General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Audley Late Night Pharmacy, 114 -116 Audley Range, BLACKBURN, Lancashire, BB1 1TG

Pharmacy reference: 1100749

Type of pharmacy: Community

Date of inspection: 23/09/2021

Pharmacy context

This community pharmacy is in a large residential area close to the centre of Blackburn. 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 medicines to some people's homes. The inspection took place during the COVID-19 pandemic.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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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 met	N/A	N/A	N/A
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. It has an appropriate range of up-to-date written procedures that the pharmacy team follows. The pharmacy team members identify potential risks to the safe dispensing of prescriptions and they make some changes to prevent errors. But they don't keep full records of all errors so they can review and improve their practice.

Inspector's evidence

The pharmacy was inspected during the COVID-19 pandemic. The team members had access to Personal Protective Equipment (PPE) but had recently stopped wearing PPE unless in close contact with people. The pharmacists wore PPE face masks and gloves when administering the seasonal flu vaccination service. Throughout the inspection the team mostly worked at separate stations in the dispensary which provided some level of social distancing. The team members regularly tested themselves for COVID-19 using a lateral flow test. The pharmacy team asked people to wear face coverings when the entering the pharmacy but reported few people complied with this request. The team kept a hand sanitiser on the pharmacy counter for people to use.

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that provided the team with information to perform tasks supporting the delivery of services. The SOPs described the roles and responsibilities of the team. The SOPs had been recently transferred to an electronic format. This provided a platform for the SOPs to be easily reviewed and amended. The inspector was informed that the team members had read the SOPs and signed the signature sheets to show they understood and would follow them. But no evidence of this was presented during or after the inspection. The team demonstrated a clear understanding of their roles and knew when to refer people to the pharmacist.

On most occasions the pharmacist or accuracy checking technician (ACT) when checking dispensed prescriptions and spotting an error highlighted this to the team member involved. The pharmacy kept records of these errors known as near misses. And the team member involved completed the record after the error was highlighted to them. The near miss records looked at did not provide details of what had been prescribed and dispensed to help the team to spot patterns. And in the sections describing the reason for the error and the actions to prevent a reoccurrence of the same error the details were limited to misreading the prescription and to double check the medicine dispensed. This meant there was little evidence of individual reflection by the team member involved with the error. The pharmacy had a procedure for managing errors that reached the person known as dispensing incidents. And it kept electronic records of these errors. The pharmacy regularly reviewed near miss errors and dispensing incidents and discussed the outcome in team meetings. As a result of one review the team identified incorrect quantities as a common error. And introduced an extra step into the dispensing process of asking a colleague to perform a second check of the quantity of medicine counted. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. The pharmacy team used surveys to find out what people thought about the pharmacy and displayed the results in the pharmacy.

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 met legal requirements. The CD

registers were kept electronically. The system captured the current stock balance for each CD register and prompted the team when a stock check was due. This helped to spot errors such as missed entries. The pharmacy had procedures for managing confidential information and the team was aware of the requirements of the General Data Protection Regulation (GDPR). The team separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. And the team members were aware of the Ask for ANI (action needed immediately) initiative. One senior team member was the lead on training the others on the ANI initiative and raising awareness amongst the team. The team members had access to contact numbers for local safeguarding teams. The delivery drivers knew to report to the team any concerns they had about people they delivered to.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with an appropriate range of skills and experience to support its services. Team members work well together supporting each other in their day-to-day work. They frequently discuss ideas to enhance the delivery of the pharmacy's services. Pharmacy team members take opportunities to complete ongoing training to keep their knowledge and skills up to date.

Inspector's evidence

The superintendent pharmacist (SI) and two regular pharmacists covered most of the opening hours. The pharmacy team mostly worked part time and consisted of a pharmacy accuracy checking technician (ACT), one pharmacy technician, three qualified dispensers, and three new team members. The new team members included a qualified dispenser and pharmacy apprentices who were supported by other team members as they undertook their training. The pharmacy also employed two delivery drivers. Several team members had worked together for many years and were known to people in the local community who used the pharmacy.

During the pandemic the team had worked well together to ensure pharmacy services were not affected. Several team members had volunteered to not take their allocated holidays during the pandemic to ensure pharmacy services continued to be provided to the local community. But they were reporting feeling tired and exhausted. The pharmacists recognised this and had plans in place to ensure the team took appropriate time off.

The team held regular meetings to discuss issues and share ideas. The pharmacy provided the team with opportunities to complete more training and team members were presented with a range of training subjects to choose from.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure and suitable for the services provided. The pharmacy has appropriate facilities to meet the needs of people requiring privacy when using its services.

Inspector's evidence

The pharmacy was clean, tidy and hygienic. It had enough storage space for stock, assembled medicines and medical devices. And it had separate sinks for the preparation of medicines and hand washing. The team wore disposable gloves when removing medicines from the original packs and placing them into multi-compartment compliance packs. The team kept floor spaces clear to reduce the risk of trip hazards. The premises were secure and the pharmacy restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area and items for sale in this area were healthcare related. The pharmacy had a soundproof consultation room that the team used for private conversations with people and for services such as the flu vaccination. The consultation room didn’t have a sink but hand sanitising products were available along with appropriate cleaning products for the team to use when regularly cleaning the room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible to people. And it suitably manages its services to help people receive appropriate care. The pharmacy gets its medicines from reputable sources and it generally stores them properly. The team carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People using the pharmacy were able to easily access the premises and were mostly from the local area. Team members spoke various South Asian languages which helped to ensure people received the correct information, advice and medical treatments when requesting an over-the-counter (OTC) medicine. The team provided people with clear advice on how to use their medicines. The team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And the pharmacy had PPP information to provide to people when required. The pharmacy didn't have anyone prescribed valproate who met the PPP criteria.

Since the last inspection the pharmacy had stopped selling codeine linctus. The pharmacists reported people rarely asked for codeine linctus. And the only prescription supply that had been to a person who regularly presented a private prescription had stopped after the person passed away. If a person did ask for codeine linctus, they were informed the pharmacy didn't sell it and signposted to their GP. The pharmacy team had been monitoring prescriptions for codeine-based products such as co-codamol tablets. And on occasion the pharmacists had raised concerns about the prescribing of these products with the prescriber.

The pharmacy provided the seasonal flu vaccination service which was popular. The three regular pharmacists were trained to administer the vaccines. And on most days, there were two pharmacists on duty together. This enabled the team to offer a walk-in service in addition to people booking appointment slots. The team also contacted people directly to offer the service. This meant team members could answer people's queries about this year's flu service and the NHS COVID-19 vaccination programme. The pharmacy allocated time between vaccinations to enable the team to clean the consultation room.

The pharmacy provided multi-compartment compliance packs to help people take their medicines correctly. The ACT managed the service with support from others in the team. To manage the workload the preparation of the packs was divided across the month. The team usually ordered prescriptions for the packs in advance of supply. This allowed time to deal with issues such as missing items and the dispensing of the medication into the packs. The team recorded the descriptions of the products within the packs and supplied the manufacturer's patient information leaflets. Occasionally the team received discharge information from the local hospitals. The team used this information to check for changes to the person's medication or to see if new medicines had been prescribed.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to separate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had 'checked by' and 'dispensed by' boxes on dispensing labels which recorded who in the team had dispensed and checked the prescription. A

sample of completed prescriptions found the team completed both boxes. The team passed on information obtained from the person's electronic record to the pharmacist who was completing the clinical check of the prescription. The pharmacist completed the clinical check before the prescription was dispensed. And marked the prescription to show this had happened. Once the medicine had been dispensed it was often accuracy checked by the ACT. The pharmacy kept a record of the delivery of medicines to people.

The pharmacy obtained medication from reputable sources. The team kept the stock on shelves tidy and used boxes to separate some medicines they identified were often picked in error. The boxes had the name and strength of the medicine written on. This helped to reduce the number of picking errors and ensured the team put medicine stock on the correct place on the shelves. The team kept medication removed from the original packaging in bottles. Several of these bottles weren't labelled with the batch number and expiry date of the medicine inside. 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 team members checked the expiry dates on medicines and kept a record of this activity. The team attached coloured dots to medicines with short expiry dates to prompt them to check the medicine was still in date. No out-of-date stock was found during the inspection. The team checked and recorded fridge temperatures each day and a sample of records found the temperatures were within the correct range. The team usually recorded the dates of opening on medicines with altered shelf-lives after opening. This meant the team could assess if the medicines were still safe to use. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record.

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 and it had a large fridge to store medicines kept at these temperatures. The computers were password protected and access to people's records restricted by the NHS smartcard system. The team positioned the dispensary computers in a way to prevent the disclosure of confidential information. The pharmacy stored completed prescriptions away from public view and it held other private information in the dispensary and rear areas, which had restricted access. The team used cordless telephones to make sure telephone conversations were held in private.

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.