General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peak Pharmacy, 85-87 Moston Lane East, New Moston, MANCHESTER, Lancashire, M40 3GP

Pharmacy reference: 1033563

Type of pharmacy: Community

Date of inspection: 06/08/2024

Pharmacy context

This community pharmacy is located near to a GP surgery. It is situated in a residential area of Oldham, Greater Manchester. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including the NHS Pharmacy First service and emergency hormonal contraception. The pharmacy supplies medicines in multi-compartment compliance packs to some people to help them take their medicines at the right time.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	2.2	Standard not met	The pharmacy does not always make sure its team members have the appropriate training for their role.
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 safely and effectively. The pharmacy keeps the records it needs to by law. And members of the team are given training so that they know how to keep private information safe. They discuss when things go wrong to help identify learning opportunities. But they do not always make a record of the actions they take to help improve the service they provide, which would help them demonstrate how they reflect on mistakes.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which were issued in May 2021, but they were overdue their stated date of review of May 2023. Head office had sent a new set of SOPs for members of the team to read but they were yet to complete this. So there was a risk that the updated written procedures weren't always being followed. The pharmacist confirmed they would prioritise the team reading and signing of the updated SOPs.

The pharmacy had systems in place to record and investigate dispensing errors, and the subsequent learning outcomes. Each member of the team had their own paper log to record near miss incidents. The pharmacist reviewed the logs each month to look for common trends. But there was no formal analysis of the records to identify underlying trends. Any learning points the pharmacist had identified were shared with members of the team. For example, they had recently discussed the different types of insulin devices and formulations available, so the team had a greater understanding about them. But details of learning were not recorded. So the pharmacy may not be able to always show how it identifies learning to improve.

The roles and responsibilities for members of the pharmacy team were described in individual SOPs. A dispenser was able to explain what their responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. The correct responsible pharmacist (RP) had their notice on display. The pharmacy had a complaints procedure. But details about it were not on display which would help to encourage people to provide feedback. Any complaints were recorded and followed up. A current certificate of professional indemnity insurance was available.

Records for the RP, and private prescriptions appeared to be in order. Controlled drugs (CDs) registers were maintained with running balances recorded and checked frequently. Two random balances were checked, and both were found to be accurate. Patient returned CDs were recorded.

An information governance (IG) policy was available. The pharmacy team had completed GDPR training. When questioned, a dispenser was able to explain how confidential information was separated into waste bags which were removed by head office for destruction. Safeguarding procedures were available and had been read by members of the team. The pharmacist had completed level 2 safeguarding training. Contact details for the local safeguarding board were available. A dispenser said they would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy does not always make sure all of its team members have the appropriate training for their role. So they may not have the correct skills and knowledge to complete the tasks they are assigned to do. There are enough members of the team to manage the workload and they understand their responsibilities. They complete additional training to help them keep their knowledge up to date. But this is not structured so learning needs may not always be identified or addressed.

Inspector's evidence

The pharmacy team included a pharmacist, six dispensers, a medicines counter assistant (MCA), and a delivery driver. There were also two team members whose role was to help manage the pharmacy's stock levels. They had read the SOPs and were trained in their job roles. But they had not been enrolled onto an appropriate training course. So they may not have the necessary underpinning knowledge required for their role. The volume of work appeared to be manageable. Staffing levels were maintained by part-time staff and a staggered holiday system.

Members of the pharmacy team completed some additional training, for example they had recently completed a training pack about children's dental health. Training records were kept showing what training had been completed. But ongoing training was not provided in a consistent manner. So learning needs may not always be fully addressed and members of the team may not be able to demonstrate how they keep their skills and knowledge up to date.

The MCA was seen selling a pharmacy only medicine using the WWHAM questioning technique. And members of the team provided examples about refusing sales of medicines they felt were inappropriate and referred people to the pharmacist if needed. The pharmacist was seen to use their professional judgement, and this was respected by members of the team. The dispenser felt well supported by the pharmacy manager, and they felt the team worked well together. Appraisals were usually conducted once every three months. Members of the team were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the manager or head office. The pharmacist was not set targets for professional 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 tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. People were not able to view any patient sensitive information due to the position of the dispensary. The temperature was controlled using air conditioning units and lighting was sufficient. Team members had access to a kitchenette area and WC facilities.

A consultation room was available. It contained a computer, desk, seating, adequate lighting, and a wash basin. But the room was cluttered with files and folders which detracted from the image expected of a healthcare setting. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them safely. 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 check that the medicines are still suitable or give people advice about taking them.

Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was also wheelchair access to the consultation room. Various posters advertised the services offered and information was also available on the website. The pharmacy opening hours were displayed and a range of leaflets provided information about various healthcare topics.

The pharmacy team initialled 'dispensed-by' and 'checked-by boxes' on dispensing labels to help show who was involved in the dispensing process. They used baskets to separate individual patients' prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing. Owing slips were used to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were kept on a shelf using an alphanumerical retrieval system. Prescription forms were retained, and 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 pharmacy's computer software alerted them when prescriptions were due to expire, and these were removed from the collection shelves. The team provided counselling advice to people when it was requested, but there was no process to routinely identify people taking higher-risk medicines (such as warfarin, lithium, and methotrexate). So, team members may not remember to discuss these medicines to help make sure they remained suitable and safe to use. Members of the team were aware of the risks associated with the use of valproate containing medicines during pregnancy. Educational material was supplied. Team members were not aware of any current patients who met the risk criteria.

Some medicines were dispensed in multi-compartment compliance packs. Before a person was started on a compliance pack the pharmacy would complete an assessment about their suitability. But details about this was not recorded, which would be a useful record in the event of a query or a concern. A record sheet was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record sheet was updated. Hospital discharge information was sought, and previous records were retained for future reference. The compliance packs were labelled with descriptions of the medications enclosed. But patient information leaflets (PILs) were not routinely supplied. So people may not always have up to date information about how to take their medicines.

The pharmacy had a delivery service, and records of deliveries 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 could be sourced from a specials manufacturer, but the team had not needed to for some time. Expiry dates of medicines were checked every two-to-three-months. A record was kept showing when a section of the dispensary had been date checked. Any short-dated stock was highlighted using a sticker and liquid medication generally had the date of opening written on. Controlled drugs were stored appropriately in the CD cabinet, with clear separation between current stock, patient returns and out of date stock. There were three clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had remained in the required range for the last three months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the MHRA. The pharmacy manager shared details of the alert with members of the team. But the records could not be found. So the pharmacy may not be able to always show they had acted appropriately in response to medicine recalls.

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 maintain the equipment so that it is safe to use.

Inspector's evidence

Team members accessed the internet for general information. This included 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 including a designated tablet counting triangle for cytotoxic medication. Equipment was kept clean.

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. The consultation room was used appropriately. People were offered its use when requesting advice or when counselling was required.

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.