via a minor ailments scheme known as Pharmacy First.

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 not all met	3.1	Standard not met	The environment of the premises does not support the safe delivery of services. There is excessive clutter and untidy shelves which increases the risks of picking the incorrect medication from the shelf. The pharmacy has inadequate space for the preparation of multi-compartmental compliance packs. It leaves the packs open for checking and stacked on top of each other. This increases the risks of medication falling out or moving in the pack. And there is the risk that items may move between different people's packs. The work benches in the room where the team prepares the packs are very untidy and cluttered. This leaves little space to work and risks dropping the packs or knocking them over.
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy does not provide all its services in a way to ensure they are safe. It doesn't have a robust process to manage the supply of multi-compartmental compliance packs. And it doesn't always check medication dispensed into these packs against prescriptions before supplying to the person. The pharmacy supplies some medication before the prescription arrives at the pharmacy. The pharmacy doesn't have a robust delivery process to ensure people have received their medication.
		4.3	Standard not met	The pharmacy doesn't manage and store all its medicines appropriately. The pharmacy mixes medication from different manufacturers in the same box. And pharmacy team members don't always record details such as batch number and expiry dates after transferring stock from the original pack to another container. This means if there is a drug recall they can't make the necessary checks. And they dont

Principle	Principle finding	Exception standard reference	Notable practice	Why
				know if the medicines are safe to supply. The pharmacy doesn't put medication returned from people in to appropriate waste bins. This means there is a risk of supplying these medicines to other people.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy identifies and manages some of the risks associated with its services. And it keeps most of the records it needs to by law. People using the pharmacy can raise concerns and provide feedback. The pharmacy team has some training and guidance so they can respond to safeguarding concerns and protect the welfare of children and vulnerable adults. The pharmacy has adequate arrangements to protect people's private information. The pharmacy has written procedures. But they have not been recently reviewed. This means there is a risk that team members may not be following up-to-date procedures. The pharmacy team members record some of the errors that happen. And although they discuss what happened, they don't review them to identify trends. So, they may be missing opportunities to learn and reduce the risks of errors in the future.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. Some SOPs had review dates due in 2017. But there was no evidence this had happened. The SOPs covered areas such as dispensing prescriptions. The team signed the SOPs to confirm they had read and understood them. The pharmacy had up to date indemnity insurance.

The team used baskets throughout the dispensing process to hold stock, prescriptions and dispensing labels. The pharmacist when checking prescriptions and spotting an error told the team member involved of the mistake. Rather than getting the team member involved to identify their error. The pharmacy had a book to capture these errors. But didn't always record them. The book showed the last entry was in March 2019. The pharmacy had an electronic system to record dispensing incidents. A sample of these records looked at found that the pharmacy didn't always capture the reasons for the error. Or, what the team did to prevent it happening again. The pharmacy did not review the error records to spot patterns for the team members to learn from. And for them to take action to prevent the same mistake happening again. The team members separated some products that looked and sounded alike. They did this to help reduce picking errors.

The pharmacy leaflet had information on how to make a complaint. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy did not always reconcile the amount of CD stock with the balance in the register. A sample of Responsible Pharmacist records looked at found they met legal requirements. The Responsible Pharmacist notice was partially hidden behind medication on the pharmacy counter. Details of private prescription supplies, and emergency supply requests met legal requirements.

The pharmacy leaflet gave people information on the private data the pharmacy kept. And how the

pharmacy stored it safely. The pharmacy stored completed prescriptions away from public view. And it held its private information in the dispensary and rear areas, which had restricted access. The pharmacy had an information governance folder containing a range of documents. The team had signed a form to state they'd read the details from the General Data Protection Regulation (GDPR). The pharmacy had a shredder to destroy confidential waste.

The pharmacy had procedures informing the team of the steps to take if concerned about vulnerable people. The pharmacist had completed level 2 training on 05/03/17 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The delivery driver reported to the team any concerns they had about people they delivered medication to. This included signs that the person was not taking their medication. The team shared this information with the GP.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has the qualifications and skills to support the pharmacy's services. The pharmacy team members receive some extra training. But they don't receive feedback on their performance. So, they may miss the opportunity to reflect and identify training needs. And progress in their role or take on a new role to help the safe and effective delivery of services. The pharmacy team has few chances to share learning and suggest changes to practice. The team members can raise concerns about the safe delivery of services. But their concerns are not always acted on.

Inspector's evidence

Two regular locum pharmacists covered most of the opening hours. One of the regular pharmacists was leaving in June. Different locum pharmacists provided cover for the remaining opening hours. The pharmacy team consisted of three dispensers, a medicines counter assistant and a delivery driver. The pharmacy had lost three members of staff including dispensers. On some days such as Friday there was only a dispenser and pharmacist on duty. The pharmacy received a large stock order on a Thursday. One of the team who had left, and not replaced, had been responsible for putting the stock away. The team had to do this job when free of other tasks such as dispensing. This meant that there were several boxes left on the floor creating trip hazards. And adding to the untidy environment. The number of deliveries had increased. But the delivery driver's hours had not changed. As a result the driver was often rushed and didn't complete all deliveries. So, the team had to complete the deliveries leaving the pharmacy short of staff whilst they did this.
The pharmacy provided extra training via modules from Numark. The team attempted to complete the training but didn't get protected time to do this. The team members did not get formal feedback on their performance. So, didn't get chance to discuss development and training needs. Team members had raised concerns about the management of stock and the untidy, cluttered environment. But nothing had changed. The team attempted to tidy the shelves but found they soon became untidy as the volume of stock coming in increased.
The pharmacist was not set targets for services such as medicine use reviews (MURs). The pharmacist did these services to benefit people using them.

Principle 3 - Premises **Standards not all met**

Summary findings

The environment of the premises does not always support the safe delivery of its services. The pharmacy has cluttered work benches and untidy shelves. So, there is an increased risk of errors happening. The pharmacy has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

The pharmacy work benches were very cluttered with baskets and stock. So, the pharmacy team had limited workspace for dispensing. The pharmacy shelves were cluttered with stock. Several packs of medication were on top of one another running the risk of picking errors. The pharmacy used the floor to store stock, boxes and completed prescriptions. The pharmacy toilet was outside. And didn't have a sink. The team used the sink in a side room in the dispensary as there was no immediate opportunity to wash their hands.

The pharmacy had a good sized and sound proof consultation room. Boxes cluttered the room. And the pharmacy team used it as kitchen area housing items such as a kettle. The pharmacy had cordless telephones for confidential conversations.

The premises were secure. The pharmacy had restricted access to the dispensary when the pharmacy was open. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale were healthcare related.

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

Summary findings

The pharmacy provides services that support people's health needs. But it doesn’t have robust processes to ensure it provides its services safely. It supplies some medicines in multi-compartmental compliance packs to help people take their medicines. But, it doesn't work in an organised way. And sometimes these packs are supplied without a valid prescription. The pharmacy doesn't always store or manage its medicines appropriately. So, there is a risk the pharmacy may supply medicines that are out of date or not fit for purpose.

Inspector's evidence

People accessed the pharmacy via a small step. The pharmacy information leaflet detailed the services offered, the opening times and the contact details of the pharmacy. The team accessed the internet to direct people requiring other healthcare services. A range of healthcare information leaflets were available.

The pharmacy provided multi-compartmental compliance packs to help people take their medicines. One of the dispensers managed the service. The team usually ordered prescriptions in advance of supply. This allowed time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Some prescriptions came as repeat dispensing. Many prescriptions were sent weekly. The team prepared four weeks packs against the medication list. The pharmacist checked these packs. And the pharmacy supplied the packs once it received the prescription. A check of the packs with the valid prescription did not take place before supplying to the person. This meant there was no opportunity for the pharmacist to take responsibility for identifying changes and taking appropriate action. For some prescriptions the pharmacy wasn’t making a valid or accurate supply. Some people wanted monthly supplies, but the pharmacy only received weekly prescriptions. The pharmacy supplied monthly packs to these people against the first prescription which only gave authority for one week. The pharmacy got the remaining prescriptions after making the supply. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the list. This helped identify missing items or changes. The team used a side room to prepare the packs. But this was very cluttered and untidy. The room had little space to work. The dispenser had discussed with the owner setting a limit on the number of packs. But no agreement had been made. The pharmacy stored dispensed packs awaiting checking on top of each other. And kept them unsealed, risking medication moving between packs or losing items. The team kept mixed boxes of medication and tablet bottles containing medication from the original pack without recording the batch number and expiry date. The team didn’t write descriptions of the products within the packs. So, the team and people getting the packs wouldn’t know what medication was in the pack. The pharmacy didn’t always supply the manufacturer’s patient information leaflets. The team placed completed packs on shelves labelled with the person’s name. Copies of hospital discharge summaries were usually sent via the NHS electronic communications, PharmOutcomes. The team checked these for changes.

The pharmacy prepared methadone in advance. This reduced the work pressure of dispensing at the time of supply. The pharmacy stored the doses with the prescription in the controlled drugs (CD) cabinet.

The pharmacy had checked by/dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample of completed prescriptions looked at found that sometimes the team only completed the checked by box. When the pharmacy didn't have enough stock of someone's medicine, they provided a printed slip detailing what was owed. And it kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of who they were delivering medicines to people. The delivery driver had a sheet to record to use when they handed over the medication to the person. The record included a section to capture a signature of receipt from the person or their representative. The delivery driver didn't get a signature to prove that they had handed over the medication. The delivery SOP stated that the driver should get a signature. The driver stated that most days they rushed to do deliveries. And to get signatures would take time.

The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy team checked the expiry dates on stock. The team used a sticker with the expiry date written on to highlight medicines with a short expiry date. For example, levetiracetam 100mg/ml with an expiry date of June 2019 had such a sticker attached. The pharmacy held a large amount of stock in a downstairs area. Several packs of medication were out of date. But they were only marked with a note on the shelf holding the items. The note could be easily lost. So, there wouldn't be a prompt for the team to not use these items. The team members usually 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. But opened bottles of Oramorph and morphine oral solutions with three months use once opened didn't have a date of opening recorded. Several bottles containing tablets removed from the original pack were without a batch number or expiry date on the label. It was unknown if these were in date. And this meant that the team could not identify if the bottle contained affected stock if a safety alert came through. The pharmacy kept several loose strips of products on the shelves. Several were missing the batch number and expiry date information. The pharmacy had many packs on the shelves filled with stock from different manufacturers. This would make it difficult to locate any affected stock when alerts came through. A box with batches from different manufacturers of carbocisteine was found. These were clearly seen as the capsules were different shades of yellow. Medication and food supplement drinks with dispensing labels from other pharmacies, mainly in Hull, were found in boxes and on the dispensary work benches. The team members explained that the pharmacy owner had brought these items in and they didn't know why they were on the work benches. The pharmacy had appropriate medicinal waste bins for out of date stock and patient returned medication. The pharmacy stored these bins in a rear area away from the dispensary storage areas and work benches. The team separated out of date and patient returned controlled drugs (CD) from in date stock in a CD cabinet that met with legal requirements. The pharmacy had a book to record patient returned CDs. But hadn't added CDs recently returned. The pharmacist did this during the inspection. The pharmacy had denaturing kits for CD destruction.

The pharmacy had 2D scanners. And it had updated the computer software to meet the requirements of the Falsified Medicines Directive (FMD) that came out on 09 February 2019. The team had not received any training on the subject. So, were not scanning FMD packs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email and the wholesalers. The team actioned the alert 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 protect 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 quality marked measuring cylinders equipment to accurately measure liquid medication. And used separate ones for methadone. The pharmacy had three pharmacy fridges to store medicines kept at these temperatures. One fridge had a glass door that allowed the viewing of stock without the door being open for a long time.
The computers were password protected and access to patients' records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information.

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.