General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peak Pharmacy, 5- 6 Concourse Way, Parr, ST. HELENS, Merseyside, WA9 3QW

Pharmacy reference: 1034698

Type of pharmacy: Community

Date of inspection: 09/02/2024

Pharmacy context

The pharmacy is located in a residential area of St Helens. The pharmacy dispenses NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines. It also provides a minor ailments service, the Pharmacy First service and a blood pressure check service.

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 generally identifies and manages the risks associated with the services it is providing. It keeps the records it is required to by law. The pharmacy records mistakes that happen during the dispensing process. It uses this information to help make its services safer and help reduce any future risk. Team members work to written procedures to help provide the pharmacy's services safely. But some standard operating procedures have not been reviewed for some time, which may mean that the information contained in them is not current.

Inspector's evidence

Standard operating procedures (SOPs) were available. Hardcopies were available at the pharmacy but there was no indication on these as to when they had last been updated. Some SOPs were also available electronically. The supervisor thought that all SOPs were available electronically but could not locate them. Members of the team were currently reading the SOPs for the new Pharmacy First service which had just been launched. Following the inspection, the area manager confirmed that a full set of SOPs were available electronically. SOPs were issued by head office, and then reviewed by the pharmacy manager locally. However, as there had not been a pharmacy manager in post since approximately 2020, a review had not been completed. The area manager provided an assurance to visit the pharmacy within the next few weeks following the inspection and review the SOPs.

Dispensing mistakes which were identified before a medicine was supplied to people (near misses) were highlighted to the team member involved in the dispensing process and recorded in a near miss log. At the end of each month all completed logs were sent to head office. But there were no recent logs available. The team confirmed there had not been any near misses in February. Steps were taken if any common trends or patterns were spotted. In the past, team members had separated olanzapine and shelf edge warnings were also stuck on the dispensing shelves to help raise awareness when assembling prescriptions. Medicines which looked or sounded alike were also highlighted with warning labels. Any instances where a dispensing mistake had happened, and the medicine had been supplied (dispensing errors) it was investigated and recorded. Information was sent to head office. The head office team contacted the pharmacy to discuss what had happened and next steps. As a result of a recent error in which the wrong strength of gabapentin was dispensed and was taken by the patient; the pharmacy had separated gabapentin on the shelves and the higher strength was also placed separately. The incident had occurred when there had been issues with the staffing levels.

A correct Responsible Pharmacist (RP) notice was displayed. When questioned, team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. A complaints procedure was in place and team members tried to resolve complaints in the pharmacy where possible. Any matters which could not be resolved were escalated to head office.

Private prescription records, emergency supply records, RP records and controlled drug (CD) registers were well maintained. Team members said unlicensed medicines were infrequently dispensed, they were able to describe the records they would keep when these medicines were supplied. Running balances for CDs were recorded and regularly checked against physical stock held in the pharmacy. A random balance was checked and found to be correct. CDs that people had returned to the pharmacy

were recorded in a register and appropriately destroyed.

Assembled prescriptions, which were ready to collect, were stored in the dispensary and not visible to people using the pharmacy. The pharmacy had an information governance policy available, and its team members had been briefed about it. The pharmacy separated confidential waste which was then sent to head office for destruction. Pharmacists had access to summary care records (SCR) and obtained verbal consent from people before accessing it.

All team members had completed safeguarding training. Team members were able to show where the numbers for the safeguarding contacts were displayed in the dispensary and consultation room. When questioned, team members were able to explain the signs to look out for which may indicate a safeguarding concern. They had made referrals to the local safeguarding boards for a few incidents over the past few years.

Principle 2 - Staffing ✔ Standards met

Summary findings

Members of the team work well together. They have the right training for their roles and are provided with ongoing training as new services are introduced . The pharmacy has an adequate number of staff to safely manage its workload.

Inspector's evidence

The pharmacy did not have a regular store-based pharmacist since 2020. Pharmacist cover was arranged by head office and they sent regular locum pharmacists when possible. All locum pharmacists had electronically signed the SOPs and Patient Group Directions (PGDs) documents. A record of this was kept by the SI. The remainder of the team comprised of five trained dispensers, a supervisor who was also a trained dispenser, an apprentice and two medicines counter assistants (MCAs). One of the MCAs was on long term leave. The supervisor felt that there were an adequate number of staff. The supervisor explained that the pharmacy was short staffed before they had recently recruited additional team members. The team were observed working effectively together and were up to date with the workload.

Team members asked appropriate questions and counselled people before recommending over-the-counter medicines. They were aware of the maximum quantities of medicines that could be sold over the counter and would refer to the RP if they were unsure.

As there had not been a pharmacy manager for some time, staff performance was managed informally by the supervisor. She briefed the team on what tasks needed to be completed, on new services as well as any targets.

To keep up to date all team members completed ongoing learning electronically. The team received emails from head office which contained information on the modules which needed to be completed. Team members were provided with time during working hours to complete additional learning. The apprentice attended a virtual training session one day week and had allocated time three days per week to complete his training.

Meetings had been held in the past when team members felt that they needed to have a team discussion or if the supervisor needed to brief the team or discuss any issues. Team members felt that they were able to raise concerns and give feedback to the area manager. The area manager visited the pharmacy a few times a month, to see how the team were managing, to address any issues or concerns and provide feedback.

The pharmacy received emails from head office every Monday which contained updates to brief its team members. this was printed and signed by the team after they had read the bulletin. Head office set targets for the services provided by the pharmacy, the supervisor explained that the team were doing well in providing services and had regular discussions about how they could improve. Team members confirmed that there was no pressure to meet the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are secure, and they are suitable for the services the pharmacy provides. People can have a private conversation with its team members.

Inspector's evidence

The pharmacy was clean, tidy, and organised. The dispensary had ample workspace which was allocated for specific tasks. A separate room was used to manage and prepare the multi-compartment compliance packs. A clean sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by members of the team.

The room temperature and lighting were appropriate. The premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for private conversations; people were not left unaccompanied within the room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from licensed sources and largely stores them properly. It generally manages and delivers its services safely and effectively and makes its services accessible to people. Team members carry out appropriate checks on people who are taking higher risk medicines and provide them with the relevant information so they can take their medicines safely.

Inspector's evidence

The pharmacy was all on one level and was easily accessible from the street. The shop floor was clear of any trip hazards and the retail area was easily accessible. Team members assisted people who needed help entering the pharmacy and the pharmacy provided a medicine delivery service. When it was necessary, the pharmacy team used the internet to find out the details of local services so that they could signpost people who needed services that the pharmacy did not provide. People who did not speak English were provided with an information label that they could hand in when they collected their medicines. And team members asked if there was anyone in the family who spoke English to help with translation if needed.

Team members felt the New Medicine Service (NMS) and Discharge Medicines Service (DMS) had a positive impact on the local population. The NMS allowed for the pharmacists to keep in contact with people when they started a new medicine and, in some cases, had resulted in referrals being made following people experiencing side-effects. Through the DMS, missing medicines were often picked up on new prescriptions issued by the prescriber and were resolved by the team without causing issues to the person being supplied the medicines.

Prescriptions were mainly received electronically. Any acute prescriptions were identified and separated, and the rest were placed in baskets in date order. Prescriptions were dispensed by one of the dispensers and left for the RP to check. 'Dispensed by' and 'checked by' boxes were routinely signed on dispensing labels, to create an audit trail showing who had carried out each of these tasks. Baskets were used to separate prescriptions, preventing the transfer of medicines between different people.

Team members were aware that the original pack of sodium valproate could not be split and made sure warnings were not covered when attaching the dispensing label. The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP). The pharmacy had completed an audit for sodium valproate and a pharmacist had spoken to people who had fallen in the at-risk group. More recently the team had corresponded with the surgery and had the prescription changed for someone who previously had their sodium valproate dispensed with their weekly multi-compartment compliance packs; so that they could dispense the medication in its original pack.

Additional checks were carried out when people were supplied with medicines which required ongoing monitoring. A second check was obtained when anticoagulants were dispensed, and the blood test results were checked at the point of handout. Similarly for people taking medicines such as Lithium team members checked if they were having regular monitoring and blood tests. The pharmacy had a range of warning cards and labels for specific medicines which were supplied to people.

The pharmacy supplied medicines in multi-compartment compliance packs to support people in taking

their medicines. There was an individual record sheet for each person on the service which had a list of all their current medication. Prescriptions were ordered by the pharmacy, a dispenser called and confirmed what medicines people needed before doing this. In the event where someone could not be contacted after a few attempts, the surgery was contacted. The pharmacy received information when people were admitted into hospital and as part of the Discharge Medicines Service also received information of any changes. Assembled packs included details of the medicines and instructions about how to take them. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the pack. And they provided people with patient information leaflets about their medicines each month.

Deliveries were carried out by one of the dispensers, who was also the delivery driver. Signatures were obtained when medicines were delivered, and the driver annotated the record with the time and date of delivery. In the event that someone was not home, medicines were returned to the pharmacy. Deliveries were usually booked in with people and they were given a time and date for when their medication was due to be delivered.

Medicines were obtained from licensed wholesalers and were stored appropriately. Fridge temperatures were monitored daily and recorded; the actual temperature was within the required range for the storage of cold chain medicines at the time of the inspection. From the records, it was seen that the maximum temperature was frequently recorded as 9 degrees Celsius. The supervisor explained that a engineer had come and changed the door handle, but hadn't made a difference to the fridge temperature and so she reported it to head office and requested for the fridge to be checked or replaced. CDs were kept securely.

Expiry dates were checked routinely and no date expired medicines were found on the shelves. Short dated stock was marked with red stickers. Previously one of the MCAs helped with date checking in the dispensary. This could mean some medicine stock may not be checked properly as they did not meet the minimum training requirements needed for support staff. The supervisor provided an assurance that in future all date checking in the dispensary would be completed by the dispensers. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. Drug recalls were received from head office by email. Once actioned the team notified head office.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services safely. And its team members uses them in a way to keep people's private information safe.

Inspector's evidence

The pharmacy had calibrated glass measures and tablet counting equipment. Equipment was clean and ready for use. A medical fridge was available. A blood pressure monitor was available and used for some of the services provided; the pharmacy also had an ambulatory blood pressure monitor. The supervisor was unsure of what the arrangements were for calibration and provided an assurance that she would check with the head office team. Up-to-date reference sources were available. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. A cordless telephone was also available to ensure conversations could not be overheard.

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.