General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Oldham Late Night Pharmacy, 87-89 Lees Road, OLDHAM, Lancashire, OL4 1JW

Pharmacy reference: 1106007

Type of pharmacy: Community

Date of inspection: 14/04/2021

Pharmacy context

This is a busy community pharmacy located on a main road near the town centre. The pharmacy dispenses mainly NHS prescriptions and sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to patients in care homes to help them take their medicines at the right time. The pharmacy stays open for 100 hours per week, opening early in the morning and closing late in the evening. The inspection was undertaken 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 manages risks to make sure its services are safe, and it keeps the records it needs to by law. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. The team has a basic understanding of how it can help to protect the welfare of vulnerable people and it generally keeps people's private information safe.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided, with signatures showing that all members of the pharmacy team had read and accepted them. Roles and responsibilities were set out in the SOPs and pharmacy team members were performing duties which were in line with their role. Some team members wore uniforms but their individual roles were not immediately apparent, so people might not be clear about this. The name of the responsible pharmacist (RP) was not displayed at the start of the inspection but this was rectified when the inspector arrived.

The risks of coronavirus to the pharmacy team and people using the pharmacy had been considered. Team members wore face masks and hand sanitizer gel was available. Most of the team members had been vaccinated against COVID-19 and they were carrying out twice weekly lateral flow testing. There were notices on the door reminding people about social distancing and the requirement to wear a mask. There were information notices about COVID-19 and a barrier in front of the medicine counter to ensure adequate space between people using the pharmacy and team members.

The RP discussed near miss errors with the member of the pharmacy team who was responsible for the error and shared any learning points with the rest of the team. The trainee dispenser gave an example of a near miss which she had discussed with the RP and how she had been told always to dispense from the prescription rather than the label, as the label might be incorrect. She pointed out medicines with similar packaging which she was extra careful when dispensing. For example, simvastatin 20mg and 40mg which had almost identical packaging. The trainee dispenser said this had been pointed out to all members of the team to be aware of. There was a near miss log to record and review errors, but this was not routinely used, so the team might be missing out on additional learning opportunities. The RP wasn’t sure where dispensing errors were recorded, but he was clear what procedure to follow in the event of an error, and this included contacting the patient’s GP if they had taken any of the incorrect medication. He said he would also inform the SI and ensure a report was completed.

The trainee dispenser said she would refer any complaints to the pharmacist. However, there was nothing was on display explaining the pharmacy's complaints procedure, so people might not be aware how to give feedback or raise concerns. There was a book to record complaints, but this had not been used since 2015. The RP said most complaints were resolved informally and only formal complaints would be recorded. He admitted the lack of recording and review might mean opportunities to improve services might be missed.

The certificate of professional indemnity insurance on display had expired. The RP confirmed that the pharmacy’s insurance had been renewed and provided a copy of the new certificate following the inspection. The RP record was appropriately maintained, although the RP had completed the time he

would leave the pharmacy in advance, so it might not be accurate if there were any unexpected changes to the RP's working hours. The controlled drug (CD) register was generally in order. Records of CD running balances were kept and balances were checked every time a medicine was dispensed. The running balance for methadone solution was audited weekly. Two CD balances were checked and found to be correct.

Confidentiality and information governance (IG) documents were available and had been signed by members of the team. The trainee dispenser correctly described the difference between confidential and general waste. Confidential waste was collected in a designated place and then taken away by a waste disposal company. Assembled prescriptions awaiting collection were not visible from the medicines counter.

The trainee dispenser was aware of the requirement to safeguard children and vulnerable adults and said she would inform the pharmacist working at the time if she had any safeguarding concerns. There was nothing on display highlighting that patients could request a chaperone to accompany them in private consultations with the pharmacist, so people might not realise this was an option.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications for the jobs they do. They are comfortable providing feedback to their manager and receive informal feedback about their own performance.

Inspector's evidence

There was a pharmacist, a pharmacy technicians (PT) and a trainee dispenser on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and the patients. Absences were covered by re-arranging the staff hours and there was flexibility within the team. There were four directors who all worked shifts as the responsible pharmacist to cover the 100 hours that the pharmacy was open. The RP explained that he would call one of the other directors in to work if necessary. The directors used an encrypted messenger system to communicate with each other; the RP explained no confidential information would be shared on this system.

The trainee dispenser explained that she was on an NVQ2 course run by a local college, and despite some delays due to COVID- 19, she was due to finish the course soon. She explained that as well as discussions with her tutor from the college, she had informal discussions about performance and development, with the pharmacist superintendent (SI). She said the pharmacy team discussed issues informally as they arose and she would be comfortable talking to either of the pharmacists or SI about any concerns she might have. There was a whistleblowing policy.

The RP was empowered to exercise his professional judgement and could comply with his own professional and legal obligations. For example, refusing to sell a codeine containing pharmacy medicine because he felt it was inappropriate.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy generally provides a suitable environment for people to receive healthcare services. It has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations. But there are some outstanding maintenance issues which detract from the professional image of the pharmacy.

Inspector's evidence

The pharmacy had recently had a new shop front fitted. This included a widened door and new window. Some work was outstanding and there was some exposed cabling above the shop front and inside the pharmacy, which detracted from the professional image. The temperature and lighting were adequately controlled. Maintenance problems were reported to one of the four pharmacy owners who owned the building.

There were two separate rooms where compliance packs were assembled and stored. These were clean and well organised. There was a kitchen area and a WC with a wash hand basin and hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks and hand sanitizer gel was available. The consultation room was small and cluttered. The RP said since the start of the pandemic, the room was rarely used, and most people receiving supervised medicine preferred to do so in the retail area. This was possible as they were often the only person in the pharmacy. The RP said he would make the consultation room suitable if a person did need a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services over extended hours, and these are appropriately managed. It gets its medicines from licensed suppliers and the team carries out some checks to ensure medicines are in suitable condition to supply. But the pharmacy could improve the way it stores and manages some of its medicines.

Inspector's evidence

There was a slight step up to the front door. The pharmacy team did not know if wheelchair users were able to access the pharmacy but confirmed it was possible for customers to enter with prams. The RP explained that people would always be served at the door if necessary. Services provided by the pharmacy were not clearly advertised, so people might not know what was offered and there was only a very small amount of health promotion information on display. The pharmacy team were multilingual, speaking Urdu, Gujarati and Bengali which helped some of the non-English speaking members of the community.

There was a home delivery service with associated audit trail. The service had been adapted to minimise contact with recipients, in light of the pandemic. The delivery driver stayed a safe distance away and the name of the person receiving the delivery was recorded. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

Space was limited in the main dispensary and the dispensary shelves were quite full and some were untidy. Dispensed by and checked by boxes were not always initialled on the medication labels to provide an audit trail, so it might not be clear who had been involved in the event of an error. This might make it harder to work out what had gone wrong. Different coloured baskets were used to prevent prescriptions becoming mixed up and the baskets were stacked to make more bench space available. Some assembled prescriptions were stored on the floor in the consultation room which risked physical damage of the medicines and contamination. Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. The RP said notes were added to assembled prescriptions if counselling was required. The team had an understanding of the valproate pregnancy prevention programme. The RP said an audit had been carried out to identify patients in the at-risk group and they had been given the appropriate information and counselling. Valproate care cards were attached to the packaging of most valproate containing medicines, and the RP said he would print the relevant information off if necessary.

Multi-compartment compliance aid packs were reasonably well managed. The care homes were split into four groups and each had a designated pharmacist who was responsible for checking the prescriptions. A labelling, dispensing and checking audit trail was completed. The end of the original packaging was sometimes used for accuracy checking, so the expiry date might not be available. And some packs were left unsealed until they were checked by the pharmacist. The RP said checking was usually carried out on the same day, but the following day at the latest. Medicine descriptions or photographs of the medication were included on the labelling to enable identification of the individual medicines. Packaging leaflets were included. Disposable equipment was used.

CDs were stored in a CD cabinet which was securely fixed to the wall. Date expired, and patient returned CDs were stored securely, although they could have been more clearly labelled and segregated to avoid confusion. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled. But not all medicines were stored as securely as they could be. Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials'. Around thirty pots of loose tablets were seen on the shelves, most of which had been appropriately labelled with their batch number and expiry date. The RP explained the medicines had been popped out of their original container for use in the compliance packs. But they had not been used, either because they were not correct, or the medication had been changed, and so they had been removed from the compliance pack. Date checking was carried out regularly and recorded on a matrix. Medicines with short dates were recorded in a diary, so they could be removed at the appropriate time and their packaging contained stickers to highlight that they were 'short-dated'. Dates had been added to opened liquids with limited stability. The minimum and maximum temperatures for the medical fridge were being recorded daily. The RP reset the thermometer at the start of the inspection and the fridge remained within range during the inspection.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely.

Inspector's evidence

Recent copies of the British National Formulary (BNF) and BNF for children were available and the pharmacist could access the internet for the most up-to-date information. There was a large medical fridge and all electrical equipment appeared to be in good working order. There was a selection of glass liquid measures with British standard and crown marks. A separate measure was marked and used for methadone solution. The pharmacy had a range of equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination. Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.