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: 09/07/2024

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 the NHS Pharmacy First service, seasonal flu vaccinations, and a private prescribing service using pharmacist independent prescribers. 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 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 has written procedures to help the team work safely and effectively. Members of the team make records when things go wrong, and they review them to identify learning opportunities. They keep the records required by law. The pharmacy offers a private prescribing service. But the service is not supported by a clear framework covering the scope of the service and the associated risks. And audits are not carried out to ensure prescribers are following policies and to help identify improvements in their practice.

Inspector's evidence

Standard operating procedures (SOPs) for NHS-based services were available on an electronic platform. Each member of the team had their own log in to read the SOPs. An electronic declaration was completed by team members when they had read and accepted each SOP. The platform would only display the SOPS which had been allocated to each person's role. But SOPs for working in the absence of a responsible pharmacist had not been allocated to non-pharmacist accounts. So team members may not fully understand what activities they can do when the pharmacist is absent.

The pharmacy provided a private prescribing service. This was provided by three pharmacist independent prescribers (PIPs), one of whom was the superintendent pharmacist (SI). People who presented with symptoms of an acute condition which required a prescription only medication (POM) were offered a private consultation with a PIP. The PIPs occasionally worked at the pharmacy occasionally and conducted the consultations in-person during these periods. A service level contract was available for the service and signed by PIPs. This detailed the expectations and responsibilities of the PIP when providing the service, such as record keeping and advice. The PIPs were said to have a prescribing formulary, but only one formulary was available to view out of the three PIPs. The formulary was used as the basis to determine the scope of the prescribing service. The pharmacy manager indicated there had been conversations with individual PIPs about their scope of practice and training. But details of these conversations were not documented. And the pharmacy had not defined a minimum level of training and experience for the service to be provided by a PIP. The SI performed random spot checks to review how PIPs were providing the service. And feedback was provided if any improvements were required. But there was no standard approach as to how the checks were performed, or documented, to show what learning had been identified. There were no audits undertaken to help determine whether PIPs were following the expectations of the service level contract or acting within the scope of practice in their formulary. So, the pharmacy may not be able to show it has a sufficient framework in place to control and ensure the quality of the consultations being performed.

Some prescribing practices had been restricted by the pharmacy, such as remote consultations, and prescribing of opiate medicines. These had been decided between the PIPs and pharmacy manager, but there was no written risk assessment to show all of the risks had been considered. For example, consent to notify peoples GPs was not mandatory. So, the pharmacy may not be able to show what mitigations had been put in place to reduce this risk.

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 the error. The records

were reviewed each month and any learning points were discussed with the team. Information posters about 'look-alike' and 'sound-alike' medicines were on display and had been discussed with team members. Dispensing errors were recorded on a standardised form and included details of any investigation.

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. And a copy of insurance for each prescriber had been seen.

Records for private prescriptions and the RP appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and checked frequently. Two random balances were checked, and both were found to be accurate. Patient returned CDs were recorded in a separate register. Records of private consultations were recorded on a standard template using a recognised consultation model. A sample of consultations were reviewed, and these generally contained sufficient detail to understand the patient interaction and care which had been provided. Some PIPs made a record of when GP letters were sent following consent, but some did not. So the pharmacy may not always be able to show it was following its process for the service.

An information governance (IG) policy was available on the electronic SOP platform, but it was not available to view by all members of the team. So some team members may not fully understand their responsibilities to help protect people's information. When questioned, a trainee dispenser was able to correctly explain how confidential information was separated for removal by a waste carrier. A notice in the retail area explained how the pharmacy handled people's information. 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. But ongoing training is not structured so learning needs may not always be identified or addressed.

Inspector's evidence

The pharmacy team included a pharmacy manager, nine dispensers, six of whom were in training, a medicine counter assistant (MCA), and two delivery drivers. All members of the pharmacy team were appropriately trained or on accredited training programmes. The pharmacy was using regular locums to provide pharmacist cover. 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 training about the new NHS Pharmacy First Service. But further training was not provided in a structured or consistent manner. So learning needs may not always be fully addressed.

PIPs undertook peer reviews as part of their annual professional revalidation requirements, and records of these were kept by the pharmacy. But the contents of the reviews related to consultation methods. And there was no peer review of the conditions being treated as part of the service, which would help to identify learning opportunities. The PIPs formulary detailed the scope of practice and the evidence used to support competency. But evidence was limited to reading guidance, and there was no method to attest skill or understanding. And there were no prescribing reviews. So the pharmacy may not be able to show PIPs have the correct learning and development opportunities to underpin and identify improvement of their work.

A trainee dispenser gave examples of how they would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales of medicines the felt were inappropriate, and refer people to the pharmacist if 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. The locum pharmacist felt able to exercise their professional judgement and this was respected by the pharmacy team. 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 with members of the team.

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 which prevented 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, and lighting was sufficient. The pharmacy team had access to a small kitchenette area 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 met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. It gets its medicines from licensed sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But there are inconsistencies in how the private consultation service is undertaken. And the lack of independnt clinical oversight means important considerations may be overlooked.

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. 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 PIPs. People presented to the pharmacy with symptoms and were offered the service if team members felt the person required clinical support by one of the prescribers. People were booked in to see a PIP when they were available at the pharmacy. The service prescribed medicines for acute conditions, such as ear and chest infections. One of the PIPs used a pre-screening questionnaire to gather some important information, such as details of current conditions and medications, pregnancy and breastfeeding status for females, and to gain consent. But this was not routinely used across all of three PIPs, which would be a useful record for future reference, and a useful step to ensure people fully understand the prescribing service. Consultation notes were recorded and could be viewed by members of the pharmacy team. But there were no examples of consultations where medicines had not been supplied, and it was not clear whether PIPs kept these equally important records in the event of a query or a concern.

The PIP who prescribed the medicine was usually the RP at the time of dispensing. This meant they conducted the clinical screening of prescriptions they had written, and there was no further oversight. The lack of an independent review of the prescription may mean important considerations and viewpoints are overlooked.

The pharmacy team initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels to provide an audit trail. They used 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. Prescriptions for schedule 3 and 4 CDs were highlighted to remind team members to check the prescription had not expired. The pharmacist explained that any prescriptions for high-risk medicines (such as warfarin, lithium, and methotrexate) were highlighted so team members could refer people to the pharmacist for counselling and advice. But records of these conversations were not recorded which would help with the continuity of patient care.

The pharmacy team were aware of the risks associated with the use of valproate-containing medicines during pregnancy. Educational material was given out when valproate was supplied. The pharmacy had previously 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 packs. Before a person was started on a compliance packs 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 or reply to a query. 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 updated. Hospital discharge information was sought and retained with the record sheets. The compliance packs were labelled with medication descriptions so that individual medicines could be more easily identified, and patient information leaflets (PILs) were given.

The pharmacy had a delivery service, 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 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 expiry date of medicines were checked at least once every six months. A date checking matrix was available, but there were gaps in the records. A spot check of the dispensary did not find any out-of-date medicines. 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. The team separated open bottles of medicine so that they could be destroyed following the inspection.

Controlled drugs were stored appropriately in the CD cabinet. CD denaturing kits were available for use. There were three clean medicines fridges, each equipped with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had generally remained in the required range for the last 3 months. Returned medication was disposed of in designated bins located away from the dispensary. 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.