General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peak Pharmacy, 18 Westdale Lane, Carlton, NOTTINGHAM, Nottinghamshire, NG4 3JA

Pharmacy reference: 1035754

Type of pharmacy: Community

Date of inspection: 04/09/2024

Pharmacy context

The pharmacy is in the Nottinghamshire town of Carlton. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing NHS consultation services to people. These include the Pharmacy First service, New Medicine Service, Blood Pressure Check service and Contraception Service. The pharmacy also provides a seasonal flu vaccination service. And it dispenses some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines.

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 suitably identifies and manages the risks for providing its services. It keeps people's confidential information secure. And it generally keeps its records as required by law. Pharmacy team members act appropriately when receiving feedback and managing concerns about the pharmacy. And they take the opportunity to escalate feedback when a situation requires this. Team members act with care to help keep vulnerable people safe. They regularly share learning following the mistakes they make during the dispensing process, and they apply timely changes to reduce the risk of similar mistakes occurring.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support its safe and effective running. A sample of SOPs found new SOPs had been introduced to support the implementation of new services, but some SOPs had not been reviewed for more than two years. Pharmacy team members accessed the SOPs electronically. They were knowledgeable about their roles and demonstrated how they worked safely when completing tasks. A team member discussed what tasks could not take place if the responsible pharmacist (RP) took absence from the pharmacy. The pharmacy employed a pharmacy technician working in an accuracy checking role (ACPT). The ACPT discussed their role and the importance of ensuring a clinical check of prescriptions by a pharmacist was recorded prior to them undertaking the final accuracy check of a medicine.

The pharmacy had a process for reporting mistakes identified and corrected during the dispensing process, known as near misses. This process involved feedback from the accuracy checker, recording the mistake and engaging in discussions to identify actions required to reduce the risk of similar mistakes occurring. Team members felt they recorded most of their near misses and they demonstrated how they acted to reduce risk by separating similar sounding medicines on the dispensary shelves following trends in near misses being identified. The pharmacy had a formal process for reporting mistakes made and identified following the supply of a medicine to a person, known as dispensing incidents. This process included submission of a dispensing incident report to the pharmacy's superintendent pharmacist (SI). Evidence of incident reporting was available and team members identified how they shared learning from incidents and reviewed their own practice to help reduce the risk of repeated mistakes.

The pharmacy had a complaints procedure. Its team members knew how to respond to feedback and concerns from people. They were busy throughout the inspection managing concerns about a new delivery process which had seen medicine deliveries previously made by the pharmacy, sent to a local area delivery hub prior to the delivery taking place. Team members were working hard to function as a liaison between people and the hub due to people reporting they were having difficulties contacting the hub. Team members were attentive to people's needs when managing the feedback and they escalated reports of medicines not being delivered to the pharmacy's area manager during the inspection. Pharmacy team members completed learning to support them in identifying concerns about vulnerable people. They understood how to report these concerns and provided examples of liaising with other healthcare organisations to support people in taking their medicines safely. The pharmacy had a safeguarding procedure and information for local safeguarding teams was accessible to its team

members.

The pharmacy held personal identifiable information in the staff-only area of the premises and on password protected computers. Team members engaged in mandatory data security learning and demonstrated how they worked to keep people's confidential information secure. The team separated confidential waste and it disposed of this securely. The pharmacy had current professional indemnity insurance. The RP notice displayed had the correct details of the RP on duty. And the RP record was generally completed in full; several records did not have the sign-out times of the RP. Some entries in the private prescription register did not include the correct details of the prescriber and the correct date the prescription was written. Records of unlicensed medicines were held with full details of who the medicine had been supplied to. The pharmacy maintained running balances in its electronic controlled drug (CD) register. Entries in the register complied with legal requirements. The team completed regular full balance checks of stock against the CD register. Random physical balance checks conducted during the inspection matched the running balances in the register. The team recorded patient-returned CDs in a register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs a team of suitably skilled and knowledgeable team members to provide its services. Pharmacy team members engage in regular learning relevant to their role. They take opportunities to share information with each other. And they feel empowered to provide feedback and raise concerns at work. They work together well and are supportive of each other. But they are under some recent workload pressures following the closure of another local pharmacy and changes to the business outside of their control.

Inspector's evidence

The RP was a regular pharmacist who worked one day a week at the pharmacy to cover the pharmacist manager's day off. They were working alongside the ACPT, two dispensers and a medicine counter assistant. The pharmacy also employed another medicine counter assistant and two other dispensers. One of the dispensers worked part of their week supporting other company-owned pharmacies in a relief role. The pharmacy was in the process of reviewing its staffing levels and skill mix due to a team member leaving the pharmacy recently and some changes to the services provided being implemented. Team members reported that they worked flexibly to support the safe running of the pharmacy, and this was observed as one of the dispensers was working additional hours to support the team in completing some stock management tasks. The team was running slightly behind with work. Team members reported that this was due to some workload not being cleared when the regular pharmacist had been on leave the week prior to the inspection. They felt workload had increased following the recent closure of a nearby community pharmacy. Team members were also observed having to break off dispensing tasks to look into queries being raised about the new delivery process. This was clearly causing pressure on the team, but team members were observed working well together and prioritising tasks to ensure people waiting received their medicines in a timely manner. The RP was required to intervene when the team discovered an urgent prescription had not been delivered the previous day.

Pharmacy team members completed ongoing learning relevant to their roles. They engaged in a formal appraisal process at work to support their learning and development. The pharmacy had a whistleblowing policy, and it advertised its employee assistance programme to its team members. It also displayed the company's vision statement in the dispensary for all team members to see. Pharmacy team members felt able to provide feedback and raise concerns at work. They felt confident in providing feedback to the pharmacy manager in the first instance. The pharmacy had some targets for its services. Team members on duty discussed how the manager balanced the delivery of consultation services alongside dispensary workload. And the RP on duty discussed how they applied their professional judgment when working. Team members engaged with each other through regular conversations during the working day about workload and patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and suitably maintained. It provides a professional environment for delivering healthcare services. People visiting the pharmacy can speak to team members in confidence in a private consultation room.

Inspector's evidence

The pharmacy was secure and maintained to an appropriate standard. Team members knew how to report maintenance concerns, there were no outstanding maintenance concerns awaiting action. The pharmacy was clean and generally tidy throughout. Some floor space within the dispensary was taken up with bags and boxes. The team explained these were bulky items such as dressings which were waiting to be collected. The team stored these to the side of the main walkway through the dispensary to help avoid the risk of them causing a trip hazard. Lighting was bright and heating arrangements were appropriate. Team members had access to appropriate hand washing facilities.

The public area was open plan and led to the medicine counter. The consultation room was a good size and provided a professional space for providing private consultation services. The team managed workspace in the dispensary effectively. For example, it used dedicated space in a quieter part of the dispensary to complete higher-risk tasks such as assembling medicines in multi-compartment compliance packs. The RP and ACPT had protected checking areas within the dispensary. The RP was able to observe activity in the public area from their checking station. A door leading off the back of the dispensary led to staff facilities and a storeroom.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible for people. It obtains its medicines from reputable sources, and it stores them appropriately. Pharmacy team members complete a range of audit trails to support them in managing any queries they receive about the pharmacy's services. They provide meaningful information to people when giving advice and supplying medicines to help people manage their medical conditions and take their medicines safely. And they make regular checks to ensure medicines are safe to supply to people.

Inspector's evidence

The pharmacy was accessed up a ramp from street level. It advertised details of its opening hours clearly for people to see. But its opening hours and the trading name of the pharmacy differed from those advertised on the NHS website which showed an old trading name for the pharmacy and indicated the pharmacy was closed for lunch. The pharmacy had a good amount of information leaflets available to provide to people accessing pharmacy services. This included information about the management of minor ailments treated through the Pharmacy First service. Pharmacists providing consultation services had access to supportive documents such as copies of patient group directions and service specifications. The RP had evidence of their personal training records and information readily available to support them in providing consultation services. Team members knew how to signpost a person to another pharmacy or healthcare professional when the pharmacy was unable to provide a service or supply a medicine.

The pharmacy protected Pharmacy (P) medicines from self-selection by displaying them behind the medicine counter. Team members understood the importance of monitoring requests for higher-risk P medicines liable to abuse. A team member demonstrated how the team monitored these requests to help inform the need to refer the request to the RP. Pharmacy team members had good knowledge of higher-risk medicines requiring ongoing monitoring. They demonstrated how these were highlighted on prescription forms to prompt extra care when dispensing. And to inform conversations with people when handing out these medicines, such as checks to ensure people were aware of adverse side effects of their medicine and were engaging in regular monitoring checks where required. But the team did not routinely record these types of verbal interventions to support continual care. The pharmacy team was aware of most of the requirements of the valproate Pregnancy Prevention Programme (PPP). A team member discussed how the pharmacy considered the risk of not supplying valproate in the manufacturer's original packaging in exceptional circumstances. But the pharmacy had not completed a formal risk assessment to support them in supplying valproate in this way when needed. The RP discussed how they would counsel people taking medicines that were subject to PPPs.

The pharmacy team used coloured baskets throughout the dispensing process. This helped to keep people's prescriptions separate and helped to manage workload priority. Pharmacy team members signed the 'dispensed by' and 'checked by' boxes on medicine labels to form a dispensing audit trail. The pharmacy team was observed providing patient information leaflets routinely when supplying medicines outside of their manufacturer's original packaging. It kept records of the medicines it owed to people. It made regular checks with wholesalers to support it in obtaining these medicines. And it informed people of long-term stock shortages and signposted them to their GP in order to review their

prescription to reduce the risk of them running out of medication. The pharmacy's process for managing its workload when supplying medicines in multi-compartment compliance packs included the use of a schedule. It used individual records to record people's medication regimens. And it held supportive information about the changes to people's medication regimens within the record. But on occasion team members used corrective fluid on the records, rather than clearly recording details of the change. A sample of assembled compliance packs found they were labelled with clear descriptions of the medicines inside.

The pharmacy sourced medicines from licensed wholesalers and a specials manufacturer. It stored medicines in their original packaging in an orderly manner. The pharmacy stored CDs in appropriately secure cabinets. Medicines were organised well inside the cabinets with separate areas used for holding assembled medicines, patient-returned medicines, and out-of-date medicines. The pharmacy kept medicines requiring cold storage in pharmaceutical fridges and medicines storage inside the fridges was orderly. Temperature records for the fridges showed they were operating within the required temperature range of two and eight degrees Celsius. The pharmacy recorded regular checks of the stock it held. These checks included reviewing the expiry date of medicines. It highlighted medicines with a short expiry date and it recorded the opening date on bottles of liquid medicines to help ensure any medicine left in the bottle remained safe to supply to people. A random check of dispensary stock found one expired medicine within stock, this was brought to the attention of the team and segregated for safe disposal. The pharmacy had medicine waste receptacles and CD denaturing kits available. It received medicine alerts by email and team members demonstrated how they checked alerts in a timely manner after receiving them.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. And its team members use the equipment and facilities appropriately to protect people's confidential information.

Inspector's evidence

Pharmacy team members had access to a number of reference resources whilst working, they had digital access to most of these. And they used NHS smartcards and passwords when accessing people's medication records. They moved out of ear shot of the public area when using the cordless phone. This helped to protect the caller's personal information. The pharmacy suitably protected information displayed on computer monitors from unauthorised view. And it held bags of assembled medicines within the staff-only area of the pharmacy. This arrangement meant people's confidential information on bag labels and prescription forms could not be viewed from the public area of the pharmacy.

Pharmacy team members used a range of clean counting and measuring equipment for liquids, tablets, and capsules. It had separate equipment for measuring and counting higher-risk medicines to mitigate any risk of cross-contamination between medicines. Team members reported that periodic safety checks of the pharmacy's equipment took place. Equipment to support the pharmacy's consultation services was stored in the consultation room. But some equipment, such as adrenaline supplies and ancillary equipment for vaccination services had expired. The team provided assurances that all equipment would be checked and replaced where needed prior to the seasonal vaccination service beginning. A discussion highlighted the need to ensure the consultation room was considered when conducting regular safety checks of stock held by the pharmacy.

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.