General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Swinton Late Night Pharmacy, 52 Swinton Hall Road, Swinton, MANCHESTER, Lancashire, M27 4BJ

Pharmacy reference: 1108068

Type of pharmacy: Community

Date of inspection: 12/09/2024

Pharmacy context

This pharmacy is located in a parade of shops in Swinton, Manchester. The pharmacy is open extended hours. It mainly dispenses prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines. The pharmacy also provides other services such as the NHS Pharmacy First, seasonal flu vaccinations and the Hypertension Case-finding 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	The pharmacy does not make sure its standard operating procedures are being followed, or that team members are familiar with them. And this increases the risk to people using the pharmacy's services.
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 have robust processes to supply medicines in multi-compartment compliance packs. Pharmacy team members prepare packs without referring to the prescriptions. And packs are stored inappropriately without dispensing labels.
		4.3	Standard not met	The pharmacy does not always store its medicines securely and in accordance with legislation. And some medicines are stored outside of their original packaging without key information relating to the batch number or expiry date.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy does not appropriately identify and mitigate the risks associated with its services. Its team members are not all familiar with its written procedures and they do not always follow them. And procedures are not available for some of the tasks that team members complete. It generally keeps the records it needs to keep by law, and they are kept accurate and up to date. The pharmacy team knows how to help protect the welfare of vulnerable people.

Inspector's evidence

Standard operating procedures (SOPs) were available. The set found in the dispensary had not been reviewed since 2016. Team members explained that these were not current. The second set of SOPs seen were template SOPs prepared by the National Pharmacy Association (NPA). There was no indication that the superintendent pharmacist (SI) had reviewed and amended them to reflect the processes team members were expected to follow. There was no information as to who had prepared the SOPs and when they had been implemented. And there was no indication that team members had read the SOPs relevant to their roles. SOPs did not cover all the services provided including the dispensing and supply of medicines in multi-compartment compliance packs. So team members may not understand how to correctly complete these tasks. Team members were not always following SOPs. For example, medicines were picked without referring to the prescription and the prescription and bag label were not always checked when medicines were handed out which was designed to reduce the risk of hand out errors.

Dispensing mistakes which had been identified before the medicine was supplied to people (near misses) were recorded on an electronic system. A QR code was displayed which was used to access the system. If pharmacists identified that certain mistakes were happening repeatedly, they were brought to the team's attention and the medicines were moved on the shelves. Team members gave examples of moving medicines which 'looked-alike' or 'sounded-alike' as well as banding together the different pack sizes of codeine tablets. Team members said it was very rare where a dispensing mistake had happened, and the medicine had been supplied to the person (dispensing errors). These were brought to the team's attention. Following a past incident the address was highlighted on the bag label for people with similar sounding names.

The pharmacy had current professional indemnity insurance. There was a complaints procedure available and complaints were brought to the managers attention. Following past feedback, people were asked to call before coming in to collect their prescription and team members would go out and give people their medicines in the car if they had mobility issues. An incorrect responsible pharmacist (RP) notice was initially displayed, this was changed during the course of the inspection. When questioned, team members were aware of the activities that could not be carried out in the absence of the RP.

Private prescription records and RP records were well maintained. There were no emergency supply records to view as the RP explained most people were referred to NHS 111. Records of unlicensed medicines supplied could not be located but team members were able to describe the records they would keep. Controlled drug (CD) registers were generally well maintained but there was a discrepancy in one of the balances checked. Following the inspection, the RP confirmed that a full balance check had

been completed and any discrepancies had been resolved.

Assembled prescriptions that were ready to collect were stored in the dispensary and were not visible to people using the pharmacy. The pharmacy had an information governance policy available, and its team members had been briefed about it. Some team members had completed training on data protection at their previous place of employment. The pharmacy separated confidential waste which was collected for destruction. The RP had access to National Care Records (NCR) and obtained verbal consent from people before accessing it.

The RP and team members including the delivery driver had completed safeguarding training. Team members gave an example of a concern they identified and explained the steps they took to protect the vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage its workload safely when all team members are present. And they work effectively together and support each other. Its team members are able to discuss pharmacy related issues as they arise, and they receive support with their training courses.

Inspector's evidence

The pharmacy team comprised of the RP, two trained dispensers and two trainee medicines counter assistants (MCA). The RP felt that there were an adequate number of staff. He explained that there was usually a second pharmacist who covered for approximately six hours on most days which allowed prescriptions to be checked more efficiently and help with the workload./ Other team members who were not present included the delivery driver and a dispenser who worked in the evening and prepared the compliance packs.

Team members asked appropriate questions and counselled people before recommending over-the-counter medicines. Requests for multiple packs of the same or similar medicines were referred to the RP. Team members had performance reviews with one of the company's directors. Pharmacists provided feedback to the team members and directors. As part of the reviews team members described they were given constructive feedback and were able to discuss their training needs and how they were performing. Positive feedback was given if performance was good and meeting expectations. Team members were able to discuss role progression.

Team members on training courses were provided with dedicated training time and were supported by one of the directors. Trainees had reviews every few weeks to discuss their work. Team members were also supported with ongoing training and were given time at work to complete training modules on the NHS eLearning for Health (ELfH) and Centre for Pharmacy Postgraduate Education (CPPE).

Team members discussed issues and concerns as they arose. They were briefed by the pharmacist on any updates relating to services. There were no numerical targets for the services provided. Pharmacists held a discussion to see how they were doing and discussed areas that they needed to concentrate on.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally clean, secure and provide an appropriate environment to deliver its services safely. People can have a discrete conversation with a team member in a private consultation room. However, team members store baskets on the floor which can create a trip hazard.

Inspector's evidence

The pharmacy had limited space. Dispensary workbenches were cluttered at the start of the inspection but were cleared by the dispenser during the course of the inspection. There were a number of baskets, containing dispensed prescriptions waiting to be checked, stored on the floor near the checking bench. This created a trip hazard. And the baskets were stored close to the shelves used to store stock medicines so there was a risk that a medicine could fall into the basket and be inadvertently supplied. The RP provided an assurance that the dispensary shelves would be rearranged to create additional space to store the baskets. A sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by members of the team. The room temperature and lighting were appropriate. The premises were kept secure from unauthorised access.

A signposted consultation room was available and suitable for private conversations. The door leading into the room from the shopfloor was locked when it was not in use.

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

Summary findings

The pharmacy does not always provide its services safely. It does not have written procedures in place for all the services it provides. And its team members do not always refer to the prescription when they are dispensing compliance packs. This could increase the risk that a mistake is made. The pharmacy does not always keep its medicines secure or store them properly. However, team members take appropriate action in response to safety alerts.

Inspector's evidence

The pharmacy was accessible from the street. The shop floor was clear of any trip hazards and the retail area was accessible to most people. Team members assisted people who needed help entering the pharmacy. Team members also helped people depending on their needs. The RP gave an example of using basic sign language with one person and writing information down for other people when needed. The pharmacy team were familiar with other services provided locally but also used the internet to signpost people who needed services that the pharmacy did not provide. People were often referred to other nearby pharmacies or to the out of hours service. The RP explained that as the pharmacy were open extended hours, they often had to refer people to the out of hours service. When needed, the pharmacy team called the service to ensure that the person was able to receive the medicines they required.

The RP felt the NHS Pharmacy First and compliance pack service had the most positive impact on the local population. He described that due to the extended opening hours, the Pharmacy First service was accessed by many people. And a number of local pharmacies had stopped providing medicines in compliance packs resulting in them moving their prescriptions to the pharmacy.

The pharmacy had an established workflow in place. Dispensing labels were generated by either the pharmacists or one of the dispensers. They were then sorted out based on the medicines were due and then dispensed accordingly. Prescriptions were all checked by one of the pharmacists. The pharmacy team initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels to provide an audit trail. However, these were not seen to be used all the time. This could make it hard for the pharmacy to identify who was involved in the dispensing process in the event that there was an error. The team used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing.

The pharmacy team were aware of the risks associated with the use of valproate containing medicines during pregnancy. The pharmacy supplied one person with sodium valproate in a compliance pack. A written risk assessment had not been completed to demonstrate that the risks of not providing valproate in its original pack had been assessed. Following the inspection, the RP forwarded a completed risk assessment to the inspector. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring.

Some medicines were dispensed in multi-compartment compliance packs. Prescriptions were ordered by the pharmacy and there was a tracker on the wall which showed when people were due their packs. Any changes on the prescriptions that were received back were confirmed with the surgery and actioned. Packs were prepared by a dispenser using the backing sheet. The dispensing SOP required

team members to refer to the prescription when picking stock. Medicines were placed into the packs and part of the original pack was retained for the pharmacist to check. But information relating to the batch number or expiry date of the medicine was not retained. So, it may be difficult to demonstrate that the medicines were safe to supply. Once the packs were prepared, they were stacked together and were left open on the shelves waiting to be checked in an unorganised manner. Some trays were stored in this way for a few days before they were checked. This increased the risk of tablets moving from one compartment to another and a risk of contamination. Packs were sealed after they were checked by the pharmacist after which they were stored on a separate shelf. Packs were not labelled until they were due to be supplied to the person. There was no audit trail to confirm prescriptions had been received for all the packs that were prepared. Prescriptions and labels where stored alphabetically in drawers but there were no prescription or labels found in the drawers for one of the prepared packs on the shelves. There was no written procedure in place for the service. This could increase the chances of team members working in ways which are not safe or effective.

Assembled compliance packs seen had not been labelled with product descriptions which could make it difficult for people to identify each individual medicine. Patient information leaflets were not routinely supplied which meant people did not have access to up-to-date information about their medicines.

The pharmacy had a designated delivery driver. An electronic system was used to audit deliveries. All deliveries were scanned into the system, and this was updated as medicines were delivered. The drivers took photographs or obtained a signature when medicines were successfully delivered. Unsuccessful deliveries were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and were generally stored appropriately. Fridge temperatures were said to be monitored daily and recorded. The record book which was used to record the temperatures could not be located during the inspection. Records beginning from January 2024 were sent following the inspection and these showed the temperature to be within the required range for the storage of cold chain medicines. The pharmacy had a large number of medicines stored in brown bottles. Most of these did not have the expiry date or batch number recorded. Some bottles seen also contained mixed batches. The dispenser started removing and disposing of these during the course of the inspection. CDs were not always kept securely in line with requirements. Expiry date checks were completed by the team in accordance with a rota. An MCA was also allocated a section in the dispensary. She had not completed any formal accredited training to carry out this task. The RP provided an assurance that her section would be assigned to another team member who was appropriately trained. Short-dated stock was marked with stickers. No date expired medicines were found on the shelves checked. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. MHRA drug recalls were received via email these were discussed with the team and actioned. The RP was unsure if any records were kept when recalls were actioned and provided an assurance that he would raise this with the SI.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. The pharmacy uses its equipment to help protect people’s personal information.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment was available. Separate measures were used for liquid CDs and separate triangles for cytotoxic medicines to avoid cross contamination. A plastic measure was available which had mould at the base. It was disposed of by the RP during the inspection. A medical fridge was available. Up-to-date reference sources were available including access to the internet.

The pharmacy had a blood pressure monitor, otoscope, thermometer, torch and pulse oximeter. The blood pressure monitor was fairly new, and the RP provided an assurance that he would speak to the SI to ensure calibration arrangements were in place. The pharmacy's computers were password protected and screens were not visible to people using the pharmacy.

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.