General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peak Pharmacy, Dale Road South, Darley Dale, Matlock, Derbyshire, DE4 2EU

Pharmacy reference: 9011170

Type of pharmacy: Community

Date of inspection: 11/02/2020

Pharmacy context

This busy community pharmacy is located in a medical centre. Most people who use the pharmacy are from the local area. The pharmacy dispenses NHS prescriptions and sells a range of over-the-counter medicines. The pharmacy relocated from another site nearby to these premises in June 2019 when the medical centre was built.

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 manages risks to make sure its services are safe, and it takes action to improve patient safety. It completes the records that it needs to by law and asks its customers for their views and feedback. Team members understand how they can help to protect the welfare of vulnerable people. They have written procedures on keeping people's private information safe, but not all team members have completed the most up-to-date training on data protection. So, they might not fully understand their role in this.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided which members of the pharmacy team had read and accepted. However, there were two other files containing different versions and additional SOPs, and it was not clear if any of these were still current, which might cause confusion for the team. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their role. They were wearing uniforms and name badges showing their role. The incorrect name of the responsible pharmacist (RP) was displayed at the start of the inspection but this was corrected during the inspection.

A business continuity plan was in place which gave guidance and emergency contact numbers to use in the case of systems failures and disruption to services. There was a SOP for dealing with an incident, error or near miss. Dispensing errors were reported to the pharmacist superintendent's (SI) office, but learning points were not usually included on the reports, so the team might be missing out on opportunities to learn. Near misses were recorded on a log and discussed with the member of the pharmacy team involved, but they were not reviewed so patterns and trends might not be identified. The team described actions they had taken to prevent re-occurrence. For example, separating the different strengths of amitriptyline and the different forms of aspirin, but these were not usually recorded. There was a poster on display highlighting common look-alike and sound-alike drugs (LASAs) such as propranolol and prednisolone, atenolol and allopurinol, quinine and quetiapine. The poster emphasised the differences between the medicines and what harm might be caused if the wrong one was supplied. It also included tips to prevent this happening. The RP explained that she had noticed that Lumigan 0.1mg/ml and 0.3 mg/ml were being supplied in very similar packaging which might cause confusion, so she had pointed this out to some members of the pharmacy team. New Services were risk assessed before commencing. For example, although the RP had completed the required training for flu vaccination, it was not started as she had not had sufficient time to shadow another pharmacist competent in providing the service.

There was a complaint SOP and the procedure and the details of who to complain to were outlined in practice leaflets which were on display. A customer satisfaction survey was carried out annually. A survey had recently been completed but the results were not yet available. Results from the 2018/2019 survey carried out in the old premises were available on www.NHS.uk website.

Insurance arrangements were in place. A current certificate of professional indemnity insurance was on display in the pharmacy. Private prescription and emergency supply records were in an electronic format but the name of the prescriber was missing on some entries which could cause a delay if queries

arise. The RP record and the controlled drug (CD) register were appropriately maintained. Records of CD running balances were kept and these were regularly audited with small adjustments made to the methadone running balances due to manufacturer's overages. Two CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately, denaturing kits were available.

The SOPs referred to a separate information governance (IG) file which contained three SOPs on confidentiality and data handling. However, this file could not be located. There was a confidentiality training booklet and documents such as a code of conduct on confidentiality and data handling procedures in one of the other SOP files, but there was no record that the pharmacy team had read these. The team had a basic understanding about confidentiality but most of them had not been trained on the General Data Protection Regulation (GDPR), and the RP did not know who to contact if there was a breach of confidentiality. Confidential waste was collected in a designated bag which were sent to head office for disposal. A dispenser correctly described the difference between confidential and general waste. Assembled prescriptions awaiting collection were not visible from the medicines counter. Paperwork containing patient confidential information was stored appropriately.

There was a safeguarding children and vulnerable adults SOP which included guidance. The RP had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding. Some other members of the team had completed safeguarding training whilst working in other pharmacies and said they would discuss any concerns regarding children and vulnerable adults with the pharmacist working at the time. The pharmacy had a chaperone policy, but there was nothing on display highlighting this to patients, so people might not realise this was an option when using the consultation room. All members of the pharmacy team had completed Dementia Friends training, so had a better understanding of patients living with this condition.

Principle 2 - Staffing ✔ Standards met

Summary findings

The team work well together in a busy environment. The pharmacy team members have the right qualifications for the jobs they do. Some members of the team get structured training. But they are not always effectively supported to complete this and other members of the team do not receive ongoing training, so there may be gaps in their knowledge.

Inspector's evidence

There was a regular pharmacist (RP), a relief accuracy checking technician (ACT), two NVQ2 qualified dispensers, a trainee dispenser and a medicines counter assistant (MCA) on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection, and the team were observed dealing efficiently with the high number of prescriptions. There were two other MCAs and a delivery driver on the pharmacy team who were not present at the inspection. Planned absences were organised so that not more than one person was away at a time. Absences were covered by re-arranging the staff hours or requesting assistance from the area relief team which consisted of around six ACTs and dispensers. The RP explained members of the relief team were not always available and MCA's absences were not covered by them, which meant their own dispensers were sometimes required to cover the medicine counter as well as dispensing. Some of the team felt there was not enough staff, as the workload had increased since moving to the new premises and the staff profile had not been adjusted. The RP confirmed this had been discussed with the area manager and staffing levels had been reviewed and deemed to be adequate for the current workload. The RP worked three days each week and two regular locum pharmacists worked the other days. There was currently no pharmacy manager and it was not clear, who in the team carried out the management duties. There was an area manager who visited the pharmacy most weeks, but the team felt they lacked day to day management. Team members were not involved in discussions about their performance and development and return to work interviews following absences were not carried out.

Members of the pharmacy team carrying out the services were either qualified or on accredited training courses. However, the pharmacy team did not have regular protected training time and one member of the team explained that they were not given sufficient time to keep on track with their course, so they carried out training over lunch. There was no structured on-going training for members of the team who were not on accredited courses, so there was a risk that their knowledge might not be kept up-to date.

Communication from head office was via the company's intranet. Weekly e-mails were sent from the SI office, highlighting professional issues. These were printed off and left out for the pharmacy team to read. A dispenser felt the team could make suggestions or criticisms informally and would feel comfortable talking to the RP about any concerns she might have. There was a whistleblowing policy.

The RP said she felt empowered to exercise her professional judgement and could comply with her own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because she felt it was inappropriate. She said a target of twelve New Medicine Services (NMS) each month had been set and the team had met this. They had been told to carry out as many Medicines Use Reviews (MUR) as possible. The RP said she didn't feel under pressure to carry out MURs

and the team had only completed around six so far.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a professional environment for people to receive healthcare services. The pharmacy has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations.

Inspector's evidence

The premises were purpose built, and the pharmacy opened six months ago. There was an entrance directly from the medical centre into the pharmacy as well as a separate external entrance. Both entrances were step free. The pharmacy, including the shop front and facia, were clean well maintained and in a good state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with three chairs. The temperature and lighting were adequately controlled. The pharmacy was fitted out to a good standard, and the fixtures and fittings were in good order. Maintenance problems were reported to head office and the response time was appropriate to the nature of the issue.

There was a small separate stockroom off the retail area where stationery was stored. Staff facilities included a kitchen area, and a WC with a wash hand basin and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand sanitizer gel was available.

The consultation room was equipped with a sink, and it was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door and in the practice leaflet. This room was used when carrying out services such as MURs and when customers needed a private area to talk.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are generally well managed and easy for people to access. The pharmacy gets its medicines from licensed wholesalers and it carries out some checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

The pharmacy, consultation room and pharmacy counter were accessible to all, including patients with mobility difficulties and wheelchair users. A list of the services provided by the pharmacy was displayed in the pharmacy and detailed in the practice leaflet. The pharmacy team were clear what services were offered and where to signpost people to a service not offered. For example, flu vaccination. The MCA explained there was a good hospital nearby with clinics and a minor injuries unit, which she sometimes signposted people to. She said this had been useful when patients were on holiday in the area and the medical centre did not have any appointments left. There was a small range of healthcare leaflets but the pharmacy was not actively involved in any health promotion and signposting and providing healthy living advice were not recorded.

Most patients were required to order their repeat prescriptions via a medicines online service. However, the pharmacy ordered prescriptions for the patients receiving their medicine in compliance aid packs. These patients were contacted to check their requirements before ordering to reduce stockpiling and medicine wastage. There was a home delivery service with associated audit trail. Each delivery was recorded, and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

The dispensary was spacious with plenty of bench space and the work flow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. The RP confirmed that a clinical check had been completed by initialling the prescription or control chart for compliance aid packs, so the ACT could accuracy check them. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. CD date stickers were available to ensure schedule 3 and 4 CDs were supplied within 28 days of being prescribed. MUR stickers were available to highlight patients who would benefit from this service. ‘Speak to Pharmacist’ stickers were used to highlight when counselling was required and high-risk medicines such as warfarin was targeted for extra checks and counselling. INR levels were requested but not recorded when dispensing warfarin prescriptions. The team were aware of the valproate pregnancy prevention programme, and the information pack and care cards were available to ensure people in the at-risk group were given the appropriate information and counselling.

Multi-compartment compliance aid packs were well managed with an audit trail for communications with GPs and changes to medication. A dispensing audit trail was completed, and medicine descriptions were usually included on the labels to enable identification of the individual medicines. The pharmacy

team confirmed packaging leaflets were included, so patients and their carers could easily access all the required information about their medicines. Disposable equipment was used. Support for people with disabilities was outlined in a SOP and an assessment was supposed to be made by the pharmacist as to the appropriateness of a compliance aid pack or if other adjustments might be more appropriate to their needs. The patient's GP usually referred people for a compliance-aid pack, so there was an assumption that an assessment was carried out by them, rather than the pharmacy.

The MCA explained what questions she asked when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

CDs were stored in two CD cabinets which was securely fixed to the wall. The CD keys were stored securely overnight. Date expired, and patient returned CDs were segregated and stored in the CD cabinets. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from ‘Specials’. No extemporaneous dispensing was carried out. The pharmacy was not compliant with the Falsified Medicines Directive (FMD). It had the software and hardware needed to comply but the team said they had not had training on the system and were not currently scanning to verify or decommission medicines.

Medicines were stored in their original containers. Date checking was carried out and documented. Short dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired medicines were segregated and placed in designated bins. There were two clean medical fridges. The minimum and maximum temperatures were recorded regularly for the main fridge and had been within range throughout the month. But the smaller fridge which was being used to store assembled prescription items awaiting collection, was not being monitored, so assurance could not be provided that the medicines were being stored at the appropriate temperature. However, the current temperature was within range at the inspection, and so were the maximum and minimum temperatures. The RP confirmed that the team would start to monitor the temperature of the small fridge, or all the contents would be transferred to the larger stock fridge.

Alerts and recalls were received via e-mail messages from the SI office. These were read and acted on by a member of the pharmacy team. A confirmation e-mail was required to be sent back to the SI office which provided a record of the action taken so the team would be able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe and use it in a way that protects privacy.

Inspector's evidence

Current versions of the British National Formulary (BNF) and BNF for children were available and the pharmacist could access the internet for the most up-to-date information. All electrical equipment appeared to be in good working order and had been PAT tested. There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were used for methadone solution. The pharmacy had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Individual electronic prescriptions service (EPS) smart cards were in use. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.