General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Windmill Late Night Pharmacy, 2-8 Longford Road, Longford, COVENTRY, CV6 6DX

Pharmacy reference: 1115367

Type of pharmacy: Community

Date of inspection: 06/02/2020

Pharmacy context

This is a community pharmacy that opens for 100 hours every week. It is located on a main road in a residential area of Coventry, in Warwickshire. The pharmacy dispenses mostly NHS and a few private prescriptions. It sells a limited range of over-the-counter medicines, provides a delivery service and can offer Medicines Use Reviews (MURs). The pharmacy also supplies medicines in multi-compartment compliance packs to people if they find it difficult to manage their medicines.

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 in a satisfactory manner. The pharmacist understands how to protect the welfare of vulnerable people. And he protects people's privacy appropriately. Pharmacists deal with their mistakes responsibly. And the pharmacy adequately maintains the records that it needs to.

Inspector's evidence

The pharmacy had sustained most of the improvements required of it since the last inspection although parts of it were still untidy (see Principle 3). The main dispensary was much more organised. This included its stock holding. The pharmacy held a range of electronic standard operating procedures (SOPs) to support its services. They were now tailored to the pharmacy's activities and had last been reviewed in October 2019.

The responsible pharmacist (RP) explained that the pharmacy was busier in the mornings with over-the-counter (OTC) queries. Prescriptions were dispensed in batches in the afternoon when it was usually quieter. The RP worked at his own pace and left a mental or physical break in between accuracy-checking prescriptions when he had assembled them. Sometimes, he checked them for accuracy the next morning. Details on dispensed medicines were also physically re-checked when they were bagged, and the RP described reading the details out to help assist with this process.

The pharmacy had been routinely recording its near misses and they had been collectively reviewed every month by the RP. Details of this had been marked on the log to indicate that the review had taken place. There were no records of near misses however, documented for the last month; the RP stated that this was because no-one had made any mistakes and that he had not identified any trends or patterns. Fast-moving lines of stock had been placed into baskets. When look-alike or sound-alike medicines were seen, the RP moved the stock to help minimise the risk of a mistake happening. This included separating different strengths of the same medicine. The RP could describe the procedure he would follow when dispensing incidents or complaints happened but stated that there had been no recent dispensing errors. His process included reporting incidents to the National Reporting and Learning System (NRLS). At the point of inspection there was no information on display about the pharmacy's complaints process. The RP mentioned the practice leaflet although this was not present. This could mean that people may not have been able to raise their concerns easily.

Confidential waste was segregated before it was shredded and prescriptions awaiting collection were stored in the dispensary. This meant that sensitive details were not visible to the public. Summary Care Records had been accessed for emergency supplies and consent had been obtained verbally from people. A safeguarding policy and details of the local safeguarding agencies were available. The RP had completed safeguarding training to level 2 in 2019 via the Centre for Pharmacy Postgraduate Education (CPPE).

The correct RP notice was on display and this provided details of the pharmacist in charge on the day. The pharmacy's indemnity insurance arrangements were through the National Pharmacy Association (NPA) and due for renewal after October 2020. Daily records of the minimum and maximum temperatures for the fridge had been kept and this verified that medicines were stored here

appropriately. A complete record of controlled drugs (CDs) that had been returned by people and destroyed at the pharmacy had also been routinely maintained. The pharmacy's records for CDs and the RP record were compliant with statutory requirements. The RP stated that very few unlicensed medicines had been supplied but he could not locate any records about this. This was the same as the last inspection; it links to parts of the pharmacy being cluttered and needs improvement.

Principle 2 - Staffing ✔ Standards met

Summary findings

The superintendent pharmacist has the appropriate skills and qualifications for his role. And he can cope with the pharmacy's current workload. But the pharmacy is not always up to date with other routine tasks such as housekeeping duties. This could increase the risk of errors.

Inspector's evidence

In line with its current volume of activity, the pharmacy was adequately staffed with pharmacists providing cover and a delivery driver. The pharmacy was up to date with its current workload and compared to the last inspection, there was a clear workflow now. However, parts of the pharmacy were still untidy and cluttered as described under Principle 3. The RP who was also the superintendent pharmacist had not set any formal or commercial targets to complete services. A very limited range of OTC medicines were sold, and the RP provided appropriate advice with each transaction. Ongoing training for him included using resources from the NPA, CPPE and online websites such as the Clinical Knowledge Summaries provided by the National Institute for Health and Care Excellence (NICE).

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's premises provide an adequate environment for the delivery of healthcare services. It has an appropriate amount of space to provide services safely. But parts of it are still untidy and are not presented as appropriately as they could be.

Inspector's evidence

The pharmacy’s premises consisted of a small-sized retail area with a sign-posted consultation room located here. There were two to three storage areas, one of which was used as an office and the main dispensary. The latter was enclosed and located at the very rear of the pharmacy’s premises. The retail space was adequately presented. A bell and CCTV alerted pharmacists when people entered the pharmacy. A very limited range of Pharmacy (P) medicines were available to purchase and most of them were stored in a location that was not visible or easily accessible to people. The P medicines could therefore, not be self-selected. Installing a barrier to help prevent people coming behind the medicines counter was discussed at the time.

The consultation room was kept locked. It was available for private conversations and services however, the RP stated that this was hardly used. Additional services such as Medicines Use Reviews (MURs) were not routinely provided or were conducted on an appointment basis. One person at a time usually entered the pharmacy but if a private conversation was required, the RP asked them to wait if the room was needed. This space was therefore mostly used as a storage room and this did detract from the overall professional use of the space.

The main dispensary was kept in an organised manner. The pharmacy’s stock holding here was organised and there was an adequate amount of space to carry out the pharmacy’s dispensing activities safely. The WC was clean. Lighting in the pharmacy was adequate; ventilation in the dispensary could have been improved. The premises were secured against unauthorised access when closed. However, some of the pharmacy’s additional storage spaces and the RP’s office were disorganised and cluttered. Some records could not be easily located. The RP was advised to ensure he routinely kept these areas clear of clutter and better organised going forward.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy has extended opening hours and can ensure that people with different needs can easily access its services. The pharmacy generally provides its services in an appropriate manner. The pharmacy delivers people's medicines to them in a safe manner. It obtains its medicines from reputable sources. And it largely stores them appropriately. The pharmacist makes relevant checks when people receive higher-risk medicines. But the pharmacy doesn't always record any information. This makes it difficult for them to show that appropriate advice has been provided when these medicines are supplied.

Inspector's evidence

The pharmacy's opening hours were advertised by the front door and a range of healthcare leaflets and posters were on display inside the premises. Three seats were available for people waiting for services. People could enter the pharmacy via a concrete ramp. This helped people with wheelchairs to use the pharmacy's services. The RP explained that written communication would be used for people who were partially deaf. He verbally explained details to people who were visually impaired and spoke Punjabi to assist members of the local population if their first language was not English.

The pharmacy provided a delivery service. Audit trails about this service had been maintained. CDs and fridge items were identified. Signatures were obtained from recipients when medicines were delivered and the process for failed deliveries involved re-trying, calling the person to inform them about the attempt made and bringing the dispensed medicine(s) back to the pharmacy. Medicines were not left unattended.

Multi-compartment compliance packs were supplied to people if they found it difficult to manage their medicines. Most prescriptions were required to be ordered by people' themselves, except for a few. The RP described comparing the previous records on the pharmacy system and retained discharge information from hospitals to help identify any changes or missing details. The RP ensured that all medicines were de-blistered into the compliance packs with none left within their outer packaging. Compliance packs were not left unsealed and patient information leaflets (PILs) were routinely provided. Mid-cycle changes involved retrieving the old compliance packs and supplying new ones. However, descriptions of medicines were not routinely provided. In addition, apart from the prescriptions as well as people's medication records, the pharmacy did not have additional records for the compliance packs to show which sections medicines were to be put into. The RP knew what each person's requirements were. This was the same as the last inspection and meant that this service relied heavily upon the RP's own knowledge. If the RP was unavailable, people's care could be compromised without any supporting records. He was therefore advised to incorporate other methods into this process.

The pharmacy's dispensing processes were more organised since the last inspection. Baskets were used to hold prescriptions and medicines. This minimised the risk of prescriptions becoming intermixed and a dispensing audit trail was used to identify people involved in the processes. This was through a facility on generated labels. The RP was aware of the risks associated with valproates during pregnancy. The pharmacy now held the appropriate educational literature to supply to people at risk. The RP described people receiving higher-risk medicines as stable. He checked the dose with people when prescriptions

were seen, counselled appropriately and asked about blood test results. This included calling people before deliveries were made and asking about the International Normalised Ratio (INR) for people prescribed warfarin. However, there were no details being recorded about this and this limited the ability of the pharmacy to verify that appropriate checks had been taking place.

The pharmacy obtained its medicines from licensed wholesalers such as OTC Direct, DE Midlands, Trident, AAH and Alliance Healthcare. Unlicensed medicines were obtained through Sterling Specials. The pharmacy held the required software and equipment such as scanners to comply with the Falsified Medicines Directive (FMD). However, the RP was not yet complying with the decommissioning process and he was unsure if he had registered with SecurMed. This was discussed at the time. Medicines requiring cold storage were kept appropriately in a fridge and stored at the appropriate temperature. CDs were largely stored under safe custody; the RP ensured the keys were maintained in a manner that prevented unauthorised access overnight. Liquid medicines were marked with the date upon which they were opened. Medicines were described as date-checked for expiry every month. Short-dated medicines were identified and stored separately. There were no date-expired medicines or mixed batches seen. However, there was no schedule or matrix used to help verify the process.

Drug alerts were received via email and action was taken accordingly. Audit trails had been maintained to verify this process. Medicines returned for disposal were stored within designated containers. This included ones to store hazardous and cytotoxic medicines as well as a list to help identify them. People requiring sharps to be disposed of, were referred to the local GP surgery. Returned CDs were appropriately segregated in the CD cabinet before their destruction and relevant details were noted.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. It keeps its equipment clean.

Inspector's evidence

The pharmacy held the necessary equipment it required to safely provide its services. This included access to the internet and various reference sources. There were a range of clean, crown-stamped conical measures with designated ones to measure methadone solution and water. There was also counting equipment such as a triangle and tweezers. The pharmacy's computers were located within the enclosed dispensary and were password protected, hence unauthorised access to them was restricted. The CD cabinet was secured in line with statutory requirements. The fridge was operating at the appropriate temperature. A dispensary sink was available to reconstitute medicines; this was clean and there was hot and cold water available. The pharmacist used his own NHS smart card to access electronic prescriptions and he was advised to ensure this was stored appropriately overnight. Two shredders were available to dispose of confidential waste.

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.