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: 14/01/2020

Pharmacy context

This pharmacy is in the village of Swillington. The pharmacy dispenses NHS and private prescriptions. It provides medicines in multi-compartment compliance packs to help some people take their medication. And it delivers medication to people's homes. The pharmacy provides the seasonal flu vaccinations. And it provides the supervised methadone consumption service.

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 generally identifies and manages the risks associated with its services. And it keeps the records it needs to by law. The pharmacy has written procedures that the team follows. And it has suitable arrangements to protect people's private information. People using the pharmacy can raise concerns and provide feedback. The pharmacy team members respond appropriately when errors happen. And they discuss what happened and act to prevent future mistakes. But they don't fully record the details of these errors or regularly review them. This means the team does not have all the information it could to help identify patterns and reduce mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The SOPs covered areas such as dispensing prescriptions. Most of the team except one of the regular locum pharmacists had read the SOPs and signed the SOP signature sheets to show they understood and would follow them. The pharmacy had up-to-date indemnity insurance.

The pharmacist when checking prescriptions and spotting an error told the team member involved of their mistake. Rather than getting the team member involved to identify their error. The pharmacy kept records of these near miss errors. A sample of the near miss error records looked at found that the team did not record details of what had been prescribed and dispensed to spot patterns. The records captured the learning points from the error and the actions taken by the team to prevent a similar mistake. But many entries had the same details recorded. The learning points often stated double check and pay attention. Many of the entries stated the action to prevent a similar error was to concentrate. So, there was little evidence of individual reflection. 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 reason for the error. Or what the team did to prevent it happening again.

The pharmacy had a template to record monthly reviews of near miss errors and dispensing incidents. But this had only been done in October 2019. This review stated the team had separated medicines with similar names to help reduce picking errors. The review stated that quantity errors were discussed with the team and the team members were asked to ensure they counted medicines accurately. The team was also reminded to not rely on the doses written on the prescription as they may not be clear for the person taking the medicine to read and understand. The team discussed medicines that looked and sounded alike (LASA). And team members were reminded to double check these products when selecting them from the shelf. The pharmacy owner described an error involving people with similar names. The owner identified the cause was keeping downloaded prescriptions in alphabetical order. So, the plan was for team members to separate downloaded prescriptions for people with similar names. But the owner had not yet shared this with the team. 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 regularly check the CD stock against the balance in the register. So, the pharmacist may not spot errors such as missed entries. 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. The pharmacy leaflet gave people information on the private data the pharmacy kept. And how the pharmacy stored it safely. 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 did not display a privacy notice. 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 from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the qualifications and skills to provide the pharmacy's services. And they support each other in their day-to-day work. Team members don't receive formal 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.

Inspector's evidence

Regular locum pharmacists covered the opening hours. The pharmacy team consisted of the pharmacist owner who provided dispensing support, three part-time dispensers and a part-time medicines counter assistant. At the time of the inspection the pharmacist owner, a locum pharmacist and the three dispensers were on duty. The delivery driver had recently left the team. So, one of the dispensers provided the service until a replacement driver was recruited. The pharmacy provided the delivery services to many people. So, the dispenser was away from the pharmacy for long periods of time which increased the workload for the other team members. The team managed this by planning the workload whilst the dispenser was away from the pharmacy.

The pharmacy provided extra training via modules from Numark. The team completed the training in their own time. The team members did not get formal feedback on their performance. So, they didn't get chance to discuss development and training needs. Following the last inspection in May 2019 the team had discussed setting a limit on the number of multi-compartment compliance packs. So, the team could provide the service safely. This had been agreed with the pharmacy owner. The pharmacy did not set targets for its services. The pharmacist offered the services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and adequate for the services provided. It has limited space for the team members to complete their dispensing tasks. But they manage the space appropriately to make sure they provide the pharmacy services safely.

Inspector's evidence

The team managed the limited dispensing space by keeping the work benches free of clutter. The pharmacy shelves were less cluttered with stock than the last inspection in May 2019. The team attempted to keep packs of medication from falling on top of each other. To reduce the risk of picking errors. The team kept most of the floor spaces clear to reduce the risk of trip hazards. 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 consultation room contained a sink.

The pharmacy had a large, sound proof consultation room. The team used this for private conversations with people. The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team provides services that support people's health needs. And it mostly manages its services well. The team keeps records of deliveries it makes to people. So, it can deal with any queries effectively. But the team doesn’t always supply information leaflets with medication to help people take their medicines safely. The pharmacy obtains its medicines from reputable sources. And it stores and manages medicines appropriately.

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-compartment compliance packs to help around 90 people take their medicines. The team members identified they had reached a maximum number of people to provide this service to. So, to take on more people could risk the safe delivery of the service. The pharmacy owner explained this to people asking about the service. And advised the person to return in a few weeks in case circumstances had changed. One of the dispensers managed the service with support from another dispenser. The team usually ordered prescriptions a week 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. 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 pharmacy received some prescriptions as part of the electronic repeat dispensing service and several prescriptions were received weekly. To manage the risk of dispensing the prescriptions in a rush each week the team prepared four weeks packs against the first prescription and the medication list. And clearly marked the pack to indicate there was no prescription to make sure the pack was not supplied to the person before the pharmacy received the prescription. The pharmacist checked these packs when the prescription arrived. The team used a side room to prepare the packs to minimise distractions. The pharmacy team partially sealed the packs and stored them on top of each other awaiting the prescription and the pharmacist check. This risked medication moving from where it had been dispensed in the pack. The team didn’t write descriptions of the products within the packs. So, the person getting the packs wouldn’t be able to identify the medication in the packs. 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 before supply. This reduced the work pressure of dispensing at the time of supply. At the time of the inspection some prepared doses were found in a basket close to the section where the pharmacist checked prescriptions. The pharmacist moved the doses to the controlled drugs (CD) cabinet.

The pharmacy team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The pharmacy displayed the PPP poster in the dispensary to remind the team of the criteria and information to be provided to people. The team had identified one person who met the criteria and the

person was provided with appropriate advice. And they were on a PPP. The team used the electronic medication record (PMR) to record conversations with people about their medicines. For example, if a person prescribed diabetic medication had an eye check or foot check in the last 12 months.

The pharmacy provided separate areas for dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept a separate one with the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. This included a signature from the person receiving the medication.

The pharmacy team checked the expiry dates on stock. And kept a record of this. The last date check was on 14 December 2019. The team used a sticker to highlight medicines with a short expiry date. No out of date stock was found. The team members 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. For example, an opened bottle of morphine oral solution with 90 days use once opened had a date of opening of 10 January 2020 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient 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 had equipment to meet the requirements of the Falsified Medicines Directive (FMD). And the team was using the equipment. The pharmacy obtained medication from several reputable sources. And it received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email and the wholesalers. The team printed off the alert and actioned it.

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 it 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 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. The pharmacy stored completed prescriptions away from public view. And it held private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.