General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Dalton Square Pharmacy (King Street), 44 King Street, LANCASTER, Lancashire, LA1 1RE

Pharmacy reference: 1033389

Type of pharmacy: Community

Date of inspection: 15/11/2023

Pharmacy context

This is a community pharmacy situated near to a GP surgery. It is located on the inner ring road of Lancaster city centre. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also supplies medicines in multi-compartment compliance aids for some people to help them take their medicines at the right time.

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	1.6	Standard not met	The pharmacy does not keep adequate records for the responsible pharmacist or patient returned controlled drugs.
		1.7	Standard not met	The shared use of NHS smartcards and lack of written procedures does not provide assurance that the pharmacy appropriately protects people's information.
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	Some pharmacy-only medicines are located in 'self-selection' areas, so the pharmacy cannot provide assurance that sales are being appropriately controlled.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

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

Summary findings

The pharmacy has written procedures to help its team work safely. And members of the team discuss things that go wrong to help identify learning. But the pharmacy does not always keep appropriate records to be able to show whether it is operating effectively. And it does not take enough care to ensure people's information is protected.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which had been issued in September 2023. A dispenser said they had read the SOPs at the pharmacy's other branch. But members of the team had not signed the training sheets. So the pharmacy could not demonstrate whether all of the procedures had been read or understood.

Dispensing errors and near miss incidents were recorded in a book. The pharmacist explained that they discussed any learning points with members of the team. But some of the records had very little detail about what had happened. So there may not always be enough information to enable a meaningful review, or show the pharmacy had fully investigated and learnt from their mistakes. The team showed that it had moved the similar named medicines colchicine and cyclizine away from each other to avoid them being mixed up.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A dispenser was able to explain what their roles and responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The correct responsible pharmacist (RP) notice was on display. The pharmacy had a complaints procedure which was explained in the practice leaflet. Any complaints would be recorded and followed up by the pharmacy team. A current certificate of professional indemnity insurance was in place.

The RP record was kept in a diary. This meant there was no standard template for recording the required information. On 13 occasions in October 2023, the RP had not recorded their registration number, and on one day the RP had finished work early but did not clarify whether this was the end of his period of responsibility, or if it was a period of absence while the pharmacy remained open. Controlled drugs (CDs) registers were maintained with running balances recorded. Two random balances were checked and found to be accurate. An electronic register was available to record patient returned CDs. But there were a number present in the cupboard that had not yet been recorded.

When questioned, a dispenser was able to explain which information should be segregated into confidential waste and how it would then be removed by a specialist waste company. But there were no written procedures available about the pharmacy's information governance policy. And the pharmacist was using the NHS smartcard which belonged to the pharmacist manager who was not present. The PIN code of the smartcard was written onto the front of the card so that anyone would be able to use it. Safeguarding procedures were available. The pharmacist had completed level 2 safeguarding training. A dispenser said he would initially report any concerns to the pharmacist on duty. Team members could show where to find the contact details of the local safeguarding board.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are appropriately trained for the jobs they do. But team members are not provided with ongoing learning and development opportunities. So learning and training needs may not always be addressed.

Inspector's evidence

The pharmacy team included a pharmacist and two dispensers. All members of the pharmacy team were appropriately trained or on accredited training programmes. The pharmacy had a low footfall and the volume of work appeared to be effectively managed. Staffing levels were maintained by relief staff and a staggered holiday system.

Members of the team were not provided with any ongoing training, and there was no formal appraisal programme. A dispenser gave examples of how they would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines they felt were inappropriate, and refer people to the pharmacist if needed. The pharmacist felt able to exercise their professional judgement and thought this was respected by members of the team. A dispenser said they felt well supported by the pharmacist and was able to ask any questions. Members of the team were aware of the whistleblowing policy and said that they felt comfortable reporting any concerns to the superintendent pharmacist. There were no professional targets in place.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to enable private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload and access to it was restricted by use of a gate. The temperature was controlled using electric heaters. Lighting was sufficient. Team members had access to a kitchenette area and WC facilities.

A consultation room was available. The space was clutter free with a desk, seating, and adequate lighting.

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

Summary findings

The pharmacy's services are easy to access for most people. But there are steps which may prevent people with reduced mobility from entering the premises. The pharmacy gets its medicines from recognised sources and carries out some checks to ensure they are in good condition. But members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might not always be able to check that the medicines are still suitable, or give people advice about taking them. And some pharmacy-only medicines are located in 'self-selection' areas, so the pharmacy cannot provide assurance that sales are being appropriately controlled.

Inspector's evidence

The pharmacy was in a listed building and there were two steps into the premises which made access difficult for wheelchair users and people with pushchairs. It was not possible for the pharmacy to provide a mobile ramp due to the position of the doorway next to a busy ring road. Team members said they would assist any person who needed to gain access into the pharmacy. But there was no external bell, so people may not always be able to attract attention if they require assistance.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing. Owing slips were used to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were kept on a shelf using an alphabetical retrieval system. Stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Team members were seen to confirm the patient's name and address when medicines were handed out. But prescription tokens were not always kept with the medicines to enable members of the team to know what they were handing out. And there was no process to routinely highlight higher-risk medicines (such as warfarin, lithium and methotrexate) to remind the team members to provide counselling. Stickers were used to flag any prescriptions for schedule 3 and 4 CDs to remind team members to check the expiry date of the prescription. Members of the team were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when the medicines were supplied. The pharmacist said she had spoken to patients who were at risk to make sure they were aware of the pregnancy prevention programme. But she had not made a record, so would not be able to demonstrate that she had provided appropriate advice, in the event of a query or concern.

Some medicines were dispensed in multi-compartment compliance aids. A record sheet was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information was sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied.

The pharmacy had a delivery service. A delivery record was kept. Unsuccessful deliveries were returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

Some pharmacy-only medicines, such as large bottles of paracetamol liquid, large boxes of ibuprofen tablets, and fluconazole thrush treatment, were found present in the retail area of the pharmacy where people were able to self-select them. When questioned, members of the team were not aware where the medicines were.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. A date checking diary was used to record any short-dated stock due to expire in the upcoming months. But the team did not record when date checking had been completed. So there was a risk that some medicines may be overlooked. Liquid medication did not always have the date of opening written on, including a bottle of oral morphine solution which needed to be used within 90 days of opening.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. There was a clean medicines fridge with a thermometer. Fridge temperatures were within the required range of 2 to 8 Celsius. Members of the team said they checked the minimum and maximum temperatures each day. But there were no records kept. So the pharmacy could not demonstrate that the medicines had always been stored in appropriate conditions. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email. Team members would check for any affected stock. But there was no record of the action taken and by whom, so the pharmacy could not demonstrate that they had been actioned appropriately.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

Inspector's evidence

The pharmacy team had access to the internet for general information. This included access to the BNF, BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication. Equipment was kept clean.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed team members to move to a private area if the phone call warranted privacy. The consultation room was used appropriately. Patients were offered its use when requesting advice or when counselling was required.

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.