General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peak Pharmacy, Turnpike House Medical Centre, 35 Newtown Road, Ronkswood, WORCESTER, Worcestershire, WR5 1HG

Pharmacy reference: 1091330

Type of pharmacy: Community

Date of inspection: 10/07/2024

Pharmacy context

This is a community pharmacy next to a Medical Centre in Worcester, Worcestershire. The pharmacy dispenses NHS and private prescriptions, sells a range of over-the-counter medicines, and provides health advice. It also offers the New Medicine Service (NMS), local deliveries and blood pressure checks. In addition, its team members provide multi-compartment compliance packs for some people who find it difficult to manage their medicines at home.

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 some processes to identify and manage the risks associated with its services. Team members understand how to protect the welfare of vulnerable people. The pharmacy protects people's confidential information well. And members of the pharmacy team deal with their mistakes responsibly. But they are not always documenting and formally reviewing the necessary details. This could mean that they may be missing opportunities to spot patterns and prevent similar mistakes happening in future. And they could do more to ensure all the pharmacy's records are fully compliant with relevant requirements.

Inspector's evidence

This was a busy pharmacy with constant footfall due to the pharmacy's location. The pharmacy had appropriate working practices in place although some areas for improvement were noted. The pharmacy team had access to a range of standard operating procedures (SOPs) which provided guidance for the team to carry out tasks correctly. This included policies to safeguard the welfare of vulnerable people, a chaperone policy, access to local contact details in the event of a concern and procedures to protect people's confidential information. There was evidence that staff had read and signed the SOPs. Team members understood their roles and responsibilities. This included how to safeguard vulnerable people and the correct notice to identify the pharmacist responsible for the pharmacy's activities was on display. Confidential information was protected, stored, and disposed of appropriately. The pharmacy was open plan. This meant that people using the pharmacy's services could see into the dispensary and hear conversations. Staff were observed ensuring that people's private information was not given out when answering telephone queries and no sensitive details were left in or could be seen from, the retail area. Computer systems were password protected and team members used their own NHS smart cards to access electronic prescriptions.

However, the pharmacy supplied specific controlled drug (CDs) against private prescriptions which had been issued by a remote, third-party prescribing service. This service was regulated by the Care Quality Commission (CQC). The pharmacy's agreement was with a specials manufacturer who was linked to the third-party prescribing service. The specials manufacturer had provided the pharmacy with a 'step-by-step process' of how to dispense the first prescription. Details about the service were clearly advertised in the pharmacy and staff signposted people to the relevant provider to obtain private prescriptions. They were subsequently received by post. Very few prescriptions had been issued through this service at the point of inspection. The pharmacy had leaflets from the third-party prescribing service which provided relevant information about the service for people. However, in accordance with the GPhC's 'Guidance for registered pharmacies providing pharmacy services at a distance, including on the internet', the pharmacy did not have a specific SOP relating to the supply of medicines under this service, and no risk assessments were seen to be completed to help identify, manage, or mitigate specific risks associated with this service. Whilst prescription numbers were very low (with only a few people signed up to this service), there had been no audits completed to verify the safety and quality of the service being provided. This was therefore, not in accordance with the GPhC's guidance. This situation was discussed with the superintendent pharmacist following the inspection. Assurances were provided and evidence received confirming that the necessary requirements to comply with this guidance were in the process of being drafted and due to be implemented.

Once prescriptions had been assembled, pharmacists usually carried out the final accuracy-check but the accuracy checking technician (ACT) who was also the manager, could assist with this. In this situation, a pharmacist clinically checked the prescription first before other staff assembled it and the clinical check was marked on the prescription. This helped identify that this stage had been completed. The ACT was not involved in any other dispensing process other than the final check, and there was an SOP to cover this process.

The pharmacy had some systems in place to identify and manage risks associated with its services. Incidents were managed by the responsible pharmacist (RP) and his process was suitable. Pharmacists and, the ACT (when working in this capacity) were based in and accuracy-checked prescriptions from a different section to dispensing staff. Team members rotated jobs but generally, one dispenser was responsible for processing repeat prescriptions, they were then placed alphabetically along with generated dispensing labels, in a set way within a retrieval system. This helped indicate to staff if there were stock issues and which prescriptions could be easily dispensed. Another member of staff was responsible for assembling multi-compartment compliance packs and this took place in a separate area which was not in view of people using the pharmacy's services. This helped reduce distractions. Staff explained that they double ticked relevant details on prescriptions such as the strength and form when preparing prescriptions. This helped ensure the correct medicine(s) had been selected.

Staff routinely recorded their near miss mistakes, and each mistake was said to be reviewed at the time with them. The manager also reviewed the details collectively and fed this information back to the team to help reduce the likelihood of mistakes recurring. Certain medicines were separated and highlighted as well as changes implemented in response to mistakes seen (such as the process of double-ticking relevant details as described above). However, details about the collective review had not been recorded every month to help verify this. The last recorded details were from April 24. Some of the pharmacy's stock was also stored in a disorganised way which increased the risk of a selection error occurring.

The pharmacy had suitable professional indemnity insurance arrangements in place and the pharmacy's records were mostly compliant with statutory and best practice requirements. This included a sample of registers seen for controlled drugs (CDs). On randomly selecting CDs held in the cabinet, their quantities matched the stock balances recorded in the corresponding registers. Records of emergency supplies and unlicensed medicines had been appropriately completed. However, there were a few issues with records verifying that fridge temperatures had remained within the required range (see Principle 4), the RP record had some gaps where pharmacists had not recorded the time their responsibility finished, prescriber details within the electronic private prescription register were seen to be incorrect and some details of the prescribers were missing or were seen to be incomplete. This could make it harder for the pharmacy to find these details in the event of a future query. In addition, whilst overages for methadone were routinely checked, they were not always documenting this information within the records for the automated software system, used to dispense methadone. Evidence was received following the inspection that the relevant amounts had been checked (current overage was 30ml) and details recorded.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members have the appropriate skills, qualifications, and training to deliver the pharmacy’s services. And the company provides them with resources so that they can complete regular and ongoing training. This keeps their skills and knowledge up to date.

Inspector's evidence

The pharmacy team at the inspection consisted of the regular, part-time RP, a locum pharmacist, the manager who was an ACT, two dispensing assistants who were undertaking accredited training courses for the NVQ3 in dispensing, a pharmacy technician, a medicines counter assistant (MCAs) and an apprentice. The team’s certificates of qualifications obtained were not seen but their competence was demonstrated. Staff covered each other as contingency. At the inspection, the pharmacy had enough staff to support the workload and the team was up to date with this. The pharmacy’s workload was due to be processed off-site at the company’s hub in the autumn. Staff wore name badges and uniforms. They asked relevant questions before selling medicines. They knew which medicines could be abused or had legal restrictions and referred to the pharmacist appropriately. Team members in training were provided with protected time to complete accredited training with opportunities available to progress. Staff communicated verbally; no team meetings were held. The manager explained that she ensured everyone was updated with the relevant information. Formal performance reviews took place annually and staff were provided with resources for ongoing training through the company’s e-learning platform. This helped ensure they continually learnt and kept their knowledge up to date.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises provide a suitable environment for people to receive healthcare services. The pharmacy is kept clean, it is secure, and professionally presented. And it has separate areas where confidential conversations or services can take place.

Inspector's evidence

The pharmacy premises had been refurbished since the last inspection and were professional in appearance. They consisted of a medium sized retail area, open-plan dispensary behind the medicines counter, with staff and storage areas to one side. In relation to the pharmacy's volume of workload, the dispensary had an adequate amount of space to carry out dispensing tasks safely. There was an extremely small space to prepare multi-compartment compliance packs. However, as the bulk of these were assembled off-site (see Principle 4), staff confirmed that this was appropriate for the small number of compliance packs prepared and stored at the pharmacy as they could also make use of the extensive shelves above and surrounding this area. The consultation rooms used for private conversations and services were spacious and suitable for their intended purpose, but they were not signposted in any way which could indicate their presence or availability to people. The pharmacy was clean although parts of it could have been tidier. The premises were bright, suitably ventilated and the ambient temperature was suitable for the storage of medicines. The pharmacy was secured against unauthorised access.

Principle 4 - Services ✔ Standards met

Summary findings

People can easily access the pharmacy's services. The pharmacy obtains its medicines from reputable sources and overall, manages its medicines appropriately. The pharmacy also supplies medicines inside multi-compartment compliance packs in a safe and effective way. But its team members do not always make relevant checks for people who receive higher-risk medicines. This limits the pharmacy's ability to show that people are provided with appropriate advice when supplying these medicines.

Inspector's evidence

People using wheelchairs or with restricted mobility could easily enter the pharmacy through the power assisted front door and the clear, open space inside the retail area. Plenty of free car parking spaces were available outside and there were six seats available if anyone wanted to wait for their prescriptions. Some of the pharmacy's services were advertised through displayed posters. Staff explained that they spoke clearly, louder where appropriate or used the consultation rooms if required for people with different needs.

The pharmacy supplied some people's medicines inside compliance packs once the person's GP or the team had identified a need for this. A waiting list was currently in operation as the pharmacy was at full capacity. Most people's prescriptions for compliance packs were dispensed off-site at the company's hub and delivered to the pharmacy once assembled. Once the prescription had been labelled through the pharmacy system, clinical and accuracy checks took place electronically before the details were submitted to the company's hub for assembly. The compliance packs were then delivered 10 days later.

Compliance packs with CDs, for people who had allergies, higher-risk medicines or required an automatic pill dispenser (Pivotell) were dispensed at the pharmacy. The team ordered prescriptions on behalf of people. They identified any changes that may have been made and queried with the prescriber if required. Appropriate records had been maintained to verify this. Descriptions of the medicines inside the compliance packs were provided and people could obtain patient information leaflets (PILs) from relevant details (such as a QR code) on the front of packs. Some higher-risk medicines were supplied inside compliance packs. This included lithium and sodium valproate. Routine checks were made for these people with these medicines about blood test results which was in conjunction with their GP practice, but no details were currently being recorded about this to help verify them. Staff were aware of the risks of placing sodium valproate inside the compliance packs due to issues with its stability. The pharmacy could justify this situation as relevant details were recorded, and each pack was only provided with this medicine de-blistered into it every week. Team members were also aware of the risks associated with valproates. They ensured that warning labels were not covered when they placed dispensing labels on them. People were counselled accordingly, and educational material was available to provide upon supply.

The pharmacy provided a delivery service and the team kept records about this service. Failed deliveries were brought back to the pharmacy, notes were left to inform people about the attempt made and no medicines were left unattended.

The workflow involved prescriptions being prepared in one area, pharmacists checked medicines for

accuracy from another section. The team used baskets to hold prescriptions and medicines during the dispensing process. This helped prevent any inadvertent transfer between them and they were colour coded to highlight priority. After the staff had generated the dispensing labels, there was a facility on them which helped identify who had been involved in the dispensing process. Team members routinely used these as an audit trail.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. The team date-checked medicines for expiry regularly and kept records of when this had happened. Short-dated medicines were routinely identified. There were no date-expired medicines or mixed batches seen. CDs were stored under safe custody and the keys to the cabinet were maintained in a way which prevented unauthorised access during the day as well as overnight. Dispensed medicines requiring refrigeration and CDs were stored within clear bags. This helped to easily identify the contents upon hand-out. CDs were stored under safe custody. Medicines returned for disposal, were accepted by staff, and stored within designated containers. This included sharps provided they were within the appropriate containers. Drug alerts were received electronically and actioned appropriately. Records were kept verifying this.

However, one of the pharmacy's fridges was packed with stock and this was affecting the air flow. Staff had been checking the fridge temperatures daily and recording this information. The records showed that for the past three consecutive days, the temperature had been consistently above eight degrees Celsius. It was also above eight degrees on the day of the inspection. The manager explained that the elevated temperature on one of these days was due to checking the expiry dates of medicines stored here. However, no details had been recorded to verify this, or about any subsequent action taken in response. This limited the ability of the team to show that they had been storing medicines requiring refrigeration at the appropriate temperatures. This was discussed and processes stressed during the inspection. Following the inspection, evidence was received confirming that excess stock had been moved, the fridge was registering the correct temperature range and that all the fridges had data loggers which tracked the temperature.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment and facilities it needs to provide its services safely. And its equipment ensures people's private information is secure.

Inspector's evidence

The pharmacy had access to the necessary equipment and resources in line with its dispensing activity. This included access to reference sources, standardised conical measures, and a clean, dispensary sink, with hot and cold running water as well as hand wash. There was also a legally compliant CD cabinet along with pharmacy fridges. The blood pressure machine and relevant equipment for the Pharmacy First service was new. This included an otoscope, thermometer, and tongue depressors. The pharmacy used an automated software system (Methasoft) to dispense methadone for people. This was calibrated and cleaned daily and staff maintained records to help demonstrate this. Confidential waste was disposed of appropriately. The pharmacy's computer terminals were password protected and portable phones enabled phone calls to take place in private if 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.