General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peak Pharmacy, 36 Abel Street, BURNLEY, Lancashire, BB10 1QR

Pharmacy reference: 1033301

Type of pharmacy: Community

Date of inspection: 26/06/2019

Pharmacy context

This is a community pharmacy in a residential area of Burnley, Lancashire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including medicines use reviews (MURs), flu vaccinations, a substance misuse service and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living 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 suitable processes and written procedures to protect the safety and wellbeing of people who access its services. It mostly keeps the records it must have by law and keeps people's private information safe. It is well equipped to protect the welfare of vulnerable adults and children. The pharmacy team members try to learn from any errors they make while dispensing. And they take steps to make sure the errors are not repeated.

Inspector's evidence

The pharmacy had an open plan retail area which led directly into the dispensary. It had a private consultation room to the side of the retail counter. The pharmacist used the bench closest to the retail counter to do final checks on prescriptions. This helped her supervise and oversee sales of over-the-counter medicines and conversations between team members and people.

The pharmacy had a set of standard operating procedures (SOPs). These were kept in a ring binder. An index was available which made it easy to find a specific SOP. The SOPs covered various pharmacy processes. For example, taking in prescriptions, dispensing and the supply of medicines in multi-compartmental compliance packs. The SOPs were prepared by the company's assistant superintendent pharmacist in October 2017 and were due for review in October 2019. All the team members had read and signed the SOPs that were relevant to their role within the last twelve months. The pharmacy defined the roles of the pharmacy team members in each SOP. The SOP showed who was responsible for performing each task. The team members said they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacy had a process to report and record near miss errors that were spotted during dispensing. The final checker typically spotted the error and then informed the dispenser that they had made an error. The team members then discussed why the error had happened. The dispenser made a record of the error into a near miss log. The records contained details such as the date of the error and the team members involved. But the team did not record the time of the error or the reason why the error may have had happened. And so, they may have missed out some learning opportunities. Every month, the pharmacist formally analysed the near miss log to check for any patterns or common trends. The findings were documented. So, the team members could read them whenever they wished. The pharmacy used a similar process to record and report dispensing incidents. These types of incidents were rare. The pharmacy recorded such incidents electronically and kept the records for future reference. The records were also sent to the company head office for analysis.

The pharmacy had a leaflet which advertised how people could make comments, suggestions and complaints. The leaflet was available for people to self-select. The pharmacy completed a feedback survey each year. It asked people who visited the pharmacy to complete a questionnaire. But the team members were unsure of the results of the latest survey. And so, they may have missed the opportunity to improve the pharmacy's services.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept electronic controlled drugs

(CDs) registers. They were in order including completed headers, and entries made in chronological order. The team members said the running balances were checked every fortnight by the pharmacy's accuracy checking technician (ACT). But they could not access the records of the checks or the register for patient returned CDs, in the ACT's absence. The running balance of MST 10mg tablets was checked and it matched the physical stock. It also kept complete records of supplies from private prescriptions and emergency supplies. The pharmacy kept the certificates of conformity of special supplies. But they were not completed correctly as required by the Medicines and Healthcare products Regulatory Agency (MHRA).

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. The pharmacy explained how they stored and protected people's information in the pharmacy practice leaflet. The team members understood the importance of keeping people's information secure. An information governance policy was in place.

The regular pharmacist and the ACT had completed training via the Centre for Pharmacy Postgraduate Education on safeguarding the welfare of vulnerable people. A SOP on safeguarding was in place. The SOP contained a flow chart to help the team raise and manage a potential concern. All the team members had read and signed the SOP. The pharmacy kept a list of the key local safeguarding contacts on a computer terminal. The team members gave several examples of symptoms that would raise their concerns. And they said they would discuss their concerns with the pharmacist on duty, at the earliest opportunity.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to manage the services it provides. The team members complete training when they can, to ensure their knowledge and skills are refreshed and up to date. They can tailor their training to help them achieve personal goals. And they feel comfortable to raise professional concerns when necessary.

Inspector's evidence

The pharmacist on duty at the time of the inspection was also the pharmacy manager. She worked two days a week. Regular locum pharmacists covered the other three days. The pharmacist was supported by two qualified pharmacy assistants, a trainee pharmacy assistant and an ACT. The pharmacist felt she had a suitable number of team members to manage the dispensing workload. She said this was reflected in the relatively short time people had to wait for their prescriptions to be dispensed. The team members did not take time off in the few weeks before Christmas. As this was the pharmacy's busiest period. The pharmacy could call on the help of a locum pharmacy technician to cover planned and unplanned absences.

The pharmacist on duty supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members accurately described the tasks that they could and could not perform in the pharmacist's absence.

The pharmacy did not provide its team members with a structured process for them to keep their knowledge and skills up to date. But it encouraged them to read literature about pharmacy services and products the pharmacy received in the post. This helped them ensure they provided correct and relevant advice to people. The pharmacy occasionally provided the team with mandatory training modules to complete. The team members had recently completed training on children's oral health. The pharmacy kept records of each team members completed training. The trainee pharmacy technician received two to three hours a week of training time. The trainee said she could tailor her training to meet her needs. For example, she recently asked for additional training on using the 'drug tariff' book. The pharmacy provided her with one-to-one support from colleagues to help her achieve her goal.

The team held monthly formal meetings and discussed topics such as company news, targets and patient safety. If a team member was not present during the discussions, they were brought up to speed the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. The team recently discussed medicines that looked or sounded alike (LASAs). The team said that these medicines were more likely to be involved in errors. The team displayed a list of LASAs on a wall. Examples included, amlodipine and amitriptyline, atenolol and allopurinol, azathioprine and azithromycin, and carbamazepine and carbimazole. The team members had also separated these items on the dispensary shelves to reduce the risk of mixing them up.

The pharmacy supported its team members with a performance appraisal every year. The appraisals were an opportunity for the team members to discuss what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. They were also able to give feedback on how to improve the pharmacy's services. And discuss their personal development. The team members said they were able to discuss any professional concerns with the pharmacist or with the company head office. The pharmacy had a whistleblowing policy. So, the team could raise a concern anonymously. The pharmacy set several targets for its team to achieve. These included services and prescription volume. The team members said the targets were reasonable and achievable. But they were not under any pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and suitably maintained. It has a sound-proof room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was clean and portrayed a highly professional image. The benches in the dispensary were kept tidy throughout the inspection. Floor spaces were clear with no trip hazards evident. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. But it was not signposted. And so, people may not know there was a room available for them to have private conversations with the team. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides an appropriate range of services to help people meet their health needs. It generally stores, sources and manages its medicines safely. But the team members don't always act promptly when they discover the fridge temperature is outside the correct range. The team members help people to safely take their high-risk medicines. And they generally manage the risks associated with dispensing medicines in multi-compartmental compliance packs.

Inspector's evidence

There was step-free access into the pharmacy. The pharmacy advertised its services and opening hours near the entrance. It also displayed contact details of other pharmacies in the local area. Seating was provided for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. A wide range of healthcare related leaflets were available for people to select and take away. The pharmacy served a high south Asian population. And the pharmacist was fluent in many south Asian languages and was observed helping people in these languages. The pharmacy was a healthy living pharmacy and engaged in various campaigns promoting healthy living. Two team members had recently visited a local school and promoted oral health.

The team members regularly used various stickers during the dispensing process that they could then use as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were available to hold prescriptions and medicines. This helped the team stop people’s prescriptions from getting mixed up. The team didn't have a robust process to highlight the expiry date of CD prescriptions awaiting collection in the retrieval area. So, there was a risk of supplying CDs, that were not stored in the CD cabinet, after the prescription's expiry date. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the owing the next day.

The pharmacy kept records of the delivery of medicines from the pharmacy to people at home. The records included a signature of receipt. And so, an there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy often dispensed high-risk medicines for people such as warfarin. The pharmacist often gave the person additional advice if there was a need to do so. But details of these conversations were not recorded on people’s medication records. So, the pharmacy could not demonstrate how often these checks took place. INR levels were not always assessed in the pharmacy. The team were aware of the pregnancy prevention programme for people who were prescribed valproate. The team said they were aware of the risks. And they demonstrated the advice they would give people in a hypothetical

situation. The team had access to literature about the programme that they could provide to people to help them take their medicines safely. The team did a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. The check identified two people. These people were contacted and given the appropriate advice.

The pharmacy supplied medicines in multi-compartmental compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance, so they had ample time to manage any queries. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The team members recorded details of any changes, such as dosage increases and decreases, on the master sheets. They dispensed the packs on a bench at the back of the dispensary. This was to make sure they weren't distracted while dispensing. The packs had backing sheets with dispensing labels attached. And these contained information to help people visually identify the medicines. The team did not routinely provide patient information leaflets with the packs. And so, people may not receive important information about their medicines. This is not in line with legal requirements.

Pharmacy only medicines were stored behind the pharmacy counter. The storage arrangement prevented people from self-selecting these medicines. The pharmacy had a date checking schedule to be completed each month. But they did not keep records of the checks. And so, it may be difficult to monitor the progress of the process. The pharmacy used stickers to highlight short-dated stock. The last check the team had completed was in January 2019. Some short-dated stickers were seen on the dispensary shelves. And no out-of-date stock was found during a random check. The team members recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received training on how to follow the directive. The pharmacy had FMD software and scanners installed. The team was unsure of when they were to start following the directive.

The pharmacy used digital thermometers to record fridge temperatures each day. A sample of the records were looked at. But the sample showed the maximum temperature had been outside of the accepted range for a month prior to the inspection. The implications of this were discussed with the team. After the inspection the pharmacist contacted the inspector and confirmed that the problem had been rectified. The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is clean and safe, and the pharmacy uses it appropriately to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource.

The pharmacy used a range of CE quality marked measuring cylinders. The team members used tweezers and rollers to help them dispense multi-compartmental compliance packs. The fridge used to store medicines was of an appropriate size. And the medicines inside were organised in an orderly manner. All the electrical equipment looked in good condition and was working.

Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones. And the team members went to a private area of the pharmacy to have conversations with people 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.