General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Leyland Late Night Pharmacy, 6 Hough Lane, LEYLAND, Lancashire, PR25 2SD

Pharmacy reference: 1106584

Type of pharmacy: Community

Date of inspection: 17/06/2019

Pharmacy context

This is a community pharmacy situated in the town centre of Leyland in Lancashire. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over the counter medicines. It also provides a range of services including minor ailment supplies and a stop smoking service. A number of people receive their medicines inside multi-compartment compliance aids. A variety of medicines are supplied to set groups of people for specific conditions after they have had a consultation with the pharmacist.

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 not all met	2.2	Standard not met	One member of staff has not completed the required training or been enrolled onto a training course appropriate for their role. So they do not meet the GPhC's policy on the minimum training requirements for pharmacy support staff.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	Some Prescription Only Medicines are supplied under the authority of PGDs. But sometimes the supplies are made by pharmacists who are not included on the PGD. This means the supplies are not lawful.
		4.3	Standard not met	Medicines are not always stored in line with safe custody requirements.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy team follows written procedures to help make sure it provides services safely and effectively. Members of the pharmacy team record things that go wrong and discuss them to help identify learning and reduce the chance of the same mistake happening again. The pharmacy generally keeps the records it needs to by law. People who work in the pharmacy are given training about the safe handling and storage of data. This helps to make sure that they know how to keep private information safe.

Inspector's evidence

There was a current set of Standard Operating Procedures (SOPs) which were last issued in January 2019. The pharmacy team had signed to say they had read and accepted the SOPs.

Dispensing errors were recorded on a standardised form. The most recent error involved the supply of the wrong number of tablets against the prescription. The pharmacist investigated the error and action was taken to help reduce the risk of further errors, including making the staff aware about the different pack sizes in stock.

Near miss errors were recorded on a paper log and were reviewed monthly by the pharmacist. But the reviews did not consider underlying factors such as the time of day. So they may not always be doing everything they can to improve. The most recent review identified mistakes involving look alike and sound alike medicines. The pharmacy team had taken actions to help learn from these mistakes e.g. placing alert stickers in the dispensary location of different Nitrofurantoin formulations.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The counter assistant was able to describe what her responsibilities were and was also clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff had badges identifying their names and roles. The responsible pharmacist (RP) had their notice displayed prominently.

The pharmacy had a complaints procedure. It was displayed in the retail area and advised people to make direct contact with the pharmacy team. Complaints were recorded on a standardised form to be followed up. A current certificate of professional indemnity insurance was on display in the pharmacy.Records for the RP, private prescriptions and emergency supplies appeared to be in order.

Controlled Drugs (CDs) registers were maintained with running balances recorded and generally checked weekly. Patient returned CDs were recorded. Records of unlicensed specials did not always contain the required details of when it was supplied and to whom. This means the information may not be available in the event of a concern or query.

An information governance (IG) policy was available. The pharmacy team had completed IG training and had signed confidentiality agreements when commencing their employment. A number of NHS smartcards were seen in use which belonged to people who were not present. This is not in line with current good practice and means there may not be a reliable audit trail to show who has used the cards. When questioned, the dispenser was able to correctly identify what information was considered

confidential waste and how it was segregated to be destroyed using an on-site shredder. A privacy notice was on display explaining how patient data was handled by the company.

Safeguarding procedures were included in the SOPs which the pharmacy team had read and signed. The pharmacist said he had completed level 2 safeguarding training. Contact details of the local safeguarding board were available. The dispenser said he would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing **Standards not all met**

Summary findings

There are enough staff to manage the workload. But one of the pharmacy team is not appropriately trained for the job they do, so may not always work safely and effectively. The pharmacy team complete some additional training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist, three pharmacy technicians – one of whom was an accuracy checker, a trainee dispenser, and four medicine counter assistants (MCA). An MCA was seen to dispense a number of prescriptions. She said she helped to dispense when it was busy and had been doing this for over three months, but she had not been enrolled onto a dispensing course. So she had not completed sufficient training to undertake this role, in line with the GPhC's minimum requirements for pharmacy support staff.

The normal staffing level between 9am – 6pm was a pharmacist, two to four dispensary staff and a counter assistant. Outside of these hours, the pharmacist was supported by at least one other member of the pharmacy team. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system.

The company provided the pharmacy team with some additional training material, such as Dementia Friends. Certificates of completed learning were kept. The training topics appeared relevant to the services provided and those completing the learning but they were not provided in a structured or consistent manner. So learning and development needs may not always be addressed.

The MCA gave examples of how she would sell a Pharmacy Only medicine using the WWHAM, questioning technique, refuse co-codamol sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said he felt able to exercise his professional judgement and this was respected by the pharmacy team and the company.

The trainee dispenser said he received a good level of support from the pharmacy team and felt able to ask for further help if he needed it. Staff did not receive regular appraisals. The MCA said she felt able to discuss any concerns she may have. The staff held regular discussions about the workload, including when there were errors or complaints. A communications diary was used to record important information so that it could be shared with those who were not present.

Staff were aware of the whistle blowing policy and staff said that they would be comfortable escalating any concerns to the company director.There were targets set for MURs and flu vaccinations. The pharmacist said he did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to allow 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. A sink was available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by use of a gate.

The temperature was controlled in the pharmacy by the use of electric heaters and fans. Lighting was sufficient. The staff had access to a kettle, microwave, separate staff fridge, and WC facilities. A consultation room was available. The space was clutter free with a computer, desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted.

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

Summary findings

The pharmacy's services are easy to access. And services are generally provided in a safe manner. But some Prescription Only Medicines have been supplied against a patient group directive (PGD) by a pharmacist who is not covered by its authority. This means the supplies are not lawful. The pharmacy gets its medicines from appropriate sources and carries out some checks to help make sure that they are in good condition. But some medicines are not stored in line with safe custody requirements.

Inspector's evidence

Access to the pharmacy was level via a single door and appeared suitable for wheelchair users. This included wheelchair access to the consultation room. Practice leaflets and a service panel provided information about the services offered. Pharmacy staff were able to list and explain the services provided by the pharmacy. If the pharmacy did not provide a particular service staff were able to refer patients using a signposting folder.

The pharmacy opening hours were displayed at the entrance of the pharmacy and a range of leaflets provided information about various healthcare topics. There were local restrictions in the area which prevented the pharmacy from ordering prescriptions on behalf of people.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery sheet was used to obtain signatures from the recipient to confirm delivery. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery. CDs were recorded on a separate delivery sheet for individual patients and a separate signature was obtained to confirm receipt.

Dispensed by and checked by boxes were initialled on dispensing labels to provide an audit trail. Dispensing baskets were used for segregating individual patients' prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using an alphabetical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out.

Schedule 3 and 4 CDs were stored in the CD cabinet, so that the pharmacist was aware about when they were being supplied. The pharmacist said high risk medicines (such as warfarin, lithium and methotrexate) were highlighted so that the pharmacy team were aware when they are being handed out and would provide counselling if necessary.

The staff 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 he would speak to any patients who were at risk and make them aware of the pregnancy prevention programme. The pharmacy team said they were not aware of any current patients who met the risk criteria.

Some medicines were dispensed in MDS compliance aids. A record sheet was kept for all MDS patients; containing details of 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 MDS packs were labelled with medication descriptions and a dispensing check audit trail. Patient information leaflets (PILs) were routinely supplied. Prescriptions checked by the ACT would also be clinically checked by the pharmacist. Prescriptions were stamped and signed by the pharmacist when this had been completed.

Some medicines were supplied to patients under a number of patient group directives (PGDs). This allowed certain medicines to be supplied to those with specified conditions as long as they met a strict inclusion and exclusion criteria. The PGDs specified they were for use only by the named pharmacist who had signed them. But consultation forms were present for supplies of Salbutamol inhalers made by a different pharmacist who was not named on the document. So these supplies may have been made without lawful provision.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a special's manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence the routine safety checks of medicines due to a software issue.

Stock was date checked on a three-month rotating cycle. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker and recorded in a diary for it to be removed at the start of the month of expiry. Liquid medication had the date of opening written on.

There were clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had been in range. Patient returned medication was disposed of in DOOP bins. Drug alerts were received electronically by email. Alerts were printed, and the details about the action taken, by whom, and when, was recorded on a matrix.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has access to the equipment they need for the services they provide.

Inspector's evidence

The staff 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 were no stickers attached to indicate they had been PAT tested.

There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication

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 the staff 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.