General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Accrington Late Night Pharmacy, 188-190 Blackburn Road, Accrington, Lancashire, BB5 0AQ

Pharmacy reference: 9011179

Type of pharmacy: Community

Date of inspection: 18/06/2019

Pharmacy context

The pharmacy is in a parade of shops in the suburbs of Accrington. Pharmacy team members mainly dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MUR), emergency contraception and meningitis vaccinations. They provide a substance misuse service, including supervised consumption and needle exchange. And, they provide emergency supplies of medicines via the NHS Urgent Medicines Supply Advanced Service (NUMSAS) and supply medicines in multi-compartmental compliance packs to care homes and people in their own homes.

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 has procedures in place to identify and manage risks to its services. But, it hasn't reviewed some of the written procedures for over two years. And, not all pharmacy team members have read the procedures relevant to their roles. So, they may not be working in a consistent and most effective way. Pharmacy team members know how to keep people's information secure. And they know what to do if there is a concern about the welfare of a child or vulnerable adult. The pharmacy keeps the records required by law. Pharmacy team members record and discuss mistakes that happen. They use this information to learn and make changes to help prevent similar mistakes happening again. But they don't always discuss or record enough detail about why these mistakes happen. So, they may miss opportunities to improve.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. The sample checked were last reviewed in 2017 and 2018. And the next review was scheduled for May 2019 or June 2021. The superintendent pharmacist (SI) said he was behind in reviewing procedures and reviewed them every two to three years. A discussion took place about the need for procedures to be reviewed at least every two years. Some pharmacy team members had read and signed the SOPs relating to their roles after the last review. But some had not. And some procedures had not been signed to confirm team member's understanding since 2014 and 2015. The pharmacy defined the roles of the pharmacy team members in each procedure.

The pharmacist highlighted and recorded near miss errors made by the pharmacy team when dispensing. Pharmacy team members discussed the errors made. They discussed what had happened and had a brief discussion about why the mistake was made. But, they did not record much detail about why a mistake had happened. And, their main solution to preventing a mistake happening again was to have a discussion. The technician said the pharmacist analysed the data collected, but she did not know how often. And, there were no records of any analysis. But, the technician said the pharmacist would tell them if they noticed a pattern of mistakes from the same person. The technician gave an example of introducing boxes on shelves to keep stock in to help prevent team members making picking errors. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people.

It recorded incidents electronically using a template reporting form. And, the samples of reports seen were comprehensive about what had happened, and the actions taken by the team to prevent recurrence. A recent example was caused by a breakdown in communication with a patient receiving their medication in a multi-compartmental compliance pack. The reasons for the breakdown had been discussed and any changes to someone's pack were now communicated to them over the phone, rather than simply sending a note with their pack.

The pharmacy had an up to date patient group direction (PGD) document available for the meningitis vaccinations service. The superintendent pharmacist said the service was mainly provided to people travelling to the Hajj pilgrimage. He provided records of recent written and physical vaccination training. And, he said he had carried out a visual risk assessment to, for example, make sure the necessary equipment was in place. And, to make sure the environment in the consultation room was suitable. But, he had not made a record of the risk assessments.

The pharmacy had a procedure to deal with complaints handling and reporting. But, it did not advertise the procedure to people. It collected feedback from people by using questionnaires. And, analysis of the last set of questionnaires was available. A pharmacy team member gave an example of some feedback where people had commented on waiting times for prescriptions. She said the team had since started to give people a waiting time for their prescriptions to help manage their expectations. And, she said that prescriptions were usually dispensed and handed out inside the quoted time.

The pharmacy had up to date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. And, they were kept electronically. It kept running balances in all registers. And most were audited against the physical stock quantity approximately monthly. Methadone registers were also kept electronically. It kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record on paper. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It collected confidential waste in dedicated bags. Pharmacy team members sealed the bags when they were full. And, the bags were collected by a contractor and sent for destruction. Pharmacy team members had been trained to protect privacy and confidentiality. They had read the procedures relating to the general data protection regulations (GDPR). And they had signed confidentiality agreements in 2018. Pharmacy team members were clear about how important it was to protect confidentiality. There was no evidence that the pharmacy had been assessed for GDPR compliance.

When asked about safeguarding, a dispenser some examples of symptoms that would raise their concerns in both children and adults. They explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And would refer to local safeguarding teams for advice. The pharmacy had contact details available for the local safeguarding service. But, there was no documented procedure about how to deal with a concern. And, staff had not received any formal training. The pharmacist had completed safeguarding training via The Centre for Pharmacy Postgraduate Education (CPPE) in 2017.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. Pharmacy team members only complete ad-hoc training but they learn from the pharmacist to keep their knowledge and skills up to date. They reflect on their own performance. And, they make changes to improve the way they do things. Pharmacy team members do not always establish and discuss specific causes of mistakes. This means they may miss chances to learn from errors and make changes to make things safer. The pharmacy team members can discuss issues and act on ideas to support the delivery of services.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were the superintendent pharmacist (SI), a pharmacy technician, two dispensers and a delivery driver. Pharmacy team members completed training ad-hoc by reading various trade press materials and training modules sent by wholesalers. And, by having regular discussions with the pharmacists about current topics. Pharmacy team members received an appraisal with the SI every year. And, they discussed their performance and areas for improvement and set objectives to help address any needs. A dispenser gave an example of an objective she had set. She said she needed to reduce the amount of distractions while working, such as talking to colleagues, to reduce the number of mistakes being made. She said she had discussed this with the pharmacist. She had reduced the amount she talked while working. And, waited until she had finished dispensing before responding to other colleagues. She explained this had helped her to reduce the number of near miss error she was making.

Pharmacy team members gave examples of restricting the quantity of co-codamol and pseudoephedrine they would supply to someone over the counter. And, they gave examples of requests for certain products they would immediately refer to the pharmacist.

A dispenser explained that she would raise professional concerns with the pharmacist or superintendent pharmacist (SI). She said he felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy did not have a whistleblowing policy. And, the dispenser said she was unsure about where to raise a concern outside the pharmacy.

The pharmacy team communicated with an open working dialogue during the inspection. A dispenser said she was told by the pharmacist when she had made a mistake. The discussion that followed did not fully explore why she had made the mistake. But, she said she would always try and change something to prevent the mistake happening again.

Pharmacy team members explained a change they had made after they had identified areas for improvement. They had changed the way they worked to help protect the person labelling prescriptions from distractions. They explained that if a team member was labelling a batch of prescriptions, it was the responsibility of other team members to serve customers and answer the phone. And, they explained this was to help reduce mistakes and to make sure the work was completed on time.

The pharmacy owners and SI did not ask the team to achieve any targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is generally maintained to the required standards. But, some floor space and benches are cluttered and untidy. It provides a suitable space for the health services provided. And the pharmacy has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was generally well maintained. Most areas of the pharmacy were tidy and well organised. But, there were some floors and surfaces that were dusty and cluttered with various items. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves throughout the premises. The pharmacy also had a first and second floor, which it used for storage.

The pharmacy had a private consultation room available. The pharmacy team used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet and a sink with hot and cold running water and other facilities for hand washing.

Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people and it manages its services safely and effectively. It stores, sources and manages its medicines safely. But, pharmacy team members don't always keep medicines in the original packs or label these stock medicines correctly. So, they may not know if these medicines expire or are recalled. The pharmacy team members dispense medicines into devices to help people remember to take them correctly. They provide information with these devices to help people know when to take their medicines and to identify what they look like. The team takes some steps to identify people taking high-risk medicines. And it provides them with some advice. But the team don't always have written information for people to take away. So, people may not have all the information they need to help them take their medicines safely.

Inspector's evidence

The pharmacy was accessed via a ramp from the street. Pharmacy team members were able to provide large-print labels for people with a visual impairment. And, they would use written communication if someone had a hearing impairment. Pharmacy team members were able to speak Punjabi and Urdu, as well as English.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. The pharmacy team used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up.

The pharmacy supplied medicines in multi-compartmental compliance packs to people in their own homes when requested. Pharmacy team members contacted patients each month to ask if any medication had changed. And, to prompt people to order their prescriptions if the surgery required people to order their own prescriptions. The pharmacy team attached labels to the pack, so people had written instructions of how to take the medicines. It added descriptions of what the medicines looked like, so they could be identified in the pack. And, it provided people with patient information leaflets about their medicines each month. The pharmacy team documented any changes to medicines provided in packs on the patient's electronic medication record. But they did not record information about who had requested the change or which team member had received the query, documented the information and made the neccesary changes. Care home staff ordered people's prescriptions. Pharmacy team members downloaded and printed the electronic prescriptions and sent them to each home for them to reconcile against their orders. The home or pharmacy staff rectified any discrepancies. Pharmacy team members sent patient information leaflets for people's medicines to the home when the medicines were first prescribed. But, they did regularly replace the leaflets they sent.

A pharmacy team member gave a clear explanation of the protocols in place to make sure over-the-counter medicines were provided to people safely. They gave examples of restricting the quantity of co-codamol and pseudoephedrine they would supply. And they gave examples of requests for certain products they would immediately refer to the pharmacist.

Pharmacy team members checked medicine expiry dates every 12 weeks. But, there were no records available of when the last date check was completed. The superintendent said they had been misplaced during some recent renovations. Pharmacy team members highlighted any short-dated items with a

sticker on the pack up to three months in advance of its expiry. And they recorded expiring items on a monthly stock expiry sheet, for removal during their month of expiry. Lists were available and no out of date medicines were found after a search of shelves. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. Several amber bottles were found containing medicines that had been removed from their original containers. The bottles sometimes had a label attached stating the name and strength of the medicine. But, the label did not record the batch number or expiry date of the medicines. Other amber bottles were found that were unlabelled.

The pharmacy obtained medicines from seven licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (CDs). Pharmacy team members kept the CD cabinet(s) tidy and well organised. And, out of date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits. The pharmacy had a second fridge on the first floor used for wholesale stock. The SI said there was a small amount of pharmacy dispensing stock kept in the fridge. But, temperatures in the fridge were not monitored or recorded. The temperature in the fridge during the inspection was within acceptable limits. The SI gave an assurance that pharmacy dispensing stock would be moved to the fridge downstairs. And, a discussion took place about the advantages of keeping dispensing and wholesale stock separate. And, the importance of monitoring fridge temperatures to comply with the pharmacy's wholesale dealers license.

The pharmacist said that he would provide the necessary information to someone presenting a prescription for valproate who may become pregnant. He said he would also check whether they were taking adequate pregnancy prevention. The pharmacy did not have a supply of information material to provide to people or the necessary warning labels to attach to valproate dispensed outside its original container. It had scanners and software available to identify counterfeit medicines. But, it had not changed the procedures to incorporate the requirements of the Falsified Medicines Directive. And, pharmacy team members had not been trained. So, it was not complying with current law.

The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The equipment available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. Pharmacy team members obtained equipment from the licensed wholesalers used. And they had a set of clean, well maintained measures available for medicines preparation. They used a separate measure to dispense methadone. And, they had marked the measure to make sure it wasn't used to dispense other medicines.

The pharmacy dispensed methadone using a MethaMeasure pump system. Pharmacy team members flushed the system with water and cleaned it each night. And, they calibrated the machine each morning, as prompted by the electronic control system. The dispensary fridge was in good working order. And the team used it to store medicines only. Access to all equipment was restricted and all items were stored securely. The pharmacy positioned computer terminals away from public view. And they were password protected. It stored medicines waiting to be collected in the dispensary, also away from public view.

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.