General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Late Night Pharmacy, 4 High Street, NEWPORT, Shropshire, TF10 7AN

Pharmacy reference: 1120591

Type of pharmacy: Community

Date of inspection: 21/01/2020

Pharmacy context

This 100-hour community pharmacy is located on the main high street in Newport, Shropshire. It dispenses prescriptions and sells a range of over-the-counter (OTC) medicines, as well as other health and beauty items. The pharmacy provides some medicines in multi-compartment compliance aid packs, to help make sure people take them at the correct time. It also provides several other services including Medicines Use Reviews (MURs), emergency hormonal contraception (EHC) and the Community Pharmacist Consultation Service (CPCS). The pharmacy provides flu vaccines during the relevant season, and a substance misuse treatment service is also available.

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 suitably identifies and manages risks. It keeps the records it needs to by law and protects people's private information. Pharmacy team members are clear about their roles. They record their mistakes so that they can learn and improve, and they understand how to raise concerns to help protect the wellbeing of vulnerable people.

Inspector's evidence

The pharmacy had a set of basic standard operating procedures (SOPs) which covered operational tasks and activities. The procedures had been reviewed within the last two years and defined the responsibilities of team members, who signed to confirm their acknowledgment and understanding. The team clearly discussed their roles and a medicine counter assistant (MCA) confidently discussed the activities which were permissible in the absence of a responsible pharmacist (RP). The pharmacy had professional indemnity insurance provided by the National Pharmacy Association (NPA), which was valid until June 2020.

Near miss records were usually recorded by the pharmacist. The team felt comfortable discussing near misses and incidents and they explained some actions that had been taken to help prevent the same mistakes from happening again. This included the use of shelf-edge stickers to encourage care with selection. Dispensing incidents were recorded using the pharmacy's patient medication record (PMR) system. Incidents were also onward reported to the National Reporting and Learning System (NRLS) and records were kept as an audit trail.

The pharmacy had a complaint procedure and the way comments and concerns could be raised were displayed in a pharmacy practice leaflet. An MCA said that concerns were escalated to the pharmacist in charge. The pharmacy also sought additional feedback through a Community Pharmacy Patient Questionnaire (CPPQ). The current survey was ongoing and previous results, displayed in the consultation room, were positive.

The correct RP notice was conspicuously displayed near to the dispensary and the RP log was suitably maintained. As were records for private prescriptions and emergency supplies. Specials procurement records did not always record patient details to provide an audit trail from source to supply, in line with requirements which could make it more difficult to resolve any related queries. Controlled drugs (CD) registers kept a running balance and regular checks were carried out. A patient returns CD register was available and previous destructions had been signed and witnessed.

Pharmacy team members had completed some training on the General Data Protection Regulation (GDPR), and they had signed confidentiality agreements. The pharmacy had some information governance procedures and the pharmacist said that it was registered with the Information Commissioner's Office (ICO), but a copy of an ICO certificate was not seen on the day. The team demonstrated a clear understanding of how they would keep people's private information safe. Completed prescriptions were stored out of view of the medicine counter and confidential waste was

segregated and shredded on the premises. Team members were in possession of their own NHS smartcards. But on the day, the card of a pharmacist who was not present during the inspection was in a dispensing terminal, which indicated that cards were not always suitably secured when not in use.

Some information resources were available on safeguarding and the pharmacist had completed training. The team discussed some of the types of concerns that they might identify and explained how some previous concerns had been discussed with a local GP. The contact details of local safeguarding agencies were accessible.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably trained for the jobs that they do. They complete ongoing training to address any gaps in their knowledge and get some feedback on their development. Team members can raise concerns about pharmacy services if needed.

Inspector's evidence

On the day of the inspection, one of the regular pharmacists was working alongside a part-time dispenser and a part-time MCA. The pharmacy employed two other regular pharmacists, to cover the remaining shifts, as well as two further part-time workers, a dispenser and an employee who was completing the NVQ3 pharmacy technician programme. The pharmacy had a vacancy for a part-time dispenser and recruitment to this post was ongoing. A notice was displayed on the pharmacy window and the position was also advertised using internet search engines. The team adequately managed the workload on the day, and overall felt that the dispensing workload was manageable. Team members usually booked leave in advance and cover was arranged amongst themselves, to help make sure a sufficient level of staffing was maintained.

Several suitable sales were observed on the day. Team members used appropriate questioning to help make sure sales were suitable and when they were unsure, they referred to the pharmacist. An MCA discussed sales in further detail and identified several patient groups who would usually be referred to the pharmacist. This included young children, people who were pregnant and those with pre-existing medical conditions. She also highlighted several high-risk medications, which may be susceptible to abuse.

Pharmacy team members were trained for the roles in which they were working and an MCA had recently been enrolled on a dispensing course for further career progression. Team members completed some ongoing training. They were informed of modules to complete using a training WhatsApp group and recent modules had covered the CPCS and some ‘look alike, sound alike’ medications. The pharmacist kept a training record to document when team members had completed the relevant modules, and if required, training could be completed within work hours. The team were also provided with general updates on an ongoing basis. Development was reviewed through one-to-one appraisals, where the team received feedback on their performance.

The team were comfortable discussing issues amongst one another and were happy to approach the pharmacist in charge. There were three main pharmacists who could each be approached if team member had issues that needed to be raised. There were no formal targets for professional services. The pharmacist said that patient satisfaction was a priority.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is suitably maintained for the provision of services. And it has a consultation room to enable it to provide members of the public with access to an area for private and confidential discussions.

Inspector's evidence

The pharmacy was situated inside an old building, but the premises were in a suitable state of repair. One of the regular pharmacists liaised with the building landlord to arrange for any necessary repair work to be carried out. General housekeeping duties were completed by pharmacy team members when time allowed, and the pharmacy was generally clean and tidy on the day. There was adequate lighting throughout and the temperature was suitable for the storage of medicines.

The retail area of the pharmacy stocked a range of goods which were in keeping with a healthcare-based business and pharmacy medicines were stored behind the medicine counter. During the inspection one pharmacy restricted medicines was identified on the retail floor of the pharmacy, this was removed by the inspector and the pharmacist placed it behind the medicine counter, to secure it from self-selection. The walkways were free from obstructions and chairs were available for people waiting for their medicines. And a variety of health promotion literature was displayed throughout.

The dispensary was suitably sized for the current dispensing workload, but there were a small number of items temporarily being stored on the floor, which may lead to medicines being mixed up or cause a trip hazard for team members. A main front bench had a computer terminal and was used for accuracy checking. And a further work bench to the rear was used for dispensing. Large shelving units were fitted throughout to provide storage for medicines and a sink was available for the preparation of medicines. The pharmacy WC was appropriately maintained, but it was being used to store a number of consumable items such as pharmacy bags and bottles, which is not appropriate and may impact on hygiene.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy generally sources and manages medicines suitably. But some stock medicines could be better organised. Its services are accessible and managed appropriately to help make sure people receive appropriate care. But the pharmacy does not always identify prescriptions for people on high-risk medicines. So, some people may not always receive additional counselling or advice about their medicines.

Inspector's evidence

The pharmacy was accessed via a small step from the main street and there was a ramp up to the main retail floor. Further adjustments could be made for people with additional needs, such as the use of large print labels, to aid those with visual impairment.

There were some promotional displays around the retail area, which advertised the pharmacy services. Services were also listed in a practice leaflet. The pharmacy participated in some healthy living public health campaigns, such as dry January and information was available to support signposting.

Prescriptions were dispensed in baskets to keep them separate and prioritise the workload. Pharmacy team members signed ‘dispensed’ and ‘checked’ boxes as an audit trail and where possible, some records of interventions were documented using the PMR system.

The pharmacy was currently participating in an audit of people prescribed lithium and valproate-based medicines. The pharmacist was aware of the risks of using valproate-based medicines in people who may become pregnant and the necessary safety literature was available for supply. Prescriptions for other high-risk medicines were not always routinely identified and records of monitoring parameters were not consistently maintained. The pharmacy highlighted some prescriptions for CDs, but this was not always consistent and an expired prescription for gabapentin was identified, which may increase the risk of a supply being made after the valid 28-day expiry date.

The pharmacy ordered some repeat prescriptions for patients. People using the collection service identified which medications were required each month and repeat prescriptions were stored in date order to be sent to the GP surgery. The pharmacy kept a record of medications requested for each patient, so discrepancies could be queried. But they did not keep a record of all requests sent to the GP surgery, so some unreturned prescriptions may not be identified. Medications for people using multi-compartment compliance aid packs were manged using a four-week cycle. Master record sheets were updated with changes to medications as an audit trail. The team reported that no high-risk medications were placed into compliance packs. Completed packs were labelled with patient details, descriptions of individual medicines were provided, and patient leaflets were supplied.

The delivery service was provided by the pharmacy team members. They kept some records of deliveries that had been made, but people did not routinely sign to confirm the secure delivery of medicines, which could make it more difficult to resolve any related queries. For deliveries containing

CDs, the prescription form was taken from the pharmacy to obtain a signature, which may increase the risk that the prescription form could be lost.

SOPs were available to cover other pharmacy services, including CPCS and the pharmacy first service. In date patient group directives (PGDs) were available and the relevant declarations of competence had been completed. Each of the regular pharmacists had completed the relevant training for the provision of the EHC, this included safeguarding training with the Centre for Pharmacy Postgraduate Education (CPPE). Suitable training had also been completed for the administration of the flu vaccine, consent was obtained, and records of administration were kept. The service was covered by an in-date PGD and equipment to aid the administration of vaccinations, including adrenaline and a sharps bin was available.

Stock medications were obtained from licensed wholesalers and specials from a licensed manufacturer. Stock medications were stored in the original packaging provided by the manufacturer, but they were unorganised in some places, which may increase the risk of a picking error. The team discussed the date checking systems and short dated medicines were highlighted. Obsolete and returned medicines were stored in suitable waste bins. There were a small number of bags of returned medicines which required sorting. The pharmacy had the necessary hardware to enable compliance with the European Falsified Medicines Directive (FMD), but updated SOPs had not yet been written and processes were not implemented in the pharmacy at the time of the inspection. Alerts for the recall of faulty medicines and medical devices were received via email. Once received an audit trail was kept for a few months, before records were discarded, but original emails were retained for reference.

CDs were stored securely, and random balance checks were found to be correct. Patient returns were clearly segregated from stock, but two expired CDs were found to be amongst stock on the day. These were marked and segregated by the pharmacist. CD destruction kits were available. The pharmacy fridge had a maximum and minimum thermometer. The temperature was checked and recorded each day and the fridge was within the recommended temperature range.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy uses its equipment in a way that protects people’s privacy. Its equipment is generally suitably maintained but the accuracy of plastic measures cannot always be guaranteed when preparing medicines.

Inspector's evidence

The pharmacy team had access to paper-based reference materials including the British National Formulary (BNF) and internet access was available to enable further research. The pharmacy had several measures available, but several them were plastic and were not British standard approved, so their accuracy cannot be guaranteed. This was discussed with the pharmacist on the day. Counting triangles for loos tablets were clean and a separate triangle was clearly marked for use with cytotoxic medicines.

Electrical equipment appeared to be in working order and screens were located out of public view. The systems were password protected and the PMR system was backed-up regularly. Cordless phones were available to enable conversations to take place in private.

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.