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: 22/11/2023

Pharmacy context

This is a community pharmacy located 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 seasonal flu vaccinations, and a private prescribing service using a pharmacist independent prescriber. The pharmacy supplies some medicines in multi-compartment compliance packs to 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	1.1	Standard not met	The pharmacy's prescribing service is not supported by clear policies and procedures. And the pharmacy cannot demonstrate that it identifies or manages the risks associated with it.
		1.6	Standard not met	Pharmacy records are not always adequately maintained. Private prescription records are incomplete. Controlled drugs records are not always accurate. And the Responsible Pharmacist record does not include records of absence. Consultation records for the prescribing service do not always have enough information to show whether the treatments are appropriate.
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	4.2	Standard not met	The pharmacy's prescribing service sometimes issues prescriptions without obtaining enough information to properly assess the patient's condition. And people using the service do not always get enough advice about what to do if their condition does not improve or gets worse. The pharmacy dispenses prescriptions against verbal instructions provided by the prescriber, or against scanned copies of the prescriptions. But the pharmacy could not show they always received the actual written copy of the prescription, which is required by law.
		4.3	Standard not met	The pharmacy does not effectively monitor its medicines fridges and temperature records are unreliable. So it cannot provide assurance that fridge medicines are always stored appropriately. Dispensary shelves are untidy and disorganised, which may increase the risk of error. Some stock medicines are stored outside their original packaging, so that they are not adequately labelled. This means the pharmacy may not

Principle	Principle finding	Exception standard reference	Notable practice	Why
				be able to demonstrate that they are safe to use.
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 make sure the team works effectively. But the procedures do not cover all of the pharmacy's services, so team members may not always know what is expected of them. The pharmacy offers a private prescribing service. But the service is not supported by clear policies and procedures. And the pharmacy cannot provide assurance that it identifies or manages the risks associated with the prescribing service. The pharmacy keeps most of the records that are needed by law but some of the records are incomplete or inaccurate. So they do not always show whether the pharmacy has acted appropriately. Team members record things that go wrong and learn from them so that they can reduce the chances of similar mistakes happening again.

Inspector's evidence

There was an electronic set of standard operating procedures (SOPs) which covered the NHS services provided by the pharmacy. Members of the pharmacy team said they had read and understood the SOPs and that this had been recorded on electronic software. But the software had a fault which meant the training records could not be viewed.

The pharmacy provided a private consultation service, which was provided by a single pharmacist independent prescriber (PIP). People would be offered a private consultation if they presented with symptoms which required prescription only medication (POM). The PIP worked at the pharmacy occasionally and would conduct consultations in-person during these periods. At other times, remote telephone consultations were offered. If a prescription was issued, the PIP would either send a scanned copy via email or provide the details to a member of the pharmacy team by telephone. There were no SOPs to specify how this service should be operated. And the pharmacy could not provide any evidence to show whether it had properly assessed the risks associated with the prescribing service. It did not have any information about the training the PIP had completed and could not demonstrate whether the PIP had the necessary knowledge for the treatments being offered. The superintendent pharmacist said that he relied on the PIP to act professionally and within their competence. But there were no audits carried out to provide assurance that the prescribing was always appropriate. Team members believed that the PIP sent an email to people's GP practice with details of any medicines they had been prescribed. But the pharmacy did not have any records of this to provide assurance that the emails were always sent. A few prescriptions for high-risk medicines, including zopiclone, opiate painkillers, and benzodiazepines, had been supplied. But there was no process for the pharmacy to seek confirmation from the person's GP surgery beforehand. So there is a risk these medicines may not be appropriate.

Roles and responsibilities of the pharmacy team were described in individual SOPs. A trainee dispenser was able to explain what their 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. A notice in the retail area advised people they could discuss any concerns or feedback with the pharmacy team. Any complaints would be recorded and followed up. A current certificate of professional indemnity insurance was on display.

Near miss dispensing incidents were recorded on a paper log. Members of the team explained that the pharmacist highlighted the mistakes and asked the person responsible to rectify their own error. The records were reviewed by the pharmacist and any learning points were discussed with the team. The

pharmacist had recently provided training to the team on reconstituting antibiotic suspensions following an incident where the incorrect amount of water was added. Dispensing errors were recorded on a standardised form that included details of any investigation.

Records for private prescriptions were kept electronically. However, the pharmacy had not recorded details about who the prescriber was on 82 occasions since 1 August 2023. An RP record was kept but did not include a space to enable the details of any RP absences to be recorded. This meant it was unclear whether any absences had happened without being recorded. Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. Two random balances were checked, and one was found to be inaccurate. The pharmacy team explained they were aware of the discrepancy and had been investigating but had not yet identified why the balance did not correspond. Patient returned CDs were recorded in a separate register. Records of unlicensed specials appeared to be in order.

A notice in the retail area explained how the pharmacy handled people's information. An information governance (IG) policy was available. And a training sheet and confidentiality agreements were signed by members of the team when they had read the policy. But newer members of the team had not yet signed. So the pharmacy could not demonstrate whether all team members knew how to protect information. When questioned, a trainee dispenser was able to correctly explain how confidential information was segregated for removal by a waste carrier. Safeguarding procedures were kept in a folder and a training sheet had been signed by members of the team. The pharmacist had completed level 2 safeguarding training. Contact details for the local safeguarding board were on display. A trainee dispenser said they would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough team members to manage the pharmacy's workload and they receive appropriate training for the jobs they do. And they complete training packs to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy team included eight dispensers, four of whom were in training, two medicine counter assistants (MCA), one of whom was in training, and a pharmacy student. All members of the pharmacy team were appropriately trained or on accredited training programmes. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about infection control. Training certificates were kept showing what training had been completed. But further training was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

An MCA was seen selling pharmacy only medicines using the WWHAM questioning technique, and appropriately referring people to the pharmacist when needed. Members of the team felt they were well supported by the pharmacist and senior manager, and able to ask any questions. They routinely discussed their work to keep each other up to date. Appraisals were conducted each year. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or SI. There were no targets in place for professional services.

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 located in a retail unit on the high street. It was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. The dispensary had a gate to prevent unauthorised access, and people visiting the pharmacy were not able to see any patient sensitive information. The temperature was controlled by the use of electric heaters. Lighting was sufficient. The pharmacy team had access to a small kitchenette and WC facilities.

A consultation room was available. The space was generally 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 offers a private prescribing service. But some prescriptions are issued without enough information being obtained to properly assess the patient's condition. This means people may not always receive a reliable diagnosis or effective treatment. And people are not always given appropriate advice. So they may not know what to do if their complaint does not resolve or gets worse. The pharmacy gets its medicines from recognised sources. But it does not always store them appropriately, so cannot provide assurance that they are always kept in good condition.

Inspector's evidence

Access to the pharmacy was level via an automatic door and was suitable for wheelchair users. Posters gave information about the services offered and information was also available on the pharmacy's website. Team members were able to list and explain the services provided by the pharmacy. If the pharmacy did not provide a particular service, the team members were able to refer patients elsewhere using a signposting folder. The pharmacy opening hours were displayed and a range of leaflets provided information about various healthcare topics.

The pharmacy's prescribing service was provided by a PIP. People would present to the pharmacy and be offered the service if the pharmacy team felt their symptoms required clinical input by a prescriber. They could have in-person consultations at times the PIP was present, otherwise they would be offered a remote consultation. The service prescribed medicines for acute conditions, such as ear and chest infections. But some medicines were prescribed remotely following a consultation between the person and the PIP on the telephone. These consultations relied on a verbal discussion without a physical assessment taking place. There were no consultation notes kept at the pharmacy, but some were provided following the inspection. The notes did not include reference to key clinical considerations for some of the presenting complaints to provide assurance of appropriate diagnosis. For example, a prescription had been issued to treat a dental abscess without determining whether systemic illness was present. But this is a required step for dental prescribing by a non-dental clinician. And a prescription for a chest infection had been issued without listening to the patient's chest to assess whether there was a risk of pneumonia. Some of the consultation notes did not reference any safety netting advice. This is advice given by healthcare professionals to instruct people what to do next if specific symptoms appear, if their condition worsens, or does not get better after a specific amount of time. There were also no consultation notes or records kept when the PIP did not think a prescription was required. So the pharmacy could not show they had adequately protected people or provided adequate advice in the event of their condition worsening.

Some private prescriptions had been dispensed from scanned copies on the understanding that the original prescription would follow. And a number of information slips were present that had been used to record people's name, address and the medicine which had been supplied in accordance with verbal instruction from the PIP about what he had prescribed. But the pharmacy did not have the corresponding valid prescriptions for some of scanned copies and information slips. So the pharmacy could not provide assurance that valid prescriptions were always received to authorise the supplies.

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.

Dispensed medicines awaiting collection were kept on a shelf using an alphanumerical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Members of the team were seen to confirm the patient's name and address when medicines were handed out. But there was no process to highlight prescriptions which contained high risk medicines such as warfarin, lithium, and methotrexate, and those containing schedule 3 and 4 CDs. This meant team members may not always know when they are handing these medicines out. So they may not be able to carry out extra checks to make sure they are being used appropriately.

The pharmacy team were aware of the risks associated with the use of valproate during pregnancy. Educational material was available to hand out when valproate was supplied. The pharmacy had completed an audit, and the pharmacist had spoken to patients who were at risk to make sure they were aware of the pregnancy prevention programme. And this was recorded on their PMR.

Some medicines were dispensed in multi-compartment compliance aids. Before a person was started on a compliance aid the pharmacy would check whether the person was suitable for this service. But they did not record the outcome, so could not demonstrate whether the checks were effective. 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 retained with the record sheets. The compliance aids were labelled with medication descriptions so that individual medicines could be more easily identified, and a dispensing check audit trail. But patient information leaflets (PILs) were not routinely supplied. So people may not always have up-to-date information about their medicines.

The pharmacy had a delivery service. Deliveries were segregated and 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. CDs were recorded on a separate delivery sheet for individual patients and a signature was obtained to confirm receipt.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. The majority of medicines were stored on dispensary shelves in alphabetical order. But the shelves were disorganised, meaning similar strengths and formulations were mixed together. Some foil strips were stored loose. And some medicines were stored in bottles without the required information on the label about expiry dates and batch numbers. This meant there could be an increased risk of an error. There were five fridges in the pharmacy. One of the fridges in the dispensary did not have a thermometer, despite having records since 1 October 2023 showing a temperature range of 2.2 to 8 Celsius. Another fridge contained medicines for delivery and did not have a thermometer or any temperature records. A third fridge had records of 3.6 to 8 Celsius, but the minimum temperature was found to be 1.1 Celsius.

Stock was date checked once every three months. A date checking matrix was signed by staff as a record of what had been checked. 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 did not always have the date of opening written on, including a bottle of morphine sulphate oral solution which expired 90 days once it had been opened. Controlled drugs were stored appropriately in the CD cabinet. CD denaturing kits were available for use.

There was a large pile of patient returned medication at the back of the dispensary was waiting to be

sorted and disposed of in DOOP bins. Drug alerts were received by email from the MHRA. But there were no records of what action had been taken so the pharmacy could not show they had been appropriately dealt with.

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

Team members had access to the internet for general information. This included access to the British National Formulary (BNF), BNFc and Drug Tariff resources. All electrical equipment appeared to be in working order. 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.