

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: 21/05/2021

Pharmacy context

This community pharmacy is in the village of Swillington. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines. And it delivers medication to people's homes. The pharmacy was inspected during the COVID-19 pandemic.

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 met	N/A	N/A	N/A
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. The pharmacy has inadequate space for the preparation of multi-compartment compliance packs. And the space it does have is not adequately managed. This includes the team stacking packs inappropriately and working on untidy and cluttered benches. This creates a significant risk of error.
		4.3	Standard not met	The pharmacy doesn't manage and store all its medicines appropriately. This includes the pharmacy team members not always recording details such as batch number and expiry dates after transferring stock from the original pack to another container. This means they won't know if it is suitable to supply.
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, particularly the risks from COVID-19. The pharmacy completes the records it needs to by law and it protects people's private information properly. The pharmacy identifies potential risks to the safe dispensing of prescriptions and it acts to prevent errors. But it doesn't keep records of all errors for the team members to review and improve their practice.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The pharmacy had completed risk assessments for all team members to identify their personal risk of catching the virus. The risk assessment also identified the steps needed to support social distancing and infection control. The retail area was large enough to provide space for people to be socially distanced from each other. And the floor of the pharmacy was marked to show people where to stand to support the social distancing requirements. The pharmacy provided hand sanitiser for the team and people accessing the pharmacy to use. And it had a policy of limiting the number of people in the pharmacy to two. The dispensary was large which enabled team members to mostly adhere to social distancing requirements. The team had access to Personal Protective Equipment (PPE) and some team members wore masks during the inspection. The pharmacy provided lateral flow tests to people as part of a national service. The team reported these were popular and several tests had been supplied.

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 team signed the SOPs to confirm they had read and understood them. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

The pharmacy had a procedure to manage errors identified by the pharmacist completing the final check of a dispensed prescription. The pharmacy had a book to record these errors, known as a near misses. The book showed entries made in December 2020 but then no entries until April 2021. The records made provided clear details on the cause of the error and the lesson learnt from the error. But the section capturing the actions taken to prevent a reoccurrence of the error had the same entry stating the error had been corrected. The pharmacy had a procedure for handling errors that reached the person, known as dispensing incidents. The pharmacy recorded dispensing incidents in the near miss record rather than using a separate record that would provide more information on the error. The near miss record had no dispensing incidents captured. The pharmacist reported there had not been any recent dispensing incidents. The pharmacy had a procedure for handling complaints raised by people using the pharmacy. And there was information available for people to know how to raise a concern or give feedback.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers mostly met legal requirements. The pharmacist owner had made incorrect entries in two CD registers. These were corrected by the pharmacist owner after being informed of the errors by the Superintendent Pharmacist. Some of the CD registers were held loosely in the folder which ran the risk of misplacing them. The RP notice was

partially hidden behind medication on the pharmacy counter which meant people would not know who the RP on duty was. The pharmacy provided people with information on the private data it kept and how it stored private information safely. The pharmacy had a procedure for handling confidential information and had an information governance folder containing a range of documents for the team to refer to. The team separated confidential waste for shredding on site.

The pharmacy had procedures informing the team members of the steps to take if they were 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 was aware of the Ask for ANI (action needed immediately) initiative but had not had an occasion when a person presented at the pharmacy asking about it. The pharmacist had raised concerns about a vulnerable person with the person's GP and the police. The pharmacist was advised the person was known to the local social services team.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy team has the qualifications and skills to support the pharmacy's services. Team members work well together and support each other in their day-to-day work. The pharmacy team members receive some extra training. But they don't receive formal feedback on their performance. So, they may miss the opportunity to reflect on their performance and identify training needs. The team has some 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

The pharmacist owner and two regular locum pharmacists covered most of the opening hours. The pharmacy team consisted of three part-time dispensers, a part-time medicines counter assistant (MCA), a part-time team member who put stock away and a part-time delivery driver. At the time of the inspection the pharmacist owner, one of the dispensers and the MCA were on duty. The team supported each other during the pandemic and often a team member worked additional hours to support other team members.

The pharmacy provided extra training for team members who had some protected time to complete their training. 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 volume of compliance packs provided and the limited space available to provide the service. But nothing had changed and the number of packs dispensed continued to increase. The team worked together in an attempt to ensure the packs were dispensed and supplied in time for people to receive their medication.

Principle 3 - Premises ✓ Standards met

Summary findings

The environment of the premises adequately supports the safe delivery of its services. But the pharmacy doesn't manage the space for dispensing well. The pharmacy has suitable 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 used the floor to store stock, boxes and completed prescriptions which was a trip hazard. The pharmacy environment was raised as a concern at the last inspection and some improvements had been made following the inspection. The pharmacy team had limited opportunities to regularly clean the pharmacy throughout the day to support infection control measures during the pandemic.

The pharmacy had a good-sized soundproof consultation room. The premises were secure and the pharmacy had restricted access to the dispensary when the pharmacy was open. 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 all its services are provided safely. The pharmacy obtains its medicines from reputable sources. But it doesn't always store or manage its medicines correctly. 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 signpost people requiring other healthcare services. The team provided people with clear advice on how to use their medicines and were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). The computer on the pharmacy counter had access to the electronic patient records (PMR). So, when a person presented the team member could check what stage their prescription was at.

The pharmacy provided multi-compartment compliance packs to help around 100 people take their medicines. Each person had a medication list detailing the person's current medication and dose times. Many prescriptions were sent weekly rather than four weeks together. To manage this the team dispensed four weeks packs against the medication list. The packs were then checked by the pharmacist. The team supplied the packs after the prescription had been sent and checked by the pharmacist to ensure there were no changes. The team used a separate room to prepare the packs. The room appeared too small for the number of packs being prepared, it was cluttered with stock and untidy. The team stored dispensed packs awaiting checking on top of each other and kept them unsealed. This ran the risk of medication moving between packs or losing items. This was raised as an area for improvement at the last inspection and the pharmacy had made changes following the inspection to meet the standard set by the GPhC. But the pharmacy had not maintained these changes. The information about each medicine within the packs did not include a description of the product. This meant the team when checking the packs and people receiving the packs wouldn't be able to identify individual medication. 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 communication system, PharmOutcomes. The team checked the discharge summary for changes and requested new prescriptions when required.

The pharmacy premises provided little space to create separate areas for labelling, 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 of completed prescriptions found sometimes the team only completed one of the boxes. The pharmacy kept a record of the delivery of medicines to people for the team to refer to when queries arose. Due to COVID-19 restrictions the delivery driver did not ask people to sign for receipt of their medication.

The team checked fridge temperatures each day and had a spreadsheet to record the readings.

However, the last entry was made at the end of April 2021. No fridge readings were recorded in May 2021. The fridges had digital readings embedded into the door and both showed temperatures within the accepted range at the time of the inspection. The pharmacy team checked the expiry dates on stock but they didn't always mark medicines with a short expiry date. So, there wouldn't be a prompt for the team to not use these items. The team members sometimes recorded the date of opening on liquids. This meant they could identify these products with a short shelf life once opened. And check they were safe to supply. But opened bottles of Oramorph and other liquids with limited use once opened didn't have a date of opening recorded. The stock on the shelves was stored in a disorganised manner which ran the risk of the team picking the incorrect item when dispensing. The team kept medication removed from the original packs in bottles. Several of these bottles weren't labelled with details of the medication inside or the batch number and expiry date of the medicine. This practice meant the team members would not know if the medication was in date and they couldn't identify if the bottle contained affected stock if a safety alert came through. The pharmacy kept several loose strips of products on the shelves rather than in the original packet. Several strips were missing the batch number and expiry date information. The pharmacy stored medicines with different batch numbers and expiry dates in the same pack. This would make it difficult to locate any affected stock when alerts came through. And this practice increased the risk of errors occurring. The last inspection highlighted issues with the safe storage and management of stock. The pharmacy responded to the action plan sent following the inspection. A follow-up inspection found the team had made improvements to meet the GPhC standards. But the pharmacy had not maintained the changes introduced after the last inspection to ensure stock was managed safely and would be fit for purpose.

The pharmacy had appropriate medicinal waste bins for out-of-date stock and patient returned medication. And it usually 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 received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email and the wholesalers. And the team took appropriate action in response to the alerts.

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 references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. 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 and the one on the pharmacy counter 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.