General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Universal Pharmacy, 25 Turbine Way, Swaffham, Norfolk, PE37 7XD

Pharmacy reference: 9011199

Type of pharmacy: Internet

Date of inspection: 10/03/2023

Pharmacy context

This NHS pharmacy is on an industrial estate on the outskirts of the town. It provides its services remotely and people cannot collect their prescriptions from the pharmacy. It dispenses people's prescriptions mostly to care homes in Norfolk and to some community patients who have difficulty in leaving their homes. The pharmacy supplies multi-compartment compliance packs to people who need help managing their medicines.

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	The pharmacy does not store its medicines in a way that complies with safe practice.
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 to help provide them safely. It protects people's personal information and team members understand their role in protecting vulnerable people. It reviews mistakes that happen during the dispensing process. But it does not record these regularly. So, it is harder for the pharmacy to use this information to help make its services safer and reduce any future risk.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) available. Team members had signed to say that they had read them. The SOPs were being reviewed by the superintendent pharmacist (SI) and the pharmacy manager.

Dispensing mistakes which were identified before the medicine was handed out and those where the medicine had reached a person were discussed with the team member who had made the mistake. But these were not always recorded which made it harder to identify and discuss trends and learning from these events.

The correct responsible pharmacist (RP) notice was displayed. The team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. And it had a complaints procedure which it told people about on its website. Complaints were dealt with by the pharmacy manager. Where the matter could not be resolved it was referred to the SI.

Records for controlled drug (CD) registers and RP records were generally well maintained. CDs that people had returned were recorded in a record as they were received. CD registers were kept manually. CD balance checks were carried out regularly.
The pharmacy had an information governance policy available. Relevant team members who accessed NHS systems had smartcards. Pharmacists had access to Summary Care Records (SCR).

Confidential waste was kept in a designated bag and collected by a contractor for secure destruction. All team members had also completed online training about confidentiality.

Some team members had completed safeguarding training. Details were available for the local safeguarding boards.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members for the services it provides. They usually do the right training for the roles they undertake. But once they complete this, there is little ongoing training to help the team members keep their skills and knowledge up to date.

Inspector's evidence

At the time of the inspection, the pharmacy team comprised of a pharmacist locum, the SI, and a pharmacy technician who was also the pharmacy manager. The pharmacy manager was training to be an accuracy checking technician (ACT). There were also a total of 13 trained dispensers, a trainee dispenser, and a number of delivery drivers, working in shifts throughout the week. The delivery drivers had not had any formal training.

The staff said that they were able to make suggestions about how the pharmacy was run. Recently they had suggested changing how the tasks were undertaken to have more dedicated teams, rather than everyone doing each job. Contingency had been built into this however, by ensuring that there was overlap between the teams. Appraisal meetings were held annually with an interim review. Team members were also given on-the-spot feedback. There was no on-going training arranged for the team, once the formally required training had been completed. Occasionally the SI had arranged ad-hoc training when required, for example updating safeguarding when required by the NHS.

The pharmacy team held monthly meetings. Team members felt able to feedback concerns and suggestions. There were no formal targets set for staff.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises are generally clean, secure and provide an appropriate environment to deliver its services. But some areas are cluttered and there are potential trip hazards for members of staff which should be addressed.

Inspector's evidence

The pharmacy premises were modern, large, bright, clean, and organised, but the fittings were temporary. The SI said that they were waiting for a shop fitting of bespoke dispensary units and another dispensing robot, but the premises had been open for nearly a year and they had yet to be given a date for this to happen. The dispensary was set over two floors; there was ample workspace which was clutter-free. Workbenches were allocated for certain tasks. But some of the benches used for dispensing consisted of piles of boxes with a worktop resting on them. These benches were not all level and would therefore not be suitable surfaces to accurately judge the level of medicine in a measure rested on them. There were not enough shelving units for the quantity of stock, so that many lines were stored in boxes, or loose on the floor around and under the shelves. This created a trip hazard.

A sink was available for preparing medicines. Hand sanitiser was also available for team members to use. The premises were kept secure from unauthorised access. The room temperature and lighting were adequate for the provision of pharmacy services. There were rest and toilet facilities for staff.

The pharmacy’s website gave information about the pharmacy‘s services, and did not allow any purchases of medicines. But some of the information on it was over five years’ old and was no longer accurate. This included information about services such as the medicines use review and “Stoptober” information. This may be misleading to members of the public.

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

Summary findings

The pharmacy generally provides its services safely. It takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use. But the way some medicines are stored is not suitable. And the pharmacy cannot demonstrate that it always manages unwanted medicines correctly. Collections of discarded medicines from nursing homes are not covered by appropriate permits.

Inspector's evidence

Most of the people receiving services from the pharmacy were based in Norfolk. The pharmacy had a close relationship with the community care team, who organised multi-compartment compliance packs for people needing them in the county. The pharmacy also served around 70 care homes (both residential and nursing homes). It also provided a dispensing service to some people living at home who did not require compliance packs.

The pharmacy had an established workflow. Prescriptions prepared for care homes, for people receiving compliance packs in the community, and for more routine dispensing were dealt with in separate parts of the building. Each of these groups had a dedicated team to do the work. Although there was some sharing of skills between the teams in case of absence.

Homes requiring original packs ordered their own prescriptions and the pharmacy checked that prescriptions for the items ordered had been received. The pharmacy then created dispensing labels and a paper medicines administration record (MAR) chart. A different person then picked the items from the shelves into a basket. A third person then attached the labels to the products and put them into bags. Finally, the items were checked by a pharmacist and the bags were put into trays for delivery. This usually happened about a week in advance of the home needing to start the medicines. This allowed for continuity if there was a power cut etc. A quadrant stamp had recently been introduced so that there was a complete audit trail showing which member of staff had carried out each task.

Prescriptions which were needed outside of the usual ordering cycle (interim prescriptions) were dispensed by another team. These were fewer in number and so fewer staff were involved. Interim prescriptions were usually emailed to the pharmacy and when they were delivered to the home the prescription was collected by the driver. The emailed prescription and the actual prescription would be checked to ensure that it was correct when the driver returned to the pharmacy by the pharmacy technician or pharmacist. At the time of the visit there were no outstanding prescriptions. However, there was no record of who had dispensed previous interim prescriptions, as usually there was only one member of the team involved. The pharmacy said that they would look into keeping an audit trail in future to show who had been involved with these prescriptions.

A few homes wanted electronic MAR charts, and prescriptions for these homes were dispensed by a separate team. There were only seven homes needing this service at the time of the inspection. These were dispensed as original packs by a team of two people.

The pharmacy had a dispensing robot to produce multi-compartment compliance packs. The packs were labelled with the information the person needed to take their medicines in the correct way. The

packs also had tablet descriptions to identify the individual medicines contained in the packs. The tubs for dispensing were filled by popping out tablets and capsules from the manufacturers' packs. A record of the batch numbers and expiry dates was kept, and the medicines were only bulk popped if the tub would be used within one week. Other less frequently used medicines were popped out of their packs when needed to fill a pack. The medicines were identified by the manufacturers' bar codes. When completed an image of the tray was taken by the computer and kept so that any questions about what was in the tray could be easily answered.

Items needed for community patients were dispensed in the upstairs dispensary. There were some Pivotel trays used, and these were labelled appropriately. Stock was brought from the downstairs storeroom, but there was a large volume of medicines in baskets on the floor, waiting to be moved back downstairs. It was not clear if these would be included in any date checking which took place.

The RP and team members were aware of the guidance for dispensing sodium valproate. Where possible, sodium valproate was dispensed in its original packaging. Placement of the dispensing label on the container so as not to obscure important information was discussed with the team. The pharmacy did not make proactive checks about higher-risk medicines, meaning that the pharmacy could not be sure that people's treatment was being monitored appropriately. A way of doing so was discussed with the pharmacy manager and the SI. They said that they would implement a way of checking that the correct blood tests were being done and the medicines supplied were suitable for the people concerned.

Assembled medicines were labelled with mandatory warnings. But no patient information leaflets (PILs) were supplied when not in the manufacturer's pack. Care homes were told to access the information themselves. The staff said that they would look into how they could better support care homes and people in the community to receive this information in the future.

The pharmacy purchased medicines for dispensing from licensed wholesalers. But there were many medicines that had been removed from the manufacturer's original outer packaging which were found amongst other dispensing stock. These included paracetamol, Nozinan and water for injections. Some Macrogol packets bearing dispensing labels were also found with dispensing stock. When asked, the SI gave no explanation as to why the medicines were not in the manufacturer's original outer packaging. Or why there were packs with dispensing labels already attached in with dispensing stock. The SI was advised to ensure that only medicines obtained direct from wholesalers be supplied to patients. And to ensure there was a robust system to keep any returned medicines separate from dispensing stock and to dispose of all returned medicines appropriately.

Fridge temperatures were monitored daily and recorded; the records showed these were within the required range for storing temperature-sensitive medicines. Expiry date checks were carried out regularly and short-dated stock was highlighted with a sticker. A date-checking matrix was in place. There were no date-expired medicines found on the shelves checked.

Each care home, including nursing homes, was supplied with yellow boxes to return their waste medicines to the pharmacy. Out-of-date and other waste medicines were collected from the pharmacy by licensed waste collectors. Invoices were seen of collections of waste medicines around every two weeks from the pharmacy. But the pharmacy did not have the necessary permits from the Environment Agency to collect medicines from nursing homes.

Drug recalls were received on the company's intranet. The team printed these and checked against stock. If the affected batches were found these were quarantined and action was taken following instructions received.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And it keeps them clean. The team uses its facilities and equipment to keep people's private information safe.

Inspector's evidence

There were various sizes of glass, crown-stamped measures, with separate ones labelled for specific use, reducing the risk of cross-contamination. Equipment was mainly clean and ready for use. A separate tablet-counting triangle was used for cytotoxic medicines to avoid contamination. Two fridges of adequate size were available. Up-to-date reference sources were available including access to the internet. The pharmacy's computers were password protected. Electrical equipment was going to be tested, but the new premises had not yet been open a year.

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.