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: 09/01/2020

Pharmacy context

This is a community pharmacy situated in the town centre of Leyland in Lancashire. The pharmacy is open extended hours over seven days. It 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. The pharmacy supplies medicines in multi-compartment compliance aids for some people to help them take the medicines at the right time. The pharmacy can also supply a range of medicines without a prescription through its patient group directions (PGDs). Such as contraceptives, salbutamol inhalers and antihistamines. At the time of inspection, the pharmacy was in the process of undergoing renovation and extension to its premises.

Overall inspection outcome

✔ **Standards met**

Required Action: None

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 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 team follows written procedures which helps to maintain the safety and effectiveness of the pharmacy's services. The pharmacy keeps the records it needs to by law. And members of the team receive training so that they know how to keep private information safe. They record things that go wrong, and they discuss them to help identify learning and reduce the chances of similar mistakes happening again.

Inspector's evidence

There was a current set of Standard Operating Procedures (SOPs) which were issued in February 2019 and their stated date of review was 2021. Members of the pharmacy team had signed to say they had read and accepted the SOPs.

Dispensing errors were recorded on a standardised form. A recent error involved the supply of nebivolol 5mg tablets instead of ivabradine 5mg tablets. The pharmacist had investigated the error and shared his findings with the pharmacy team. Near miss incidents were recorded on a paper log. The pharmacist explained that he would discuss the near miss records with the pharmacy team to identify any common trends. Details of any actions taken were usually documented on a patient safety review sheet. Only a limited amount of action had been taken in the last two months due to the improvements being made in the pharmacy. The pharmacist said during this time he would continue to discuss any incidents with the pharmacy team.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A dispenser 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. The responsible pharmacist (RP) displayed their notice prominently. The pharmacy had a complaints procedure. A notice in the retail area advised people they could discuss any concerns or feedback with members of the pharmacy team. Any complaints were recorded and followed up. A current certificate of professional indemnity insurance was on display.

Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order. Controlled Drugs (CDs) registers were maintained with running balances recorded and they were checked every two weeks. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded.

An information governance (IG) policy was available. The pharmacy team had completed in-house IG training and each member had signed a confidentiality agreement. When questioned, a dispenser was able to correctly identify what information she considered to be confidential waste and how it was segregated and removed by a waste carrier. A privacy notice was on display explaining how patient data was handled by the pharmacy.

Safeguarding procedures were included in the SOPs. The pharmacy team had completed in-house safeguarding training, and pharmacy professionals had completed level 2 safeguarding training. Contact details of the local safeguarding board were available. A pharmacy technician said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and team members are appropriately trained for the jobs they do. Members of the pharmacy team complete some additional training to help them keep their knowledge up to date. They get regular feedback from their manager to help them improve.

Inspector's evidence

The pharmacy team included a pharmacist, five pharmacy technicians – one of whom was an accuracy checker, three dispensers - two of who were in training, three pharmacy students and three drivers. Members of the pharmacy team were appropriately trained or enrolled on accredited training programmes. The normal staffing level between 9am to 6pm was a pharmacist and two to four dispensary staff. 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 suitably managed. Staffing levels were maintained by using part-time staff and a staggered holiday system.

The pharmacy provided the team with various training resources, such as in-house training provided by the pharmacist and a training package about children's oral health. A record of training was kept for each member of the team and the training topics appeared relevant to those completing the learning. But ongoing training was not provided in a structured or consistent manner. So learning and development needs may not always be fully addressed.

A dispenser gave examples of how she would sell a Pharmacy (P) medicine using the WWHAM questioning technique, refuse sales of medicines that were liable to abuse that 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. A dispenser had recently commenced her employment and said they felt a good level of support and she was able to ask for further help if she needed it.

Each member of the pharmacy team had a monthly meeting with the pharmacist to discuss their work and areas they could improve. The pharmacy technician said she felt the process was a good chance to receive feedback about her work. Staff were aware of the whistleblowing policy and staff said that they would be comfortable escalating any concerns to the pharmacist or a 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 premises had recently undergone major building work to create an upstairs floor and extend the premises to the rear. The building work was suspended over the Christmas period so that the pharmacy's services were not impacted during a busy time of year. So the pharmacy was mid-way through a refit and it was disorganised. The dispensary was cluttered with boxes and stock, creating a tripping hazard for staff and reducing the effectiveness of the workspace. This may increase the risk of an error occurring. Customers were not able to view any patient sensitive information due to the position of the dispensary and access to the dispensary was restricted by use of a gate. The temperature was controlled in the pharmacy by the use of electric heaters. Lighting was sufficient. The staff had access to a kitchenette 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. There was a separate entrance for substance misuse patients to collect their medicines through a hatch. This enabled the privacy and dignity of these patients to be protected.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from recognised sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was wheelchair access to the consultation room. Practice leaflets and a service panel provided information about the services offered. Pharmacy staff were able to 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 and a range of leaflets provided information about various healthcare topics.

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 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. The baskets were colour coded to help prioritise dispensing. The pharmacist performed a clinical check of all prescriptions and then signed the prescription form to indicate this had been completed. When this had been done an accuracy checker was able to perform the final accuracy check. 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 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.

Prescriptions for schedule 3 and 4 CDs were not routinely highlighted. So there was a risk that these medicines could be supplied after the prescription had expired. The pharmacist said he would highlight high-risk medicines (such as warfarin, lithium and methotrexate) with a sticker so the pharmacy team were aware when they were 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 was in the process of completing an audit, and he would speak to any patients who were at risk to make sure they were aware of the pregnancy prevention programme.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacy would refer them to their GP to complete an assessment about their suitability. 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 sheets were 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.

Some medicines were supplied to patients using a variety of patient group directions (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 pharmacist said he had completed the necessary training required by the PGDs and the records of supplies were kept.

Medicines were obtained from licensed wholesalers, and unlicensed medicines sourced from a special's manufacturer. The pharmacy was not yet meeting the safety features of the Falsified Medicines Directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine checks of medicines. Stock was date checked on a three monthly basis. A date checking matrix was signed by staff as a record of what had been checked. The stock had been checked about two weeks ago and the pharmacist said he would restart the process once stock had been put away in the dispensary. 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.

Controlled drugs were stored appropriately in the CD cabinets, with clear segregation between current stock, patient returns and out-of-date stock. Methameasure equipment was used to help provide the substance misuse services in an appropriate manner. 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, were recorded on a matrix.

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 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 Methameasure equipment was calibrated each day and cleaned regularly. 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.