General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peak Pharmacy, 35 Plains Road, Mapperley, NOTTINGHAM, Nottinghamshire, NG3 5JU

Pharmacy reference: 1085170

Type of pharmacy: Community

Date of inspection: 02/01/2024

Pharmacy context

The pharmacy is on a main road in Mapperley, a suburb of Nottingham. Its main services include dispensing NHS prescriptions, selling over-the-counter medicines and providing information to people to support them in living healthy lives. It provides a number of NHS services including flu vaccines and advice and treatment for a range of minor illnesses through an extended care service. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it delivers medicines to people's 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

Overall, the pharmacy acts effectively to identify and manage risks associated with providing its services. It mostly keeps the records it needs to by law. And it responds well to the feedback it receives from people using its services. Pharmacy team members act openly and honestly by recording and discussing their mistakes. They understand how to recognise, and report concerns to help keep vulnerable people safe. And they keep people's confidential information secure.

Inspector's evidence

The pharmacy used standard operating procedures (SOPs) to define its working practices. But its current SOP folder contained multiple versions of SOPs, some of which were no longer relevant with implementation dates as far back as 2010. And the latest version of SOPs in the folder had not been reviewed in the last two years. The responsible pharmacist (RP) contacted the superintendent pharmacist's team to seek clarification about the latest version of SOPs available. These were stored on a secure communication platform accessible by all team members. But pharmacy team members had not read this latest version of the SOPs. The RP provided assurances that appropriate learning would take place to ensure all team members refreshed their understanding of the current SOPs. And a discussion highlighted the need to archive older versions of SOPs to avoid any confusion moving forward. Team members 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 RP took absence from the pharmacy. The RP had good supervision of tasks taking place at the medicine counter and in the dispensary. Team members 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 RP took absence from the pharmacy. The RP had good supervision of tasks taking place at the medicine counter and in the dispensary.

Pharmacy team members engaged in ongoing learning following the mistakes they made and identified during the dispensing process, known as near misses. This learning involved feedback from the RP, recording the mistake and engaging in ongoing discussions to identify actions required to reduce the risk of similar mistakes occurring. The team separated some stock medicines into baskets on the shelves. This prompted them to make additional checks during the dispensing process. A pharmacist had also created notices of common mistakes and displayed the notices at the assembly and checking stations to prompt additional checks of medicines at higher risk of being involved in a mistake. The pharmacy team followed a formal process of reporting mistakes identified following the supply of a medicine to a person, known as dispensing incidents to its superintendent pharmacist. The team had engaged in regular patient safety reviews up until June 2023. Records of these reviews showed clear learning and action points. The RP acknowledged that recently the team had not taken the opportunity to share its learnings through the structured patient safety review process. They explained this was due to an increase in pressure on the team due to staff sickness and workload increasing.

The pharmacy had a complaints procedure. Its team members understood how to respond to feedback and concerns from people. And they knew how to escalate a concern to either the RP or area manager if it could not be resolved locally. The team took onboard the feedback it received. For example, it had implemented a book to record details of retail items it ordered at a person's request. This helped to ensure all team members knew who the item was for and could retrieve it efficiently when a person

attended to collect it. The pharmacy had a safeguarding procedure and information for local safeguarding teams was accessible to its team members. Team members engaged in e-learning to support them in recognising and reporting safeguarding concerns. A team member explained how they would act to keep a person safe from harm in the event they required access to a safe space. Both regular pharmacists had completed relevant safeguarding learning to support them in their roles.

The pharmacy held most personal identifiable information in the staff-only area of the premises and on password protected computers. It held some completed prescriptions in a basket at the medicine counter. Care was taken to ensure no personal information was on view and this area was supervised at all times. Confidential waste was separated, and this was disposed of securely. The pharmacy had current 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. A sample of private prescription records seen generally complied with legal requirements. But some entries 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 as required. The pharmacy maintained running balances in its electronic controlled drug (CD) register and completed regular full balance checks of stock against the register. A random physical balance check conducted during the inspection complied with the running balance 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 has a team of people with the appropriate knowledge and skills to provide its services safely. It appropriately supports its trainee team members with their learning. Pharmacy team members engage in regular conversations to help manage workload and to minimise risk. They demonstrate enthusiasm for their roles. And they understand how to provide feedback and raise concerns at work.

Inspector's evidence

The RP was one of two pharmacist managers that split the working week between them. A relief dispenser, a trainee dispenser and a trainee medicine counter assistant were also on duty. The pharmacy also employed a dispenser, a medicine counter assistant, another trainee medicine counter assistant, and a delivery driver. One team member was currently on planned leave, and another was on unplanned leave. Some support from the relief team was available during periods of low staffing. The company set some targets associated with the delivery of NHS services. The RP enjoyed providing consultation services and clearly demonstrated how they used their professional judgment when providing these services.

The pharmacy had three team members in training roles. These team members were enrolled on GPhC accredited training courses. They were able to take time during quieter periods of the day to complete some learning for their courses. And those spoken to felt confident in seeking support from one of the managers. In addition to this mandatory learning all team members undertook periodic e-learning relevant to their roles. Team members had not had the opportunity to engage in a recent appraisal. The RP demonstrated how ‘colleague development handbooks’ had recently been provided to team members to support them in planning for an upcoming appraisal. Team members engaged with each other through regular conversations during the working day. They reported that the pharmacists led briefings to share patient safety information and to share information about changes to services. The pharmacy had a whistleblowing policy. It advertised details of its employee assistance programme to its team members. And team members were confident in sharing feedback with each other. They knew how they could escalate concerns if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and maintained to an appropriate standard. It offers a bright, clean, and professional environment for delivering its services. Team members work hard to manage dispensing services safely in the limited space available to them. People can speak with a pharmacy team member in a private consultation room.

Inspector's evidence

The pharmacy was secure and generally well maintained. Team members knew how to report maintenance concerns and had recently reported an issue with the guttering near to the main entrance of the pharmacy. The pharmacy was clean and relatively tidy throughout. Lighting was bright and heating arrangements were appropriate. The public area was open plan with the medicine counter on the side wall close to the consultation room. The consultation room was small with room for only one seat. The RP explained they would normally stand when providing consultations, such as administering flu vaccinations. But they were hopeful that a planned refit of the pharmacy would better utilise the available space in the room and make it more accessible to people.

The pharmacy's dispensing volume had increased in recent years. The dispensary was small for the level of activity taking place and there was little clear work bench space. The RP provided examples of how workload pressure increased during busier periods due to the space limitations. And this increased the risk of a mistake being made. This was in the process of being addressed by the owners, and the team had seen the plans for the re-fit which would see the size of the dispensary increase. Team members were observed working well in the available space. And provided examples of how they managed higher-risk tasks safely. Off the dispensary was a small stock room, staff kitchen and toilet facilities. Due to the space restrictions in the dispensary the team used the kitchen sink to support them in dispensing some medicines, such as antibiotic reconstitutions. A separate sink in the staff toilet was available for handwashing.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is accessible to people. It obtains its medicines from reputable sources. And it stores these medicines safely and securely. The pharmacy team engage people in conversations about their health and wellbeing. And they provide appropriate information when supplying medicines to help people take their medicines safely.

Inspector's evidence

The pharmacy had two entrances, both at street level. One entrance was from the street and the other from the public carpark at the back of the pharmacy. It advertised details of its opening hours clearly for people to see. But its opening hours differed from those advertised on the NHS website which showed the pharmacy closed for lunch. Team members promoted services through conversation and interactive displays. For example, a current health promotion display showed people how much sugar was in a range of fizzy drinks. 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. The team were vigilant of repeat requests for some P medicines that were subject to misuse. And the RP discussed how they managed these types of requests. The pharmacy team was aware of the requirements of the valproate Pregnancy Prevention Programme (PPP), and they knew about the recent legal change which required valproate to be dispensed in its original packaging. The RP discussed counselling that would be provided when supplying valproate. The most recent valproate audit had shown the pharmacy did not dispense valproate to people within the at-risk group. Pharmacists provided verbal counselling and advice to people when supplying medicines. They counselled people on the use of higher-risk medicines. But they did not record these conversations on the patient medication record (PMR) to support continual care. Pharmacists providing consultation services had access to current patient group directions (PGDs) and supportive information to support them in delivering these services safely. And the team benefitted from a positive relationship with local surgeries who regularly referred people to the pharmacy for support when appropriate.

The team kept each person’s prescription separate throughout the dispensing process by using baskets. It had audit trails for its delivery service and to support it in managing medicines it owed to people. It kept a record of the prescriptions it ordered on people’s behalf. Pharmacy team members signed the ‘dispensed by’ and ‘checked by’ boxes on medicine labels to form a dispensing audit trail. The pharmacy had a schedule to support it in managing workload when supplying medicines in multi-compartment compliance packs. It used individual records to record people’s medication regimens. And it updated these records with care following confirmation of changes to a person’s medication regimen. A sample of an assembled compliance pack found dispensing audit trails were used when supplying medicines in this way. And the pharmacy provided patient information leaflets for the medicines it supplied in the compliance packs.

The pharmacy sourced medicines from a licensed wholesaler and a specials manufacturer. It stored medicines in their original packaging in an orderly manner throughout the dispensary. The pharmacy stored CDs in appropriately secure cabinets. Medicines inside were held in an orderly manner. The

pharmacy kept medicines requiring cold storage in suitable fridges. Storage space for these medicines was at capacity. Temperature records for the fridges showed they were operating within the required temperature range. The pharmacy team reported completing regular date checks of stock medicines. But records of these checks were not available. A random check of dispensary stock found no out-of-date medicines. Stock bottles of liquid medicines were annotated with details of their opening dates. The pharmacy had medicine waste receptacles and CD denaturing kits available. But storage space for holding bags of medicine waste was limited and it was reported this could sometimes compromise space available in the small storeroom. The pharmacy received medicine alerts by email. Team members printed and annotated the alerts to show the action taken in response to them.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has a range of equipment to support its team members in providing its services safely. Pharmacy team members use the equipment in a way which protects people's confidentiality.

Inspector's evidence

The pharmacy used designated space to hold bags of assembled medicines waiting for collection and delivery. But this space was limited due to the size of the dispensary. This meant the team stored some sealed bags on the floor against the dispensary shelves. It took appropriate care to ensure these did not pose a trip hazard. The pharmacy's computer monitors were suitably protected from unauthorised view. Pharmacy team members used a cordless telephone handset. This allowed them to move out of earshot of the public area when discussing confidential information over the telephone. They had accessed digital reference resources whilst working. And they used NHS smartcards and passwords when accessing people's medication records.

Pharmacy team members used a range of clean counting and measuring equipment for liquids, tablets, and capsules. Equipment to support the pharmacy's consultation services was readily available. This included a blood pressure machine from a recognised manufacturer and appropriate equipment to support the emergency treatment of an anaphylactic reaction.

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.