General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Peak Pharmacy, 431 Barton Road, Stretford, MANCHESTER, Lancashire, M32 9PA

**Pharmacy reference:** 1107028

**Type of pharmacy:** Community

**Date of inspection:** 20/11/2023

## Pharmacy context

This pharmacy is in a health centre located in the Stretford area of Manchester. It dispenses NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs. The pharmacy provides a range of NHS and private services.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

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 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 written procedures available to help its team provide services in a safe and effective manner. Members of the team record their mistakes so that they can learn from them. The pharmacy largely keeps the records it needs to by law. Members of the team keep people's information safe and are aware of the actions to take to protect the wellbeing of vulnerable people.

### Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) which covered the services that it provided. Its team members had read the SOPs and they signed each one to show this. The SOPs detailed which team members it was directed at based on their roles. And members of the team appeared to be knowledgeable about their roles and when to seek advice from the pharmacist.

The pharmacy maintained a record of near misses on a near miss log. This is when a mistake is identified upon completion of an accuracy check. The mistake was highlighted to the team member involved and they were required to identify the mistake as part of the learning process. They would then correct the mistake and make a record on the near miss log. The log was completed regularly but it often missed the additional information to explain the contributory factors or what action had been taken. This may make it harder for pharmacy team members to identify the common causes of mistakes and subsequently change processes to help prevent mistakes occurring. The pharmacy manager explained near misses were reviewed each month but didn't make a record. They would share the findings verbally and instil any changes based on the review. An example of this was identifying an increase in mistakes involving gabapentin and pregabalin. As a result, shelf edge warnings were added so that it acted as a prompt to team members to double check the medicine during the dispensing process. The pharmacy had a process in place for recording and reporting dispensing errors. This is when a dispensing mistake occurs but is not identified before the medicine is supplied to people. There were no recent records of dispensing errors, but the pharmacy manager explained that errors were investigated, and a record was made which was shared with the superintendent pharmacist (SI).

The pharmacy largely maintained the records it needed to by law. Records for controlled drugs were kept electronically on the pharmacy computer. The running balances of CDs were recorded and checked against the physical stock regularly. And team members made a separate record of patient-returned CDs. A random sample of the recorded balances were checked against the physical CD stock and found to be correct. The pharmacy dispensed private prescriptions and made a record in an electronic prescription register. But the details of the prescriber were often inaccurate. A responsible pharmacist (RP) records was kept but on some occasions the sign out time was missing which means that it may not accurately reflect when an RP was present. Team members were aware of the tasks they could not complete in the absence of a pharmacist. The pharmacy kept records of unlicensed medicines that were supplied to people.

The pharmacy had professional indemnity insurance in place which covered the services it provided. And it advertised how people could raise a complaint or provide feedback. Its team members explained they would try and resolve any complaints verbally but would escalate the complaint to head office when this was not possible.

Pharmacy team members completed online data protection training to help keep people's information

safe. They used the consultation room to have private conversations with people and separated confidential waste for secure disposal. Documents that contained people's information were kept secure from unauthorised access and passwords were required to access the patient medical record (PMR).

The pharmacy had an SOP about safeguarding vulnerable people which its team members had read. When questioned, the medicines counter assistant was able to explain the signs to look out for which may indicate a safeguarding issue. This included physical signs of abuse such as bruising or behaviour changes that may indicate abuse. The pharmacist explained the team remained vigilant when young adults requested emergency hormonal contraception. The details of the local safeguarding contacts were readily available if a concern needed to be raised

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy has enough trained team members to safely provide the services that it offers. It provides support to members of the team who are on training courses. Members of the team feel comfortable to raise concerns or provide feedback.

### Inspector's evidence

The pharmacy team consisted of a regular pharmacist, who was the pharmacy manager, a foundation trainee pharmacist, a dispenser who worked as an accuracy checker (ACD), a dispenser, a medicines counter assistant and two delivery drivers. Some team members were absent which included two part time dispensers. All team members were qualified for the roles they fulfilled. The pharmacy was advertising for a dispenser vacancy following a member of the team recently leaving.

Members of the team were aware of their roles to help manage the workload safely and effectively. One team member explained their job was to label prescriptions for people that received medicines in multi-compartment compliance packs. Another team member was helping assemble prescriptions for people that were waiting in the pharmacy to be supplied their medicines. The medicines counter assistant explained the questions they would ask when selling pharmacy medicines. And they identified medicines that are liable to misuse. In such cases, they would refer to the pharmacist if they felt the sale was inappropriate or if repeated requests were made.

The pharmacy team were seen working well together and they supported each other as people entered the pharmacy during busy periods. There were enough qualified team members to manage the workload safely. The pharmacy completed annual appraisals with its team members to discuss how they have performed and to help identify any future training needs. Members of the team also felt comfortable raising concerns or providing feedback to the pharmacy manager. The pharmacy manager held team meetings at least once per month to discuss changes to processes, the introduction of new services and to discuss near misses. This allowed them to share key information with the rest of the team members. Updated or new SOPs were left in a designated area for members of the team to read.

Training was provided by a recognised third-party provider and support was given in the form of online and face to face tutorials. The foundation trainee pharmacist was given protected learning time to complete their learning and they felt well supported by the rest of the pharmacy team. Members of the team completed regular online training and a record of completion was maintained. This included training for safeguarding, information governance and health and safety.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy premises is suitable for the services that it offers. And it has a consultation room available for people to have private conversations.

### Inspector's evidence

The pharmacy was clean, organised and well lit. It had climate control to help maintain the room temperature at a suitable level. Its team members cleaned the pharmacy daily. The pharmacy had adequate bench space to safely assemble prescriptions and a separate area was created to assemble and store multi-compartment compliance packs. A sink with hot and cold water was available. It was clean and suitable to prepare medicines that required mixing before being supplied to people.

A consultation room was available for people to have a private conversation or receive a pharmacy service. It was clean and tidy which helped maintain a professional appearance. It was large enough for the services that the pharmacy offered.

The dispensary area was behind the front counter and unauthorised access was restricted. Suitable staff facilities were available which included a small kitchen area, washroom and rest area. The pharmacy was secured when closed.

## Principle 4 - Services ✔ Standards met

### Summary findings

The pharmacy offers services that are easily accessible and provides them safely. It obtains its medicines from licensed sources and stores them appropriately. Its team members provide advice to people when supplying higher-risk medicines to help make sure they are used correctly.

### Inspector's evidence

The pharmacy had a small step leading to the entrance. A ramp was available for people with a wheelchair or pushchair. The entrance was wide and led into the retail area of the pharmacy. The opening hours of the pharmacy were displayed on the entrance door. A range of health information leaflets were situated on a wall opposite the entrance for people to access if they required additional information.

The pharmacy provided a range of services including seasonal flu vaccinations, New Medicine Service, Discharge Medicines Service and Community Pharmacy Consultation Service. But its main workload was dispensing NHS prescriptions. Prescriptions were placed into baskets to prevent them getting mixed up. And different coloured baskets were used to help prioritise the workload or help make it easier to identify medicines that needed to be delivered to people's homes. Team members initialled 'dispensed-by' and 'checked-by' boxes on dispensing labels to help identify who was involved in both processes if a query arose. Medicines were accuracy checked by the pharmacist or ACD. The pharmacist completed a clinical check of prescriptions before the ACD completed an accuracy check but no record of the clinical check was made. This meant the pharmacy did not have an audit trail to show who was responsible for each clinical check. And there may be an increased chance risk of clinical checks being overlooked. An SOP was available for accuracy checking and had been read by the ACD. They did not accuracy check medicines that people hadn't previously been supplied with or if the dosage of current medicines had changed.

The pharmacy did not routinely give owing slips to people when the full quantity of a medicine wasn't supplied. This means people might forget to collect the remainder of their medicines and not be compliant to the prescriber's written instructions. Medicines that required special storage conditions, such as fridge items or CDs, were highlighted on prescription bags using stickers so that they could be added before the medicines were supplied. The pharmacist also attached stickers to medicine bags if they needed to provide additional advice to people. This served as a reminder to team members. CD stickers were also used to prompt members of the team to check the prescription was still valid at the time of supply.

The pharmacy supplied some people with medicines in multi-compartment compliance packs. Most of the packs were assembled off site at an associated dispensing hub. The prescriptions were ordered by the pharmacy team and labelling information was sent electronically to the hub for the packs to be assembled. Once assembled, they were returned to the pharmacy for collection or for the packs to be delivered to people. Completed packs had appropriate warning labels printed on them. And descriptions were also included to make it easier for people to identify the individual medicines. But the pharmacy did not routinely supply patient information leaflets. Which may make it harder for people to access additional information about their medicines. The pharmacy made a record of the medicines that people were supplied with in the multi-compartment compliance packs. And it used the records to

check any changes that the prescriber had made. Copies of discharge letters for people leaving hospital were stored so that an audit trail of any changes was maintained.

Education materials were provided to people taking valproate containing medicine to highlight the risks. And the pharmacist was aware of the requirement to supply people with original packs so that the warning card and patient information leaflet was supplied each time. They explained two people of childbearing age were taking valproate containing medicines and the correct advice had been supplied which included the Pregnancy Prevention Programme. Pharmacy team members routinely asked for blood test information from people taking warfarin and a record was made on the PMR. This was required so that the prescriber could issue new prescriptions.

A medicine delivery service was offered to people who could not get to the pharmacy. Deliveries were completed by two part-time drivers, and they kept a record of completed deliveries. A note was left if people were not available to accept a medicine delivery.

The pharmacy obtained its medicines from licensed sources, and it stored them securely to prevent unauthorised access. Its team members checked the expiry dates of medicines regularly but did not make a record. This may make it harder to identify which areas of the pharmacy had been checked and by who. Medicines that were due to expire in the next three months were highlighted with a red sticker. Obsolete stock was separated to help reduce the risk of unsafe medicines being supplied to people and a record was made so that the head office team could see what medicines were being disposed of. Medicines with special storage requirements were stored appropriately. CDs were stored in two cabinets and date-expired stock and patient returns were clearly marked and separated. Medicines that required cold storage conditions were stored in two fridges. One fridge was for medicines awaiting collection and the other had stock that was used to fulfil prescriptions. The temperatures of both fridges were seen to be in the required range and the pharmacy kept a daily record of the temperatures.

The pharmacy received alerts regarding defect medicines from head office by email. Its team members printed the alerts and stored them in a folder. A record of the actions taken, and by who, was made on an audit sheet.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment it needs to safely provide the services that it offers. And its team members maintain the equipment appropriately.

### Inspector's evidence

The pharmacy had a selection of clean calibrated glass measures to help its team members measure liquid medicines. And it clearly marked measures that were used for higher risk medicines to prevent cross-contamination. Clean counting equipment was also available for tablets and capsules. Electrical equipment was in good working order and had been PAT tested in 2023. The pharmacist explained they use the internet to access resources such as the British National Formulary (BNF).

The pharmacy had four computer systems installed which held people's clinical records. The screens were not visible to members of the public and the computers were password protected to prevent unauthorised access. Members of the team used cordless phones so they could have conversations without being overheard by people.

## 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. |