General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rutland Late Night Pharmacy, 45A,B,C,D High Street, Oakham, Rutland, LE15 6AJ

Pharmacy reference: 9011894

Type of pharmacy: Community

Date of inspection: 16/07/2024

Pharmacy context

This is a community pharmacy situated in the town centre. Most of its activity is dispensing NHS prescriptions and selling medicines over the counter. The pharmacy supplies medicines in multi-compartment compliance packs to people who live in their own home. In addition, the pharmacy provides a wide range of private services including weight loss medicines, travel vaccinations, aesthetics, hay fever injections, ear syringing and treatment for a range of acute presentations which consist mainly of acute infections such as urinary tract infections and chest infections.

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 identifies and manages the risks associated with the provision of its services. And the pharmacy keeps the records it needs to by law. The pharmacy manages people's electronic personal information safely. Team members record things that go wrong so that they can learn from them.

Inspector's evidence

The pharmacy had a set of up-to-date standard operating procedures (SOPs) which had been signed by the pharmacy team members to show they had read and understood them. The pharmacy also had SOPs and guidance in place to support the other services such as the private prescribing services that the pharmacy offered. Staff were seen following the SOPs which included dispensing medicines and handing medicines out to people safely. Staff understood how to sell medicines safely. Staff knew that prescriptions were valid for six months apart from some controlled drugs (CDs) which were valid for 28 days. The pharmacy highlighted Schedule 3 and 4 CDs and kept them on a separate shelf to remind the person handing out the medicine of the shorter validity of these prescriptions.

In addition to dispensing prescriptions, the pharmacy provided a wide range of NHS and private services. NHS services included 'Pharmacy First.' Private services included weight loss medicines, travel vaccinations, aesthetics, hay fever injections, ear syringing, and treatment of a range of acute presentations which consisted mainly of acute infections such as UTIs or chest infections. Most of the pharmacy's services were provided face-to-face at the pharmacy but some services including the weight loss service could also be accessed online. A pharmacist independent prescriber (PIP) provided the private services. Some services such as travel vaccinations, hay fever injections and weight loss medicines were provided through a patient specific direction (PSD) written by the PIP. When people presented with an acute complaint the consultation was only undertaken by the PIP. And a private prescription was written, not a PSD. Following the previous inspection, the pharmacy had asked another prescriber (a peer) to carry out a clinical audit to check if the PIP's prescribing decisions were aligned with national guidelines and to assess whether adequate clinical decisions and justifications for prescribing were made, and suitable information was provided to the person throughout the consultation process. The peer found they had no issues to report about the PIP's prescribing.

The pharmacy provided aesthetics treatments which included botulinum toxic injections, derma fillers and platelet rich plasma treatments. All assessments were undertaken by the PIP. The PIP had detailed information and guidance to provide the service safely. The pharmacy also ran an ear syringing clinic where an audiologist undertook the assessment and carried out the ear syringing.

The pharmacy had some processes for learning from dispensing mistakes that were identified before reaching a person (near misses) and dispensing mistakes where they had reached the person (errors). Near misses were discussed with the member of staff at the time. The aim was to record them in the significant event log, when the log was checked only a small number of near misses had been recorded. The pharmacy manager said that it was possible that not all near misses were being recorded. The recording of near misses had been discussed at the previous inspection. The pharmacy manager said that she was not sure whether a review of near misses was undertaken and asked the inspector to check with the superintendent who was not present during the inspection. When the SOP was reviewed it said that near misses should be recorded but did not set out any further actions such as a review to

learn from these events. In a follow up visit the superintendent said that all near misses were now being recorded and the near miss log had more near misses entered. He said that near misses had been discussed in the team meeting and he now made minutes of the meetings which he showed the inspector.

The pharmacy maintained the necessary records to support the safe delivery of pharmacy services. These included the Responsible Pharmacist (RP) record, the private prescription book, and the CD register. The entries checked at random in the CD register during the inspection agreed with the physical stock held. Date-expired CDs were clearly marked and separated to prevent dispensing errors. There were a number of patients-returned CDs in the cupboard which had been separated from stock CDs. The pharmacy had a designated register for patient-returned CDs but not all the patient-returned CDs had been recorded in the register. This could mean that diversion of patient-returned CDs could go unnoticed. The pharmacist said that he would make sure that going forward patient-returned CDs were entered when they were received.

The pharmacy had a complaints procedure and an information governance policy. Access to the electronic patient medication record (PMR) was password protected. Confidential information was stored and destroyed securely. Professional indemnity insurance was in place. The pharmacy's team members understood safeguarding requirements and could explain the actions they would take to safeguard a vulnerable person. For the private prescribing service, the Summary Care Record (SCR) was checked routinely to make sure a person was not receiving treatment for mental health conditions, to safeguard more vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy’s team members work together to manage the day-to-day workload within the pharmacy. They have the skills to deliver services safely, and they know how to raise a concern if they have one. The pharmacy team has informal training from the pharmacist but doesn't have structured ongoing training which could mean that learning needs are not always addressed .

Inspector's evidence

During the inspection, the pharmacy team managed the day-to-day workload of the pharmacy effectively. There were two pharmacists, three trained dispensers and one trainee dispenser, and one trained counter assistant.

One of the pharmacists was a pharmacist independent prescriber (PIP). The PIP was the only prescriber working at the pharmacy but he was very experienced and also worked in roles within the NHS where he prescribed regularly. He explained how he shared any learning from his other NHS roles and looked to help improve his own service as a result. He provided training certificates to cover the range of clinical services he provided at the pharmacy. There was no evidence of the PIP being incentivised to prescribe and there was evidence of a number of orders being rejected when the PIP thought a supply of a medicine was inappropriate. When asked, members of the team said they would be comfortable discussing any issues they had at work with the pharmacist and knew how to raise a concern if they had to. They had an annual review where they were able to give and receive feedback. Staff were given informal training by the pharmacist and were given some opportunities for development, for example they had completed training to provide vaccinations. But did not have regular ongoing training to keep their skills and knowledge up to date.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's website provides all the required relevant information to people using its services. People can receive services at the pharmacy in private when they need to. The pharmacy keeps its premises safe, secure, and appropriately maintained.

Inspector's evidence

Outside, the pharmacy had several bright modern facias. One facia was in a different colour and had Rutland Private Clinic written on the sign. The pharmacy used 'Rutland Private Clinic' as an alternative trading name to advertise the services provided by the pharmacy. All healthcare activities were provided by the registered pharmacy. The pharmacy had reasonable access for people with a disability or a pushchair to get into the pharmacy. Inside it was neat and tidy with good fixtures and fittings, and a clear route to the pharmacy counter. It had soft lighting and suitable seating. The dispensary which was upstairs was a reasonable size for the services provided. There was suitable heating and lighting, and hot and cold running water was available. The pharmacy had three consultation rooms for people to access services or have a private conversation with the pharmacy team. Unauthorised access to the pharmacy was prevented during working hours and when closed.

People could find out information about the services provided, book face-to-face appointments and also access remote treatments through the pharmacy's two websites: www.rutlandpharmacy.co.uk, which provided information about both the NHS and private services that the pharmacy provided and www.rutlandclinic.co.uk which gave information about the private services that were provided. People accessing online services submitted information through an online questionnaire which started on the conditions page. The websites gave suitable information about who was providing the services, and how to raise a concern if necessary.

The websites advertised a hay fever vaccination service but no longer made specific reference to use of a medicine which was not licensed for this purpose. The Rutland private clinic website said that there were three prescribers working at the pharmacy. The inspector was advised that two prescribers no longer worked at the pharmacy and the PIP said their names would be removed from the website.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's healthcare services are suitably managed and are accessible to people. The pharmacy gets its medicines and medical devices from reputable sources. It stores them safely and it knows the right actions to take if medicines or devices are not safe to use to protect people's health and wellbeing.

Inspector's evidence

The pharmacy had reasonable access for people with a disability or a pushchair to get into the pharmacy. The pharmacy team understood the signposting process and used local knowledge to direct people to local health services. During the inspection, the RP was mainly upstairs in the dispensary where medicines were dispensed. Staff communicated with each other by going up and down the stairs or through a walkie talkie, as necessary. This separation made supervision more difficult. Since the previous inspection, the superintendent had introduced a new SOP to manage these risks. This SOP said that the pharmacist should be present in the retail pharmacy area as much as possible. And that counter staff must not sell over-the-counter (OTC) medicines without the presence of a pharmacist in the retail area. Team members were aware of the new process and said that there was usually a pharmacist in the retail area or in one of the consultation rooms that they could speak to. But if there wasn't they used the walkie talkie to ask the pharmacist to come downstairs.

The pharmacy provided a range of private services which were mainly face-to-face at the pharmacy, but some services were also available online. Private services included weight loss medicines, travel vaccinations, aesthetics, hay fever injections, and treatment of a range of acute presentations which consisted mainly of acute infections such as urinary tract infections (UTIs) or chest infections. Other services included aesthetics and ear wax removal. Some services were provided through a patient specific direction (PSD) written by the Pharmacist Independent Prescriber (PIP). The PIP or a second pharmacist carried out a consultation. The PSD included all the relevant questions to ask the person when undertaking a consultation. The PIP then reviewed the consultation, and if appropriate signed the PSD to authorise the pharmacist to administer the treatment or for the medicine to be supplied. When people presented with an acute complaint the consultation was only undertaken by the PIP. And a private prescription was written, not a PSD. When records were checked during the inspection, there was a clear audit trail for who wrote the prescriptions. And the consultation records checked showed that the PIP had conducted appropriate assessments and had ruled out any red flags. Safety-netting and counselling advice were also clearly documented.

Following the previous inspection, the pharmacy's recording process for the private prescriptions it issued had been amended. It now included additional details including a record of the consultation, the reasons for prescribing or not prescribing. The previous inspection had found that some prescribing was not in line with national and local antibiotic guidance. The PIP said he used national guidelines when prescribing medicines. The PIP also explained he followed Leicester, Leicestershire and Rutland antibiotics guidelines as the vast majority using the prescribing service were local people. Records checked showed that the PIP was prescribing in line with national and local guidelines.

The pharmacy was providing a weight loss service. Most people had a face-to-face consultation, and a supply was made via a PSD if appropriate. There was a set of screening questions that the person

answered before the pharmacist would undertake a weight check to work out the BMI. The consultation covered all the key information and records of BMI were documented. People had to have a BMI of above 30 to qualify for the various weight loss treatments. People were also able to access the weight loss service through the website. People completed an online questionnaire. The information from the online questionnaire for weight loss was comprehensive and covered the main points to help inform the PIP before making a prescribing decision. Completed questionnaires were reviewed by the PIP before the PIP decided if the person was suitable for the treatment. And they checked information, including weight, on the person's Summary Care Record (SCR). The PIP used their own professional judgement when prescribing. The PIP verified the majority of peoples weight via a video consultation with the person standing on the scale. The PIP explained some patients also uploaded evidence of their weight via photographic evidence. Examples were seen where orders had been rejected such as a person requesting weight loss medicine which was not appropriate.

The pharmacy offered a 'hay fever injections' service which was advertised on the website and in the pharmacy. This service was provided via a PSD and the questions covered all the key points. Records seen indicated that people were advised when they were given a medicine for an off-label use.

The RP verbally explained that the pharmacy did not use an external company to confirm the identity of people using the online service for weight loss medicines, but the PIP checked the age and identity of people by asking to see their passport or driving license. This was uploaded via the website or checked via a video consultation. If the pharmacy was not able to verify the person's identity or age the order was refunded. The pharmacy made a record to show that it had made this check.

The pharmacy asked people to give consent for their regular GP to be informed about the treatment they were receiving. On the records seen everyone had given consent and the PIP subsequently confirmed that everyone who accessed the services had given their consent. The PIP stated that if a person gave consent, the pharmacy would send information to the GP via post about the medicines it had supplied. At the follow up visit the PIP said that the system generated a template ready to print out to send to the GP. And showed letters waiting to be posted of consultations that had occurred on the day of the inspection. But the PIP could not show evidence the pharmacy had posted historical letters. The PIP explained that a person would very rarely not give consent to share information with their GP but in the event they did, the PIP would make a risk-based assessment and document justification for any supply made.

The pharmacy used a dispensing audit trail which included use of 'dispensed by' and 'checked by' boxes on the medicine label to help identify who had done each task. Baskets were used to keep medicines and prescriptions for different people separate to reduce the risk of error. The pharmacy supplied medicines in multi-compartment compliance packs to people living in the community to help them take their medicines at the right time. The pharmacy spread the workload for preparing these packs across the month, using a tracker to make sure packs were prepared and supplied on time. Compliance packs seen included medicine descriptions on the packs to make it easier for people to identify individual medicines in their packs. The pharmacy was not routinely supplying patient information leaflets. The pharmacy manager said they would start supplying them. The pharmacy team knew the advice about pregnancy prevention that should be given to people in the at-risk group who took sodium valproate.

Stock medicines were stored on shelves in their original containers, some of the containers were stored a little untidily. Opened bottles of liquid medications were marked with the date of opening so that the team would know if they were still suitable for use. The pharmacy manager explained the process for date checking medicines; A check of a small number of medicines did not find any that were out of date. CDs were stored appropriately. A record of invoices showed that medication was obtained from

licensed wholesalers. Aesthetic products were obtained from reputable sources and stored appropriately. The pharmacy had a process for managing drug alerts which included a record of the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. The pharmacy maintains its equipment and facilities adequately.

Inspector's evidence

The pharmacy used suitable measures for measuring liquids. The pharmacy had up-to-date reference sources. The pharmacy team checked fridge temperatures daily to make sure medicines were stored within the required range of 2 and 8 degrees Celsius. The pharmacy's portable electronic appliances looked in reasonable condition but had not recently had a portable appliance test.

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.