General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Peak Pharmacy Direct, 8 Littlemoor Centre, Chesterfield, Derbyshire, S41 8QW

Pharmacy reference: 9011982

Type of pharmacy: Community

Date of inspection: 24/07/2023

Pharmacy context

This busy community pharmacy is located in a small retail area on the edge of the town centre. The pharmacy dispenses NHS prescriptions, and it sells a range of over-the-counter medicines. A large proportion of the prescriptions are sent to the company's hub to be dispensed and most prescriptions are delivered to people's homes. The pharmacy has an express collection machine so people can collect their medicine at any time of the day and when the pharmacy is closed. The pharmacy first opened in November 2022.

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	2.2	Good practice	The team members have the appropriate skills, qualifications and competence for their roles, and the pharmacy effectively supports them to address their ongoing learning and development needs.
		2.4	Good practice	The pharmacy team works 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 manages risks to make sure its services are safe, and it acts to improve patient safety. Members of the pharmacy team work to professional standards and they complete all the records that they need to by law. 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 members keep people's private information safe and understand how they can help to protect the welfare of vulnerable people.

Inspector's evidence

The pharmacy had electronic versions of the standard operating procedures (SOPs) for the services it provided. A new member of the pharmacy team, who had carried out their induction training at another branch, didn't know if they had read the SOPs. And the pharmacy manager could not locate the records which showed which members of the pharmacy team had read which SOPs, but he confirmed that he would make sure the new team member had read all the SOPs relevant to their role and ensure that there was an up-to-date record in the pharmacy of who had read which SOP. Other members of the pharmacy team confirmed that they had read the SOPs, including the relief dispenser, and the locum pharmacist who said this was a requirement when he first started to work for the company. Roles and responsibilities were set out in SOPs. The pharmacy sent prescriptions to another pharmacy in the company (the hub) to be assembled. The SOP which covered the hub and spoke process did not accurately reflect the current process. The pharmacy manager explained that this was because the SOP was designed to reflect the new way of working when the pharmacy started with a new hub which was due to be up and running soon. Following the inspection, the pharmacy manager discussed this with the area manager, and she confirmed that she would obtain the correct version of the SOP for the team to use to avoid any confusion.

Pharmacy team members were performing duties which were in line with their roles and were clear what activities could be carried out in the presence and absence of a pharmacist. Team members were wearing uniforms and name badges showing their roles. The name of the responsible pharmacist (RP) was displayed as required by the RP regulations.

There was an SOP for dealing with an incident, error or near miss. Near misses were recorded on logs and were reviewed and discussed with the pharmacy team. Actions were taken to prevent similar incidents happening again. For example, by separating paroxetine and pantoprazole, which had similar sounding names and packaging. A 'Check pack size 28/30' alert was in front of one medicine where quantity errors had occurred. Tramadol modified release had been separated from the original form, and capsules had been separated from tablets, as these had been previous near miss errors. The pharmacy team reported dispensing errors to the pharmacist superintendent's (SI) team. The SI team reported them on the National Reporting and Learning System and shared learnings with other pharmacies in the group in a weekly email. All controlled drugs (CDs), including schedule 3 and 4 CDs, received a second check by another team member before the pharmacist or accuracy checker completed their final accuracy check. Clear plastic bags were used for assembled CDs and medicines requiring refrigeration to allow an additional check at hand out.

There was a SOP for dealing with complaints and the complaints procedure and the details of who to

contact about a complaint were available on the company's website (www.peakpharmacy.co.uk). But there was nothing on display in the pharmacy showing these details, so people using the pharmacy might not know how to raise a concern or leave feedback. The trainee medicine counter assistant (MCA) said they would refer any complaints to the pharmacy manager. The pharmacy manager explained that he would attempt to resolve the issue locally but would give the complainant a printed version of the complaint's procedure, which included the details of head office, if the complaint couldn't be resolved at the time.

Insurance arrangements were in place. Private prescription records, the RP record, and the CD registers were available in electronic form and appeared to be appropriately maintained. The pharmacy occasionally received private prescriptions from external online providers. There was a list which the SI team had provided for pharmacy teams to refer to which showed which providers they had approved as meeting the electronic prescription requirements, and which ones might need further support from the SI team. Records of CD running balances were kept and these were regularly audited. The pharmacy manager confirmed that any CD discrepancies which could not be resolved were reported to the SI team who would inform the CD accountable officer for the area if necessary. Two CD balances were checked and found to be correct. Patient returned CDs were recorded and disposed of appropriately.

There were SOPs on confidentiality and data handling and team members had completed training on data security. Confidential waste was collected in designated bags which were sent to head office for destruction by a third-party company. The trainee MCA correctly described the difference between confidential and general waste and had a basic understanding about patient confidentiality. The pharmacy manager believed that the people whose prescriptions were assembled at the hub had been sent a letter explaining this process, and they had been given the choice to opt out.

There was a safeguarding children and vulnerable adults SOP. The pharmacy manager had completed level two training on safeguarding, and other members of the team had completed level one training. A dispenser said she would discuss any concerns regarding children and vulnerable adults with the RP or pharmacy manager. The pharmacy had a chaperone policy, and a dispenser confirmed that a chaperone was usually offered when people used the consultation room, but there was nothing on display highlighting this, so people might not realise this was an option. Members of the pharmacy team knew about the safe space initiative where people suffering domestic abuse could use the consultation room to access help and support, and the pharmacy was registered for this.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy's team members are well trained, and they work well together in a busy environment. They are enthusiastic and knowledgeable. The pharmacy encourages them to keep their skills up to date and supports their development. They are comfortable providing feedback to their manager and they receive feedback about their own performance.

Inspector's evidence

There was a pharmacy manager, a locum pharmacist, three NVQ2 (or equivalent) qualified dispensers, a trainee MCA, and a delivery driver on duty at the time of the inspection. The pharmacy manager was an accuracy checking technician (ACT) and one of the dispensers was an accuracy checking dispenser (ACD). The staffing level was adequate for the volume of work during the inspection and the team were observed working collaboratively with each other and people who visited the pharmacy. 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 pharmacists, pharmacy technicians (PTs) and dispensers. One of the dispensers on duty was a member of the relief team. The pharmacy manager had prepared a detailed staff rota which was to ensure that all the required activities had been allocated to different members of the team. The pharmacy manager liaised with the area manager about the pharmacy's services and staffing levels, which was important as this was a new and growing business. There was a team of around ten delivery drivers who delivered prescriptions from the pharmacy. They had a separate manager who kept them up to date with any changes to procedures.

Members of the pharmacy team carrying out the services were qualified or on an accredited training course and they could access online training resources to keep their training up to date. Training records were available for each member of the team and included modules on domestic abuse, harassment and bullying, cancer, obesity, infection control and antimicrobial resistance. The pharmacy manager had carried out additional training on clinical governance. The SI's team were able to access the pharmacy team's training records to see if there were any outstanding training requirements. The trainee MCA was given around one hour training time each day. One of the dispensers had been trained to provide the ear wax removal service. The training had been carried out online as well as face-to-face. She had been required to attend a full day practical course before an assessor observed her in practice in the pharmacy and signed her off as competent.

There was a formal appraisals process where team member's performance and development were discussed. New members of staff received a review after one and three months. The area manager visited the pharmacy two or three times each month and provided support to the pharmacy team. The pharmacy manager was part of an electronic messaging group with other managers in the area, where ideas and concerns could be raised. He was also in regular contact, and felt well supported, by the SI team. The pharmacy team received a weekly email from head office which covered a range of topics including the company's performance, patient safety matters, and amendments to SOPs. These messages were printed off and read and signed by the pharmacy team. The latest email contained professional information such as clarification on the new pre-payment process for hormone replacement therapy (HRT), as well as general information such as highlighting a colleague's charity

work.

The pharmacy team discussed issues on a regular basis and key messages were displayed on a notice board. Team members also communicated through an electronic messaging group to ensure people who were absent were included. Team members described an open and honest culture in the organisation and confirmed that they felt comfortable admitting and reporting errors. They felt that learning from mistakes was the main focus. A dispenser said she would feel comfortable talking to the pharmacy manager or area manager about any concerns she might have. There was a whistleblowing policy.

The pharmacists were empowered to exercise their professional judgement and could comply with their own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because they felt it was inappropriate. The team weren't 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 private consultation rooms so that that people can receive services in private and have confidential conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy premises, including the shop front and facia, were clean, spacious 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 had been fitted out to a high standard. Maintenance problems were reported to head office via a maintenance portal and there was an in-house maintenance team. Staff facilities included a staff room with 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. There were two consultation rooms which were uncluttered, clean and professional in appearance. The availability of the rooms was highlighted by signs on the door. The rooms were used when carrying out services such as administering injections and when customers needed a private area to talk. A small section at the front of the pharmacy had been excluded from the registered premises to allow for the express collection machine.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are well managed and easy for people to access. 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 rooms and pharmacy counter were accessible to everyone, including people with mobility difficulties and wheelchair users. There was a power assisted door at the entrance. A list of services provided by the pharmacy was displayed in the window. These were also stated on the company's website with the pharmacy's opening hours and contact details. All the services available in other branches of the company were shown on the website. This helped to inform people of services and support available elsewhere. The pharmacy team was clear what services were offered and where to signpost people to a service not offered. For example, travel vaccinations, which were provided by a neighbouring branch. There was a small range of healthcare leaflets and a dispenser said she was carrying out healthy living pharmacy training so the pharmacy could be more proactive in providing healthy living advice and health promotional activities.

If a person had opted to use the express collection machine, then a flag was added to their patient medication record (PMR), so the team knew to place their completed prescription into the machine. Once the prescription had been dispensed and loaded into the machine the person was sent a text or email with a unique collection code which they were required to enter into the machine to access the medicine. Collection was required within three days. Items requiring refrigeration, CDs and large bulky items were not placed into the machine and had to be delivered or collected from the pharmacy in the usual way.

There was a home delivery service with associated audit trail. The delivery driver confirmed the safe receipt in their records. A note was left if nobody was available to receive the delivery and the medicine was returned to a delivery hub, where it was stored securely, before it was returned to the pharmacy the following day. The delivery driver described the delivery process, and he knew what action to take to protect people's confidential information and he knew who to reports any safeguarding concerns to.

The pharmacy provided an ear wax removal service. It included a digital otoscopy examination, microsuction and a full hearing screening. The dispenser who carried out this service explained that it was a popular service and she had already identified a potentially serious issue where she referred a person to the hospital's ENT department for treatment.

Space was adequate in the dispensary and the workflow 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. When the ACD or ACT carried out the final accuracy check, the pharmacist was required to confirm they had completed the clinical check by initialling the prescription. The prescriptions dispensed at the hub were clinically checked by a pharmacist at the hub. The hub pharmacy downloaded a duplicate copy of the prescription token which they dispensed from, and the medication labels were initialled by the

dispenser and accuracy checker to provide a dispensing audit trail. The clinical check was carried out using the prescription token and the information on the repeat prescription slip. The pharmacist at the hub wasn't able to see the patient's previous history but could communicate electronically with the main pharmacy if they had any queries. Prescriptions received from the hub were sealed and the pharmacy supplied these to the patient without opening 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. 'Speak to Pharmacist' stickers were used to highlight when counselling was required, and high-risk medicines were targeted for extra checks and counselling. The RP was aware of the valproate pregnancy prevention programme and said he would have discussions with anyone in the at-risk group and confirm they had a discussion with their GP about pregnancy prevention. He said he would add a note on their patient's medication record (PMR) confirming this. The RP said he would highlight the valproate care card which was attached to original packs and ensure it was not obscured by the medication label. Records of referrals to GPs and interventions were maintained and recorded on PMRs.

A member of the pharmacy team explained what questions they generally asked when making a medicine sale and knew when to refer the person to a pharmacist. They were clear what action to take if they suspected a customer might be misusing medicines such as a codeine containing product. But one team member was observed selling a pharmacy (P) medicine which can be misused without asking all the required questions or providing any additional advice, so there was a risk that the medicine might not have been the most appropriate option.

CDs were stored in three CD cabinets which were securely fixed to the walls. Assembled prescriptions, date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. P medicines were stored behind the medicine counter so that sales could be controlled. Recognised licensed wholesalers were used to obtain stock medicines and appropriate records were maintained for medicines ordered from 'Specials.' Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out, and short-dated stock was clearly highlighted with red stickers. A dispenser, who carried out the routine date checking, knew which part of the dispensary had been recently checked, but she didn't usually make a record, so there was a risk that some parts of the pharmacy might be missed. The expiry dates of medicines were checked as they were put onto the dispensary shelves and anything with a date of less than six months was highlighted with a sticker. Expiry dates were checked as part of the dispensing process. Expired and unwanted medicines were segregated and placed in designated bins. One medicine which contained a short-dated sticker had expired the previous month and was still located on the dispensary shelves. It was put in the designated bin when this was pointed out.

Alerts and recalls were received from various sources including wholesalers, the central alerting system, and the SI team. 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 were able to respond to queries and provide assurance that the appropriate action had been taken. In some circumstances the team were required to send a confirmation e-mail to the SI team.

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

The RP could access the internet for the most up-to-date information sources for reference. He said he usually used his mobile phone to access the electronic British National Formulary(BNF). There were two clean medical fridges for storing medicines. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the previous week. All electrical equipment appeared to be in good working order. There was a selection of clean glass liquid measures with British standard and crown marks. The pharmacy had a range of clean equipment for counting loose tablets and capsules. 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. PMRs were password protected. Individual NHS 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. The team could contact a 24-hour helpline if problems occurred with the express collection machine. The pharmacy manager was alerted if there were any problems with the machine outside working hours. He could attend the pharmacy or ask another key holder to attend, if necessary, although support could also be provided remotely.

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.