General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: NHL Pharmacy, 270 New Hall Lane, PRESTON, PR1 4ST

Pharmacy reference: 1116346

Type of pharmacy: Community

Date of inspection: 07/11/2024

Pharmacy context

This community pharmacy is situated on a high street, in a residential area of Preston. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including flu vaccinations and the NHS Pharmacy First service. The pharmacy supplies medicines in multi-compartment compliance packs to some people to help them take their medicines at the right time. An optician forms part of the premises and is a separate entity to the pharmacy.

Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

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, and this helps them to provide services effectively. And they know how to keep people's information safe. The pharmacy generally keeps the necessary records as required by law. Members of the team discuss and record when things go wrong. And they review the records to help identify further learning opportunities.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) which were issued in February 2024. Members of the pharmacy team had signed training sheets to say they had read and understood the procedures.

The pharmacy had systems in place to identify and manage risk, such as the recording of dispensing errors and details of the subsequent learning outcomes. The pharmacist discussed near miss incidents with members of the team at the time they occurred to help identify potential learning points. Details of the incidents were recorded on electronic software and reviewed at the end of the month. But the last review was in August 2024, so there may be a delay before any recent learning was identified and actioned. To improve their work, the team had identified a new process for checking medicines which had barcodes which could not be identified by the pharmacy's accuracy checking software. Any affected medicines were referred to a pharmacist for an additional accuracy check.

The roles and responsibilities for members of the team were documented within the SOPs. A dispenser explained what their responsibilities were and was clear about the tasks that could or could not be conducted in the absence of a responsible pharmacist. The correct responsible pharmacist (RP) notice was on display. The pharmacy had a complaints procedure. Any complaints were recorded and followed up by a member of the team. A current certificate of professional indemnity insurance was available.

Records for the RP and private prescriptions appeared to be in order. But unlicensed specials did not always contain the necessary details about who the product was supplied to and when. The team acknowledge the importance of these details and would correct these records following the inspection. Controlled drug (CD) registers appeared to be in order. Running balances were routinely recorded and checked on a frequent basis. Two CD balances were checked, and both were accurate. A separate CD register was available to record patient returned CDs.

An information governance procedure was available, and members of the team had signed confidentiality agreements. When questioned, a dispenser described how confidential information was separated for it to be removed by a waste contractor. A privacy notice was on display describing how confidential information was stored and handled by the pharmacy. Safeguarding procedures were available and included the contact details for the local safeguarding team. The pharmacist had completed level 2 safeguarding training. Members of the team explained they would refer any concerns to the pharmacist in the first instance.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the workload safely. And they complete the necessary training for their role. But ongoing learning is not routinely provided, so learning needs may not always be identified or addressed.

Inspector's evidence

The pharmacy team included a pre-registered pharmacy technician, five dispensers, two of whom were in training, a medicine counter assistant, a pharmacy student, and a delivery driver. The pharmacy used regular locum pharmacists. All members of the pharmacy team were appropriately trained. The workload appeared to be manageable. Staffing levels were maintained by part-time staff and a staggered holiday system.

Members of the pharmacy team had previously conducted training sessions as part of team meetings about topics they were interested in. For example, they had conducted a role play exercise regarding a pharmacy first enquiry. Details of the training was recorded as part of team meeting records. But there had not been any documented learning since April 2024, and the team's learning needs may not be met. A dispenser provided examples of selling a pharmacy only medicine using the WWHAM questioning technique, refusing sales which they felt were not appropriate, and referring people to the pharmacist when needed.

Members of the team felt well supported by each other. They were seen working well together and assisted each other with any queries they had. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. There were no targets for professional based services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available for people to have a private conversation with a member of the team.

Inspector's evidence

The pharmacy was clean and appeared adequately maintained. The size of the dispensary was sufficient for the workload and access was restricted by use of a gate. Customers were not able to view any patient sensitive information due to the position of the dispensary. The temperature was controlled by the use of central heating. Lighting was sufficient. The staff had access to a kitchenette and WC facilities.

A consultation room was available with access restricted by use of a lock. 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. A separate consultation room was used for the substance misuse service.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them effectively. 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 members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might not always be able to check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

The pharmacy and consultation room were accessible by those with additional mobility needs. Information was on display about the services offered. The pharmacy opening hours were also on display.

The pharmacy used a patient medication record (PMR) system which had built-in accuracy checking software. Prescriptions were organised into different 'workflows' on the PMR system and assigned to different roles within the pharmacy team. The first workflow was for a pharmacist to complete a clinical check of each prescription. The prescription was then released to the dispensing team, who picked the stock and scanned each box of medication using the PMR system. If the medication matched the prescription, a dispensing label would print, and the dispenser affixed this to the box. If it did not match the dispenser amended the product or request assistance from the pharmacist. The pharmacist did not perform a further accuracy check unless the medicine fell within an exception category. For example, a CD or a split pack. The PMR system kept an audit trail of who carried out each stage of the process.

Dispensed medicines awaiting collection were kept on collection shelves. Barcode scanners were used to record the location of the bags. Stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Members of the team were seen confirming the patient's name and address when medicines were handed out. The barcode scanner highlighted any prescriptions which had expired and could no longer be supplied, such as 28-day prescriptions for schedule 3 or 4 CDs. The team highlighted the need for any additional counselling advice using 'speak to pharmacist' stickers. But the team did not routinely highlight prescriptions containing higher-risk medicines (such as warfarin, lithium, and methotrexate) to remind the team to provide counselling advice and help ensure people continued to take their medicines safely. Members of the team were aware of the risks associated with the use of valproate and topiramate-containing medicines, and the need to supply full packs. Educational material and counselling advice was provided with these medicines. But details of the counselling advice was not recorded, which would help with the continuity of patient care.

Some medicines were dispensed into multi-compartment compliance packs. Before a person was started on a compliance pack, the team completed an assessment about the person's suitability. A record was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record was updated. Hospital discharge information was sought and kept for future reference. The compliance packs were supplied with patient information leaflets (PILs), but they did not contain medication descriptions. So people may not always be able to identify their medicines. The team acknowledge this was important and they would begin to provide this information.

The pharmacy had a delivery service, and delivery records were kept. Unsuccessful deliveries were

returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

Medicines were obtained from licensed wholesalers, and any unlicensed medicines were sourced from a specials manufacturer. The expiry dates of medicines were checked once every three months. Date checking records were available. Short-dated stock was highlighted with a sticker. But a number of loose strips of medicines were found on the shelves, and liquid medications did not have the dates of opening written onto the bottle. The team had already identified a need to correct this and tidy the dispensary shelves which were disorderly. The pharmacist confirmed there was a plan already in place to carry out this task outside of opening hours during the weekend.

Controlled drugs were stored in the CD cabinets, with separation between current stock, patient returns and out of date stock. There were four fridges, each equipped with a thermometer. The minimum and maximum temperatures were recorded on most days and had been within the required range for the past month. The pharmacist acknowledged there were gaps in the recording of the fridge temperatures, and the team agreed to improve the frequency of recording these details going forward. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received on electronic software, which kept a record of who had actioned the alerts, and when.

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 keep the equipment clean in a manner expected of a healthcare setting.

Inspector's evidence

Team members accessed 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. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were used for methadone to prevent cross contamination. The pharmacy also had counting triangles for counting loose tablets. Equipment appeared clean.

An electronic methadone dispensing system was used by the pharmacy. Each day the team calibrated the machine with three separate volumes to check it was correct. And the machine was cleaned down at the end of the day. 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.

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.