General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peak Pharmacy, Netherfield Medical Centre, Knight Street, Netherfield, Nottingham, Nottinghamshire, NG4 2FN

Pharmacy reference: 9011449

Type of pharmacy: Community

Date of inspection: 11/08/2021

Pharmacy context

The pharmacy is in a newly built medical centre in the Nottinghamshire town of Netherfield. It relocated to its new premises in January 2021. The pharmacy's main services include dispensing NHS prescriptions and selling over-the counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people to take their medicines. And it delivers some medicines to people's homes. The pharmacy was inspected during the COVID-19 pandemic.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	1.1	Standard not met	The pharmacy does not adequately identify and manage all the risks with providing its services. Team members do not access the most up-to-date written procedures to support them in providing the pharmacy's services. And they do not follow a robust process to record and monitor the mistakes they make during the dispensing process. There is evidence that some risks associated with information governance and record keeping have gone unrecognised.
2. Staff	Standards not all met	2.4	Standard not met	The pharmacy relies heavily on informal processes which do not promote a culture of openness and shared learning. This has the potential to impact both on the safety of pharmacy services and the wellbeing of the pharmacy team.
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 not all met**

Summary findings

The pharmacy does not adequately identify and manage all the risks with providing its services. Team members do not access the most up-to-date written procedures to support them in providing the pharmacy's services. And they do not have a robust process to record and monitor the mistakes they make during the dispensing process. There is evidence that some risks associated with information governance and record keeping have gone unrecognised. Pharmacy team members have appropriate knowledge of how to manage feedback from people. And they understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had risk assessed its services due to the ongoing pandemic. This meant that some services such as blood pressure checks were on hold. And the team signposted people to access a self-use blood pressure kiosk within the medical centre. A sign at each entrance to the building advised people to wear a face covering when entering. Markers on the floor continued to support people with social distancing within a healthcare environment. And the pharmacy had robust plastic screening fitted around the medicine counter. This helped to reduce the risks associated with contracting COVID-19. All team members continued to wear type IIR face coverings whilst working. And they had access to other personal protective equipment (PPE) if needed.

The pharmacy's dispensary was organised and workflow was efficient. Team members kept each person's prescription separate throughout the dispensing process by using coloured baskets. The pharmacy had dedicated space for the assembly of medicines and for accuracy checking. And the team used a high counter in the middle of the dispensary to hold baskets of medicines awaiting a final accuracy check. Team members faced prescriptions in these baskets forward, this helped the pharmacist identify workload priority.

The pharmacy had standard operating procedures (SOPs) to support the safe running of the pharmacy. But the SOPs presented for inspection were written in 2012. There was some evidence of team members completing training against SOPs in 2018. But it was not clear on the training records which version of the SOPs they had read. No up-to-date SOPs were found in a paper format during the inspection. But a search of the intranet found a copy of some SOPs stored electronically. Team members indicated that they were not aware of the SOPs being available on the intranet and had not read electronic versions as part of any training. The electronic versions of the SOPs were more recent but were due for review. The situation highlighted a risk that team members may not be working in accordance with the details within the most up-to-date SOPs. This risk was heightened when team members described some working practices and the roles and responsibilities associated with the management of controlled drugs (CDs) which contradicted good practice. Following the inspection the superintendent pharmacist (SI) confirmed the company was currently reviewing its SOPs and would be publishing them on a bespoke electronic platform in the future. The SI confirmed the most recent version should be available in a paper format in all pharmacies, and the electronic version seen was a back-up copy only.

The pharmacy had no formal near miss record in place on the day of inspection. Team members were aware that near misses had been recorded in the past. But they could not recall seeing a record for

some time. The current process for managing a near miss was for the pharmacist to feedback to the team members involved, and team members corrected their own mistakes. There was some evidence of learning from mistakes. For example, a team member discussed the need to take extra care when dispensing 'look-alike and sound-alike' medicines (LASAs). The lack of formal records meant the team did not have the opportunity to review patterns in near misses. And this made it more difficult for team members to demonstrate any risk reduction actions applied following these types of mistakes. The pharmacy currently had a trainee dispenser in post, and a discussion took place about the value of using near miss records to support the learning process. The pharmacy reported dispensing incidents electronically. But there was limited evidence of timely reporting following an incident. The last incident reported had occurred in November 2020 prior to the pharmacy moving premises. But team members recalled a more recent incident, records related to any incident since the pharmacy had relocated were not available.

The pharmacy had a complaints procedure. But it did not advertise this prominently within the public area of the pharmacy. Team members were aware of how to manage feedback. And felt confident in escalating a concern from a member of the public or another healthcare professional to either the pharmacist or the pharmacy's head office if needed. Some team members had completed training associated with safeguarding vulnerable adults and children. One team member was in a training role and was aware that their coursework covered this training. This same team member discussed how she would manage a hypothetical safeguarding situation by raising the matter with the pharmacist and the person's GP. And the pharmacy's delivery driver discussed how they had managed and reported a previous safeguarding issue at a different pharmacy within the company. The responsible pharmacist (RP) on duty on the day of inspection confirmed he had completed level two safeguarding training. And he was confident in obtaining details of local safeguarding agencies should a need to report a concern arise.

The pharmacy had up-to-date indemnity insurance arrangements in place. It maintained running balances in the CD register. Team members were regularly involved in entering and signing CDs out of the register and undertaking full balance checks against the register. Team members described undertaking physical balance checks of CDs against the register, and then taking the register to the pharmacist to sign. This meant the pharmacist was signing for a check which they hadn't personally completed. Balance checks were not always completed regularly. The register provided details of the most recent balance checks completed in February 2021 and May 2021. Records associated with patient returned CDs were mostly in order. But some recently returned CDs required entering into the patient returned CD register. The RP notice was displayed prominently with the correct details of the RP on duty recorded. The RP register was not kept in accordance with requirements, this was because there were frequent gaps in the signing out section of the register. The pharmacy held an electronic record of the private prescriptions it dispensed. This was generally kept in accordance with legal requirements. But the team did not always record details of the prescriber. The pharmacy held records associated with unlicensed medicines in accordance with the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA).

The pharmacy held most personal identifiable information in the dispensary. But it held some dispensing tokens and other documents such as private prescriptions in the consultation room. It stored most of these records in cupboards which could not be locked. And the consultation room door was not locked between use. On the day of inspection a tote containing bags of assembled medicines with prescription forms attached was stored on the floor of the consultation room. A team member identified that these were uncollected items which required processing. And explained a locum pharmacist had moved the tote to the consultation room the week before the inspection. A discussion took place about the risks associated with leaving the consultation room unlocked, and the acute risk of

storing prescription only medicines in the room. The tote was immediately relocated to the dispensary and the team acted to secure the room from unauthorised access by locking it. The need to ensure the room remained secure between use due to the information held inside was reiterated during feedback at the end of the inspection process. The pharmacy held confidential waste in designated bags. The team sealed these bags prior to them being collected for secure disposal.

Principle 2 - Staffing **Standards not all met**

Summary findings

The pharmacy relies heavily on informal processes rather than using structured formal processes to promote openness, honesty and learning. This means the team misses opportunities to share feedback and review risks associated with its workload management. And this may impact people accessing the pharmacy's services. The pharmacy employs suitably skilled team members and it has processes in place to support team members who have a concern at work. But more could be done to encourage the team to provide regular feedback.

Inspector's evidence

The pharmacy team consisted of a pharmacist manager (on leave on the day of inspection), a pharmacy technician, a qualified dispenser and a trainee dispenser who had completed medicine counter training previously. The pharmacy also had a regular delivery driver employed to provide its medicine delivery service. The RP on duty on the day of inspection was a locum pharmacist who had not previously worked at the pharmacy. Team members identified some escalated workload pressures in recent months due to some sick leave within the team. There had been no regular relief support during this time. But relief support had been provided to prevent lone working by the pharmacist.

The trainee dispenser had commenced her new role within the last few weeks. And discussed the support she was able to offer to her dispensary colleagues by undertaking the training. A structured training plan had not yet been discussed with the trainee. The pharmacy was operating with locum pharmacists for the next few weeks, and the team informed pharmacists of the trainee's role as they commenced their shifts. Team members engaged in some ongoing learning to support them in their roles. The most recent learning had involved the completion of e-learning modules related to mental health and wellbeing. But team members reported that their last appraisal had been some years ago. This meant they didn't have regular opportunities to formally review their learning and development, and to discuss how they were feeling at work. Team members were not aware of any targets in place related to the pharmacy's services. And the RP confirmed targets were not discussed with him when booking his shift.

During the inspection team members disclosed some information relating to concerns about the management of workload and priorities in the pharmacy. And it was clear team members were under some degree of stress. Examples of concerns related to the management of higher risk activities such as assembling medicines in multi-compartment compliance packs without distraction. And the task distribution amongst the team. There was evidence of some tasks not being completed on days when some team members did not work. For example, fridge temperature records were not routinely recorded on a Saturday. The team recognised that some of the formal processes designed to support the management of workload were not being used as intended. And this was hindering communication and as such the development of a culture of openness and honesty in the workplace. Team members had not fed back how they were feeling formally. The pharmacy did have a whistle blowing policy to support team members in raising concerns at work. Team members were aware of how to raise a concern and had awareness of the whistleblowing policy. But confirmed they had not formally raised the issues prior to the inspection.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is well designed. It provides a professional and hygienic environment for delivering healthcare services. People accessing the pharmacy can easily speak with a member of the team in private when required.

Inspector's evidence

The pharmacy was modern and provided a professional image for the delivery of pharmacy services. The premises were clean, relatively organised and secure against unauthorised access. A large open plan public area provided access to healthcare and general sales list medicines. Off this area was a good size consultation room. The room offered a private space to hold confidential conversations. And it was seen to be used by the RP when providing counselling to a parent and their child during the inspection. The dispensary was behind the medicine counter and it was a suitable size for the level of activity undertaken. The team had enough workspace for managing higher risk activities such as assembling multi-compartment compliance packs. The pharmacist's workbench provided ample space for tasks associated with checking prescriptions and administration work. To one side of the dispensary was a staff room and toilet facilities. Lighting was bright throughout the pharmacy and air conditioning ensured the pharmacy stored medicines under 25 degrees Celsius.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy obtains its medicines from reputable sources. And it generally stores its medicines safely and securely. The pharmacy's services are accessible to people, and the pharmacy regularly provides appropriate information to people about the medicines they are taking. It has some effective audit trails to help support the management of most of its services. But there is an inconsistent approach to documenting who has been involved in the whole dispensing process. This approach may heighten the risks associated with safely providing medicines in compliance packs.

Inspector's evidence

People accessed the pharmacy through automatic sliding doors. One door led off a ramp with a handrail from a residential street. And the second door led directly from the medical centre carpark. The pharmacy raised a shutter between the medical centre and pharmacy during the day to support access between the two healthcare providers. The pharmacy had some leaflets associated with healthy living and its services inside its consultation room. The RP explained how he would signpost a person to another pharmacy or healthcare provider if they required a service which could not be provided if the regular pharmacist was not working. For example, access to free emergency hormonal contraception.

The pharmacy protected Pharmacy (P) medicines from self-selection as it displayed them behind the medicine counter. A team member was observed clearly explaining to the RP why she was referring a request for an over-the-counter medicine to him. The referral highlighted how the team member had applied appropriate questioning techniques to gather important information about the suitability of the product for the person requesting it. Team members explained how the regular pharmacist provided counselling when handing out medicines. This included asking questions relating to ongoing monitoring of higher risk medicines, such as the frequency of INR checks. But there was no evidence of this counselling recorded on people's medication records. Team members demonstrated their understanding of the requirements associated with the valproate pregnancy prevention programme. And the RP explained his approach to counselling people within the high-risk group. This included the need to liaise with the person's GP for confirmation of a pregnancy prevention plan. The team recognised the requirement to issue the patient card when dispensing valproate to people within the high-risk group. The pharmacy team clearly identified prescriptions for CDs. For example, team members attached stickers to bags of assembled medicines containing schedule three and four CDs. The stickers contained the expiry date of the prescription.

The pharmacy's delivery driver explained how the delivery process had been adapted due to the pandemic. If the pharmacy was aware a person was self-isolating it recorded these details on the delivery record. This ensured a contact free delivery could be made. The pharmacy retained an audit of all deliveries. It had robust processes in place for managing the ordering of prescriptions. The audit trail included details of the medicines ordered to help a team member follow up on queries prior to a person attending to collect their medicines. The pharmacy held part-assembled medicines in baskets on designated shelving in the dispensary. It held prescription forms associated with these medicines in the baskets alongside the medicines. This ensured the prescription was available throughout the whole dispensing process. The team also retained prescriptions for owed medicines, and dispensed from the prescription when later supplying the owed medicine.

Pharmacy team members signed the 'dispensed by' box on medicine labels to form a dispensing audit trail. 'Checked by' boxes were signed for medicines supplied through the regular dispensing service. But the 'checked by' box on assembled multi-compartment compliance packs waiting for collection were not signed. A team member confirmed this was normal practice. And team members identified that an accuracy check had taken place by verbal handover from the pharmacist and the original containers used to fill the packet being removed from the basket when the pack was handed back to them to bag. This practice potentially increased the risk of a mistake related to the supply of medicines in this way. The pharmacy had individual record sheets in place for the compliance pack service. These were used to monitor and record changes. But occasionally details of a change were not recorded in full. For example, one record included a change from 10mg to 5mg, but did not specify the name of the medicine. Hospital discharge records associated with changes were kept to support some of the changes made. Some assembled packs contained clear descriptions of each medicine inside the packs. The team had temporarily stopped providing descriptions on packs during the pandemic to help manage workload more efficiently. A discussion took place about the benefits of re-establishing descriptions on each pack.

The pharmacy sourced medicines from licensed wholesalers. It stored medicines in an orderly manner, most were within their original packaging, on shelves and in dispensary drawers. Some amber bottles containing lactulose were found on a dispensary shelf. The bottles did not have any details of the batch number or expiry date of the medicine inside, and as such were moved to the pharmacy's medicine waste storage area. The pharmacy stored CDs appropriately within the CD cabinet. It stored assembled higher risk medicines such as CDs and insulin in clear bags. This prompted additional checks when handing out the medicine. The pharmacy's fridge was clean and a good size for stock held. The pharmacy maintained an electronic fridge temperature record. But there were some gaps in the record. Temperatures either side of these gaps were within the accepted temperature range of 2 and 8 degrees Celsius.

There was evidence that date checking tasks has recently been completed as the pharmacy identified short-dated medicines with stickers. But there was no record in place to support the date checking process. A random check of dispensary stock found no out-of-date medicines. The pharmacy team did not annotate liquid medicines with details of their opening date once opened. But no liquid medicines which had a shortened shelf-life after opening other than CDs were seen. A check of the CD register confirmed the contents of the open bottles held in the CD cabinet were used within their shortened shelf-life. The pharmacy had appropriate medicinal waste bins and CD denaturing kits available. It received medicine alerts through email. And team members were knowledgeable about a recent alert and discussed the action they had taken when checking the alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it requires to provide its services. Pharmacy team members use this equipment appropriately and in a way which protects people's privacy.

Inspector's evidence

The pharmacy had up-to-date written and electronic reference resources available. Written reference resources included the British National Formulary (BNF) and BNF for children. Pharmacy team members had access to the internet and intranet. Computers were password protected, and computer monitors faced into the dispensary. The pharmacy stored bags of assembled medicines on designated shelving to the side of the dispensary. This protected information on bag labels from unauthorised view. Pharmacy team members used cordless telephone handsets. This allowed them to move out of earshot of the public area when a phone call required privacy.

The pharmacy team used crown-stamped measuring cylinders for measuring liquid medicines. Equipment for counting capsules and tablets was also available. There was separate equipment available for counting and measuring higher risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. And it was clean and appropriately maintained.

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.