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: 26/07/2022

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 it sells a range of over-the-counter 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	1.2	Good practice	The pharmacy team records and analyses adverse dispensing incidents to identify learning points which it incorporates into day-to-day practice to help manage future risks.
2. Staff	Standards met	2.2	Good practice	The team members have the appropriate skills, qualifications and competence for their role and the pharmacy effectively supports them to address their ongoing learning and development needs.
		2.4	Good practice	The pharmacy team work well together. Team members communicate effectively, and openness, honesty and learning are encouraged.
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 acts to improve patient safety. It completes the records that it needs to by law, and it asks its customers for their views and feedback. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. They record their mistakes so that they can learn from them, and they act to help stop the same sort of mistakes from happening again. The team has written procedures on keeping people's private information safe. And team members understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) for the services provided which members of the pharmacy team had read and accepted. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their roles. They were wearing uniforms and name badges showing their role. The name of the responsible pharmacist (RP) was displayed as required by the RP regulations.

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. This plan was being followed as there had been a technical problem and the pharmacy's computers had been offline for three days. It was not possible to download prescriptions from the electronic prescription service (EPS) or access the patient medication record (PMR) system and label prescriptions. People who could not wait for the issue to be resolved were directed to other local pharmacies where they were able to collect their prescription. Some labels for acute prescriptions, such as antibiotics, were handwritten.

There was a SOP for dealing with an incident, error or near miss. The pharmacy team reported dispensing errors to the pharmacist superintendent's (SI) office and included the actions they had taken to prevent a re-occurrence. For example, following a labelling error the team were reminded to take extra care when using the repeat labelling function on the PMR system in case of changes. Patient safety learnings from other pharmacies in the group were shared in a weekly email sent from the SI office which highlighted professional issues. These messages were printed off and read by the pharmacy team. The pharmacy manager explained that the team had been alerted to a particular brand of metoprolol where the boxes were identical in size but contained different quantities. The team ensured that these were clearly separated on the dispensary shelves to prevent picking errors. The pharmacy manager pointed out other examples where medicines had been separated because the packaging looked identical and might cause confusion, such as letrozole 2.5mg, 14 and 28 pack sizes and codeine 30mg tablets, 30 and 100 pack sizes. The team were currently focussing on ensuring that each dispensing basket only contained one person's prescriptions as incidents had occurred when two different patients were put in the same basket. This was because their prescriptions had been mixed together when the EPS tokens were printed off. Near misses were recorded on a log and discussed with the member of the pharmacy team involved. The pharmacy manager said he looked for patterns and trends and would highlight them to the team. The records were formally reviewed annually when a patient safety report was completed. There were posters on display highlighting common look-alike and sound-alike drugs (LASAs) such as propranolol and prednisolone, atenolol and allopurinol, quinine and

quetiapine. The posters 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.

There was a SOP for dealing with complaints but there was nothing on display highlighting this, so people might not know how to raise a concern. A customer satisfaction survey was being carried out and people were being asked to provide their feedback in a questionnaire. Results from previous surveys were not displayed.

Insurance arrangements were in place. A current certificate of professional indemnity insurance was on display in the pharmacy. Private prescription records, the RP record and the controlled drug (CD) register were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately, denaturing kits were available.

There was an information governance (IG) file which contained SOPs on confidentiality and data handling. A new member of the team had read and signed information on confidentiality as part of a 'starter pack' which she was required to complete when she started working at the pharmacy. She had a basic understanding about confidentiality and she understood the difference between confidential and general waste. Confidential waste was collected in designated bags which were sent to head office for disposal.

There was a safeguarding children and vulnerable adults SOP which included guidance. The pharmacy manager had completed level 2 training on safeguarding. Another member of the team confirmed they had completed safeguarding training online and said they would discuss any concerns regarding children and vulnerable adults with their manager or the pharmacist. The pharmacy had a chaperone policy, but there was nothing on display highlighting this, so people might not realise this was an option when using the consultation room. Members of the pharmacy team were aware about the ‘Ask ANI’ scheme where people suffering domestic abuse could use the code words to alert the staff that they needed help.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are well trained and they work effectively together in a busy environment. They have the right training and qualifications for the jobs they do, and the pharmacy encourages them to keep their skills up to date and supports their development. Team members are comfortable providing feedback to their manager and they receive informal feedback about their own performance.

Inspector's evidence

The RP was a regular pharmacist (RP) who usually worked three days each week at the pharmacy. Two regular relief pharmacists worked the other days, which helped to ensure consistency in the team. The pharmacy manager was an accuracy checking technician (ACT). There was also a relief NVQ2 qualified (or equivalent) dispenser, a medicines counter assistant (MCA), a new member of the team and a delivery driver on duty at the time of the inspection. There were two qualified dispensers on the pharmacy team who were not present at the inspection due to illness. Absences were covered by re-arranging the staff hours or requesting assistance from the area relief team which consisted of pharmacists, pharmacy technicians (PTs) and dispensers. The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and the people who visited the pharmacy. Team members were observed managing the challenging situation with the pharmacy's computer systems being offline calmly and effectively.

Members of the pharmacy team carrying out the services were qualified and could access online training resources to keep their training up-to-date. Training records were available for each member of the team and the pharmacy manager demonstrated recent training which had been completed on suicide awareness, antimicrobial stewardship and weight management. He confirmed that the new member of the team would be enrolled onto an accredited MCA training course when she had completed three months at the pharmacy. A Saturday assistant was working through the MCA course and was supported by the pharmacist who usually worked there on Saturdays. Team members had informal discussions about their performance and development with their manager. There was an area manager who visited the pharmacy most weeks. The pharmacy manager said that he had a discussion with them about his duties when he commenced his new role. The pharmacy team received communications from head office via the company's intranet and a weekly email from the SI office. The team discussed issues on a daily basis. A dispenser confirmed that they would feel comfortable talking to the RP or pharmacy manager about any concerns they might have. There was a whistleblowing policy. The RP was 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. Targets were in place for the New Medicine Service (NMS) and the NHS hypertension case finder service. The RP said she was not made to feel under pressure to achieve targets.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy, including the shop front and facia, was clean well maintained and in a good state of repair. The retail area was free from obstructions, professional in appearance and had four chairs for people to use whilst waiting for prescriptions and services. The temperature and lighting were adequately controlled. The pharmacy was fitted out to a high 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 which could be accessed from 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 washing notices were displayed, and 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. This room was used when carrying out services such as supervised administration 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 team members are helpful and give healthcare advice and support to people in the community. The pharmacy sources, stores and supplies medicines safely. And it carries out appropriate 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. There were two step free entrances into the pharmacy. One entrance led directly from the medical centre. This had been closed during the pandemic and was still not in use. The external entrance had an automatic door. A list of the services provided by the pharmacy was displayed in the pharmacy. There was a healthy living area displaying information on Covid, Monkeypox and children's dental care. The pharmacy changed the topics regularly and kept a photographic record of their health promotional activities. There was a home delivery service with associated audit trails. Each delivery was recorded. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy.

The dispensary was spacious, and the workflow was organised into separate areas with designated checking areas. 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. 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. 'Pharmacist' stickers were used to highlight when counselling was required. The RP explained she often added notes to high-risk medicines to make it clear what extra checks and counselling was required. The team were aware of the need for a pregnancy prevention programme (PPP) when prescribed valproate, and the care cards were available to ensure people in the at-risk group were given the appropriate information and counselling. The RP confirmed that she would add a note to the person's PMR when she had a conversation about PPP with them.

Support for people with disabilities was outlined in a SOP. Most people requiring multi-compartment compliance aid packs had their packs dispensed and supplied from a neighbouring branch. Some people preferred to have their medicines dispensed locally and a small number of compliance aid packs were assembled at the pharmacy. These were well managed with an audit trail for communications with GPs and changes to medication. Medicine descriptions were included on the labels to enable identification of the individual medicines. Packaging leaflets were not usually included, so patients might not be able to easily access all the required information about their medicines. Disposable equipment was used.

The new member of staff explained what questions she asked when making a medicine sale and knew when to refer the person to a pharmacist. She was clear what action to take if she suspected a customer might be abusing medicines such as a codeine containing product. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

CDs were stored in two CD cabinets which were securely fixed to the wall. Date expired, and patient returned CDs were segregated and stored in the CD cabinets. Patient returned CDs were destroyed using denaturing kits. Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials.' No extemporaneous dispensing was carried out. Medicines were stored in their original containers. Date checking was carried out, but this was not documented, so some parts of the dispensary might be missed. 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 and had been within range throughout the month.

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

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe to use.

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. The RP explained she often accessed the data sheet compendium and the National Institute for Health and Care Excellence (NICE) guidance online. 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 separate tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination. Computer screens were positioned so that they were not 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.