General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Swift Delivery Pharmacy, 210B Wellgate, ROTHERHAM, South Yorkshire, S60 2PD

Pharmacy reference: 1108666

Type of pharmacy: Internet / distance selling

Date of inspection: 05/03/2024

Pharmacy context

This pharmacy offers services to people at a distance through its website swiftpharm.co.uk and people can contact the pharmacy by telephone. People only access the premises for consultations on minor illnesses or the urgent supply of medicines following a referral as part of the NHS England Pharmacy First consultation service. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines. It dispenses medicines to people living in care homes. And it delivers medicines to people through its delivery services.

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 Services, including medicines management	Standards not all met	4.3	Standard not met	There are out-of-date medicines in stock, some medicines are not packaged or labelled appropriately. And the pharmacy's monitoring processes are not effective in ensuring all medicines are held safely and securely within a suitable environment.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy adequately identifies and manages risks for the services it provides. It informs people how they can provide feedback about its services. And it keeps people's confidential information secure. The pharmacy keeps the records it needs to by law up to date. Its team members understand how to recognise and raise concerns to help safeguard vulnerable people. They engage in some discussions following the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its team members in working safely and effectively. But it had not reviewed these since they were implemented in 2019. The pharmacy was in the process of introducing new duties for one of its team members enrolled on an accuracy checking course. The pharmacy manager, who was the responsible pharmacist (RP) during the inspection, recognised the need to review SOPs to ensure they remained relevant. They were confident that all team members had read the SOPs. But not every team member had signed the SOPs to provide assurance they had understood them. Team members were observed completing dispensing tasks safely. A team member demonstrated how they used the inbuilt safety features of the patient medication record (PMR) system effectively when completing dispensing tasks. Another team member described the tasks that could not take place if the RP took absence from the premises.

The team used the functions of its PMR system to support a series of checks throughout the dispensing process. This relied on barcode technology to complete checks during the assembly process and the final accuracy check of the medicine. The RP undertook clinical checks of all prescriptions and recorded these on the PMR before dispensing activity began. A team member demonstrated how the PMR flagged mistakes made during the dispensing process, known as near misses. The PMR did not produce dispensing labels until a near miss was rectified. The team referred queries, including any medicines that did not scan to the RP for a manual accuracy check. Team members discussed their near misses and demonstrated how they reviewed stock layout in the dispensary following mistakes. But they did not keep a record the mistakes they made, including those picked up by the RP such as quantity errors. A discussion took place about the advantages of recording near misses at all stages of the dispensing process to help share learning and reduce risk. The pharmacy had a procedure for reporting and investigating mistakes made following the supply of a medicine to a person, known as a dispensing error. And it kept records of these mistakes. A review of these records identified the root cause of the mistake, contributory factors and the actions taken to reduce the risk of a similar mistake occurring.

The pharmacy had a complaints procedure, and it advertised how people could provide feedback to the pharmacy on its website. A team member explained how they would manage a concern and escalate this to the manager if needed. The pharmacy had procedures and information to support its team members in recognising and reporting safeguarding concerns. And its team members had access to contact information for local safeguarding teams. A team member discussed recent safeguarding learning they had completed. They felt confident in their ability to identify and report a safeguarding concern when providing pharmacy services at a distance. The RP took the opportunity to update their own safeguarding learning immediately following the inspection.

The pharmacy had current indemnity insurance. The RP notice displayed the correct details of the RP on duty. And the RP record was completed in full. The pharmacy kept its CD register in accordance with legal requirements. It did not undertake regular physical balance checks of stock against its register. And a balance discrepancy identified during the inspection acted as a reminder for the importance of carrying out regular checks. The RP rectified the balance discrepancy immediately following the inspection and had identified the discrepancy had been caused by two missed entries. The pharmacy had a patient-returned CD destruction register and this was kept up to date. It completed certificates of conformity for the unlicensed medicines it dispensed. And it made the necessary records when dispensing a private prescription. The pharmacy kept people's confidential information secure within its premises. It segregated its confidential waste, and this was securely collected and disposed of at regular intervals.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a small and dedicated team to provide its services. Pharmacy team members are supported in their roles. They communicate well with each other. And they engage in regular conversations to help them manage workload safely. Pharmacy team members understand how to provide feedback and raise a concern at work.

Inspector's evidence

The RP was the regular full-time pharmacist manager. A locum worked at the pharmacy one day a week and there were appropriate arrangements to cover the RP's leave. A qualified level two dispenser and two apprentices were working alongside the RP during the inspection. The pharmacy also employed a delivery driver and a pre-registration pharmacy technician. The pre-registration pharmacy technician was currently completing an accuracy checking course. Team members worked flexibly to cover both planned and unplanned leave. They were observed working well together throughout the inspection and were happy in their work. The apprentices received regular learning time at work. They felt supported in their roles and were confident in seeking out information to support them in their learning. All team members engaged in some learning to support the safe delivery of pharmacy services. For example, they had engaged in learning for the PMR system prior to it being fully implemented.

The pharmacy did not set specific targets for its team members to meet. There was a focus on planning workload to ensure it was completed in suitable time. For example, ensuring medicines were ready to be delivered to care homes ahead of the next cycle beginning. Pharmacy team members engaged in some conversations about workload and safety. But they did not keep a record of these discussions to help them go back and measure the effectiveness of any changes they agreed to make. The pharmacy had a whistleblowing policy and team members were confident in providing feedback and suggesting ideas at work. They knew how to raise and escalate a concern about the pharmacy if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are adequately clean and secure. They offer space for people to have a private consultation with a pharmacist. The pharmacy's website provides information to help assure people they are accessing services from a registered pharmacy.

Inspector's evidence

The pharmacy premises were secure and adequately maintained. They were located on the first-floor level of a two-storey commercial building. Pharmacy team members had access to a secure storeroom and toilet facilities located in another part of the building. Pharmacy team members had access to appropriate hand washing facilities. Heating and ventilation arrangements were appropriate. The pharmacy was generally well lit. But lights did flicker a number of times during the inspection. The RP explained this had been reported and an electrician had visited and had provided assurances that there were no electrical problems within the premises. The pharmacy's website provided details about the owners, and people were able to view the pharmacy's registration status on the GPhC register using a link on its website. The website advertised the name of the superintendent pharmacist but did not provide their registration number or details of how people could check their registration status.

The pharmacy had a good size dispensary with a large purpose-built island in the centre. The team used the island to complete most of its dispensing activity. But it did not maximise use of the space as it held some baskets of picked medicines waiting to be assembled on the dispensary floor. A discussion highlighted the risk of this practice and team members moved the baskets on to a work bench. A room leading off the dispensary was signposted as a consultation room. The RP used this room to accuracy check medicines as it provided a quiet, distraction free space for this activity. But the team had not fully considered the risk of using the room for two different purposes. It currently held multi-compartment compliance packs waiting to be checked within the room rather than in the dispensary. This meant the room was not immediately available to provide a suitable space for holding a private consultation.

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

Summary findings

The pharmacy does not safely manage its stock medicines. It has out-of-date medicines present in stock and not all stock medicines are appropriately packaged and labelled. The pharmacy does not effectively monitor the arrangements for storing medicines requiring refrigeration and for holding some CDs. The pharmacy obtains its medicines from reputable suppliers and its team members follow effective processes and make appropriate records when delivering its services.

Inspector's evidence

People accessed the pharmacy's services through either the website, by email or by telephone. The website referred to some face-to-face consultation services including a period-delay service. The RP explained the pharmacy had never provided this service and agreed to follow this up with the website developers to ensure the information on the website was correct. The website advertised the new NHS England Pharmacy First service, the RP discussed the implementation of this service, including training for the service. And they demonstrated the information they had available to them to support them in providing the service safely. The website included health information for people to read. It also offered General Sales List (GSL) and Pharmacy (P) medicines for sale. Online sales were fulfilled by a third-party pharmacy registered with the GPhC. The website provided details about this third-party pharmacy within its terms and conditions webpage.

The pharmacy supplied medicines in both original packs and in multi-compartment compliance packs. It had considered some risks associated with supplying medicines in compliance packs. For example, the RP explained how they contacted medicine manufacturers if they needed further information before making the decision to supply a medicine in this way. The RP was familiar with the requirements of the valproate Pregnancy Prevention Programme (PPP). And they knew about the most recent legal changes which required valproate to be supplied in its original packaging unless in exceptional circumstances. But they had not completed risk assessments as required before supplying valproate in compliance packs. The RP provided information after the inspection to confirm they had carried out the necessary risk assessments.

The pharmacy used some audit trails to support it in managing its services. This included team members identifying their involvement in the dispensing process. It kept records of the CDs it delivered to people. The RP stated the delivery driver kept a separate record of all the deliveries they made and discarded this shortly after all deliveries were completed. So, these records were not available to pharmacy team members. This meant it may be more difficult for pharmacy team members to resolve a query about the delivery service should one arise. The pharmacy provided medication administration records (MARs) for all the medicines it supplied to the care homes. It prioritised urgent medicines for people living in care homes for same day delivery. The pharmacy kept records of the medicines it owed to people, and it had a process for contacting its wholesalers to try and obtain these medicines.

The team used baskets throughout the dispensing process. This helped to organise workload and reduced the risk of mixing up medicines. The pharmacy had not carried out assessments with people to make sure supplying medicines in multi-compartment compliance packs was the safest and most suitable way of supply for them. It had recently increased the number of people it supplied with

medicines in this way. The RP explained the pharmacy was nearly at capacity for this service. They had considered the space required and safe staffing levels to safely manage the workload when making this decision. They were aware of other pharmacies offering this service and could signpost people to these pharmacies if needed. Pharmacy team members used the PMR system to support it in keeping records for people receiving compliance packs. They used the PMR to record any changes to people's medicines. A sample of assembled compliance packs contained clear descriptions of the medicines inside. But the pharmacy only supplied patient information leaflets when requested or when new medicines were dispensed. A discussion highlighted the need to provide patient information leaflets routinely when supplying medicines.

The pharmacy sourced medicines from licensed wholesalers and a licensed specials manufacturer. Medicine storage in the dispensary was disorderly. Some loose tablets, loose blister strips containing medicines and discarded repeat slips were found amongst boxes of stock medicines. And the pharmacy stored some of its medicines in amber bottles, some of which contained no label to show the medicine's details, batch number or date of expiry. This increased the risk of a mistake occurring and it made it difficult for team members to identify the contents of an amber bottle, and to conduct appropriate checks to ensure the medicine was safe to supply. The pharmacy did not keep records of the checks it made of medicine expiry dates. Team members labelled short-dated stock as part of its date checking processes. Random checks of stock medicines found a number of date-expired medicines.

The pharmacy stored medicines subject to cold chain requirements in two fridges. It also stored open packets of food and some drinks inside one of these fridges. A discussion highlighted the risk of cross contamination between food and medicines. And the team acted immediately to store all medicines in one fridge and food in the other fridge. Both fridges were fitted with thermometers. The temperature reading on both fridges was within the required range of two and eight degrees Celsius. But the maximum and minimum temperature readings on both thermometers were significantly out of this range. The pharmacy team generally kept records of its fridge temperatures. But it had no records for the current or previous month. The pharmacy held its CD stock in a secure cabinet. But its out-of-date CDs were not held securely. Following a conversation, efforts were made to secure these CDs. And the RP was provided with information about how to request a visit from the NHS CD accountable officer’s authorised witness to allow for safe destruction of the CDs. The pharmacy had medicine waste receptacles available to support the team in managing pharmaceutical waste. It received details of drug alerts and recalls by email, but it did not routinely keep an audit trail of the checks it made about the alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Overall, the pharmacy has the equipment it needs to provide its services. Its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members had access to up-to-date reference resources. They accessed the internet to help resolve queries and to obtain up-to-date information. They used password-protected computers and NHS smart cards when accessing people's medicine records. The pharmacy held people's confidential information within the premises, and it monitored visitor access to the premises appropriately.

The pharmacy had a range of clean equipment available to support the delivery of pharmacy services. This equipment included a standardised glass measuring cylinder for measuring liquid medicines. And a laptop computer fitted with a high-quality camera to support the RP in carrying out remote consultations. Pharmacy team members had spoken about the risks off handling some medicines when removing them out of their original packaging for assembly in multi-compartment compliance packs. But the pharmacy did not make personal protective equipment, such as gloves, available to its team members to use when dispensing these medicines.

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.