General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Littleover Pharmacy, 562 Burton Road, Littleover, DERBY, Derbyshire, DE23 6DF

Pharmacy reference: 1030324

Type of pharmacy: Community

Date of inspection: 20/09/2023

Pharmacy context

This community pharmacy is situated on a busy main road in the Littleover area of Derby. It dispenses NHS prescriptions and sells a range of over-the-counter medicines. And it offers both NHS and private services which includes an on-site prescribing service for minor illnesses. The pharmacy supplies medicines in multi-compartment compliance packs and offers a delivery service. Enforcement action has been taken against this pharmacy, which remains in force at the time of this inspection, and there are restrictions on the provision of some services. The enforcement action taken allows the pharmacy to continue providing other services, which are not affected by the restrictions imposed.

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 identifies and manages the risks associated with the services that it provides. The pharmacy provides an on-site walk-in prescribing clinic with risk assessments in place to help make sure that the service is being provided safely. But the risk assessments are not tailored to the service being provided. So, they may not always effectively manage the risks involved. Team members follow written procedures so that they can carry out tasks safely. The pharmacy keeps the records that are needed by law. It protects people's information and regularly takes the opportunity to learn from mistakes that may occur.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) that had been reviewed earlier in the year. Pharmacy team members had signed most of the SOPs to state that they have read and understood them. Two team members had not signed specific SOPs that were important to their roles and responsibilities. They confirmed that they had read the SOPs but had neglected to sign them. This was rectified once highlighted to the team members. Members of the team were seen following the SOPs when labelling and dispensing prescription medicines that needed to be checked by the pharmacist. They were also aware of their roles for the day. The medicines counter assistant explained that they would mainly help to serve people on the front counter and hand over their prescriptions to them. They were also aware of what they could and could not do if the responsible pharmacist (RP) had to take a short leave of absence.

The pharmacy offered a pharmacist led prescribing service which was managed by the superintendent pharmacist (SI). Training records for the SI were available for people to see as they were placed in the consultation room, providing an assurance that they were suitably trained. This also included a training certificate for an ear micro suction service. A risk assessment was available for the prescribing service which covered the common potential risks, but these were generic to all prescribing services. The risk assessment had not been tailored to reflect the specific risks relating to the way the service was being managed, the conditions being treated, and the medicines being prescribed. This could help further improve the service being offered.

The SI kept records that were associated with the prescribing service. This included consultation notes, copies of the prescriptions issued and copies of letters that they had sent to inform them about the treatments that had been prescribed. To safeguard the SI checking his own prescriptions, they referred people to nearby pharmacies to have their prescription dispensed. This was done when another pharmacist was not available. This was covered in the SOPs for the prescribing service.

The SI had available examples of consultation notes which were completed each time people accessed the walk-in service. These were kept on people's clinical record and followed the Calgary-Cambridge model of consultations. Letters that were sent to people's doctors to explain the outcome of the consultation were also available. The NHS summary care record platform was used to confirm the identity of people using the system, along with any allergies. Risk assessments and SOPs were provided by recognised training providers. The risk assessments had undergone an independent, external review found them to be sufficient when looking at the potential risks involved with the service. The SI provided at least three safety netting points to each patient to make sure they were aware of what to

do if their condition got worse or needed additional healthcare support. And they would contact the local walk-in centre if they were not able to prescribe any suitable medicines. One record described an occasion where the SI had not been able to prescribe any suitable medicines for a viral infection. This was clearly documented in the consultation notes with the appropriate advice given.

The pharmacy had professional indemnity insurance in place to cover the services they were providing. Pharmacy team members made records of mistakes that occurred when dispensing medicines also known as near misses. The pharmacist would highlight the mistakes to the team member involved and they would make a record in a near miss log so that they could reflect on it. Monthly reviews of near misses were completed but they often had the same actions without the specific details. For example, a common action was to review medicines that look alike and sound alike but the names of which medicines they reviewed for that month were missing. This means that the team members may not be able to fully reflect on some of the common mistakes and introduce actions to reduce the likelihood of them occurring again. The team gave some examples of actions they have taken to prevent similar mistakes occurring such as highlighting the different strengths of warfarin and the separation of amlodipine and amitriptyline. The pharmacy did not have any recent examples of dispensing errors. This is when a mistake is made during the assembly of a prescription and is not picked up by the pharmacist when they complete a final check. But team members were aware of the requirement to record them if they happened and discuss them with the SI.

The RP record was kept electronically and was complete. Details of any second pharmacists on duty were also recorded. The pharmacy supplied medicines that were prescribed on private prescription forms. This also included the prescriptions that the SI generated in the pharmacy. An electronic private prescription register was kept on the pharmacy computer. The records were largely complete, but on some occasions the address of the prescriber did not match the address on the prescription. The pharmacy kept appropriate records of any unlicensed medications that they dispensed.

Records for controlled drugs (CD) were also kept electronically. The records were in line with legal requirements and running balances were recorded. Balance checks of these medicines were completed frequently as per the SOP. A few of the balances were checked against the physical stock held in the CD cabinet and were found to be accurate. Two CDs had a negative balance recorded, following the destruction of CDs in April 2023. The SI explained that this was due to an issue with the software, which had been escalated to the software provider for investigation. There was also a separate record for CDs that had been returned to the pharmacy. These were kept separate from the normal stock and the record was signed when the medicines were destroyed appropriately.

The pharmacy had an SOP in place to support the team in keeping people's information secure. The pharmacy team were seen having discrete conversations in the dispensary so not to be heard. And they made sure they discarded people's information in a safe manner to protect their privacy. A shredding company was being used to help them with this. Confidentiality agreements were in place for all the team members.

The pharmacy team members were able to explain what signs to look out for to identify any safeguarding issues and the steps to take to support them. And they had a safeguarding SOP in place. The details of the local safeguarding contacts were displayed in the dispensary in the event a referral or advice was required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to effectively manage the workload. Team members complete appropriate training so that they can carry out their roles and responsibilities. And support is provided to those on training courses to help them progress. Team members communicate effectively with each other and can raise concerns if they need to.

Inspector's evidence

The pharmacy team consisted of a regular locum pharmacist, four qualified dispensers and a delivery driver. There was also a trainee dispenser and trainee medicines counter assistant. Team members on training courses felt well supported while working towards their respective qualifications and were given sufficient time to complete the work they needed to.

The pharmacy team were observed working well together and communicated with each other when a query about someone’s prescription arose. They also helped each other serve people entering the pharmacy. The team were on track with their daily jobs and appeared to handle the workload effectively. The pharmacy team had two team members who were employed to cover holidays and any absences to make sure the team didn’t fall behind on the workload.

Team members received an appraisal every quarter which helped them understand their progress and allow them to talk about any ambitions to progress in their roles. The management team was very supportive of progression and gave people the opportunity to develop if they wished to do so. One of the dispensers described that they felt comfortable approaching the management team with any concerns or feedback and felt it was a nice environment to work in. Different modes of communication were being used to inform the pharmacy team of any changes to process, keeping up to date with pharmacy news and sharing the targets for the following month. Team meetings were also held each month to review any near misses and discuss team performance. Targets are set for various services but there was no pressure to achieve them. There were no incentives in place to hit targets for any of the services being offered.

The pharmacy team members understood when they would need to refer to the pharmacist for advice. The medicines counter assistant explained that they would refer to the pharmacist when any pharmacy medicines were being sold. They would also speak to the pharmacist if they felt that someone might be misusing medicines that are addictive.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy's environment is suitable for the services that it provides. It is generally clean and tidy, but some areas are disorganised which may detract from the professional appearance. A consultation room is available for the confidential provision of pharmacy services, including a walk-in prescribing service.

Inspector's evidence

Overall, the pharmacy was clean and tidy. There were some areas of the dispensary that were cluttered, including an area where appliances and dressing were being stored. This could increase the risk of mistakes happening, but generally the pharmacy managed the space well. Pharmacy team members were responsible for cleaning and a rota was in place to help share the duties equally. Fixtures and fittings were well maintained and suitable for the storage of medicines. The pharmacy called upon several contractors if any repairs were required at short notice and a business continuity plan was displayed with these details. There was a clean sink with hot and cold water available which was used for making medicines that require mixing before handing out to people.

The pharmacy had a consultation room which was suitable for the services that were being provided but was untidy which may create an unprofessional look. The room was situated between the shop floor and the dispensary and access was restricted using a hatch that was locked to prevent unauthorised access. Opposite the room was a bay of shelving where prescriptions awaiting collection were stored. A curtain was used to close off this section when people were using the consultation room to protect people's data.

There were two electronic screens in the pharmacy to advertise the services that were being provided. The lighting and temperature were both suitable to support the work being completed. The pharmacy was left secure overnight.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of NHS and private services safely and effectively. It offers a prescribing service to treat minor illnesses and carries out checks to make sure that medicines are being prescribed safely. But the pharmacy does not always provide the correct safety advice when supplying higher-risk medicines.

Inspector's evidence

The pharmacy had a small step leading to the entrance, but this did not seem to pose any difficulty to people with wheelchairs or prams. There was a manual door to enter the pharmacy which led into the retail area. Some chairs were available for people who decided to wait for a pharmacy service. The pharmacy clearly advertised the services it was offering using a combination of television screens, banners, and posters. No social media advertising was being used. The pharmacy offered a prescription delivery service for people that wanted their medicines delivered to their home. A record of deliveries completed was being kept but there were no details of what time the delivery was made or who received the medicines. This meant it may be harder for the team to respond to any queries it received regarding the delivery service.

The pharmacy offered a walk-in clinic for minor illnesses allowing people to be treated for chest infections and other acute infections. This was managed by the SI who was a qualified independent prescriber. Although this was classed as a walk-in service, the pharmacy team booked appointments for people so that they could effectively manage the workload. The service involved physical checks when it was required, and this was documented in the consultation notes. Letters to people's doctors were sent to notify them of the medicines being supplied. People were required to give consent before any information was shared.

The pharmacy dispensed both NHS and private prescriptions. Team members used baskets to separate prescriptions intended for different people to help reduce the risk of any mistakes happening. They also signed dispensing labels to indicate who was involved in the prescription assembly process. Once this was complete the pharmacist would then carry out a clinical and accuracy check. They too would sign the dispensing label once this was done. This helped the team identify who was involved in the complete prescription process if a query were to arise. Medicines that were waiting to be collected were stored securely and a curtain was used to close this area off as it was located opposite the consultation room. This was done to protect people's data. A range of stickers were used to make it easier to identify if a prescription included a cold-chain item or a CD that needed to be added. Prescriptions for schedules 2,3 and 4 CDs were also highlighted so that they were not handed out beyond their legal limit of 28 days.

Medicines were dispensed into multi-compartment compliance packs for some people who required additional support to take them in a safe manner. This was managed by one of the dispensers but most of the team members knew how to make the packs in case they needed to help. The production of these packs was generally done as per the SOP in place but there were some instances where the description of the medicine or patient information leaflets were not provided. This may make it harder for people to identify the medicines they are taking or access additional information if they wanted to. The SI provided assurances that this would be corrected.

The pharmacist was aware of when they would need to provide additional advice to people taking medicines of higher risk. For example, they would check when people on warfarin last had a blood test. The pharmacy dispensed sodium valproate to a handful of people. Educational materials were available and warning cards were provided when dispensing these medicines. And dispensing labels were applied so not to cover the warnings on the original pack. The requirement to check women of childbearing age were on the Pregnancy Prevention Programme was not always carried out.

The pharmacy obtained its medicines and devices from multiple licensed sources and stored them appropriately to prevent unauthorised access. Medicines that required cold storage were stored in a fridge with the temperature maintained within the required range. Records of the temperature were recorded daily. Team members were able to explain the actions they would take if the temperature had gone outside of the range. The expiry dates of medicines and devices were checked frequently, and this was recorded on date checking matrix. Stock that was short dated was highlighted so that it could be picked up during the dispensing process. MHRA drug alerts and recalls were received by email. The team printed these and checked them against the stock on the shelves. And they detailed what action they took, and the date action was taken.

CDs were stored securely in a locked cabinet with the key kept by the RP on duty. When the premises was closed, the key was locked away securely and access restricted. CD stock that had expired or was returned to the pharmacy was clearly marked and segregated from the normal stock so that it was not mixed up during the dispensing process. Amber medicine bottles were seen to be reused for CD instalments as several labels were placed on top of each other. This was unhygienic and could increase the risk of contamination. The RP agreed he would use new bottles for each instalment in future.

The pharmacy accepted medicines that were no longer needed by people, these were kept secure and segregated from the normal stock while awaiting destruction. Collections of the unwanted medications was carried out by a licensed waste company.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It maintains the equipment appropriately and keeps it securely.

Inspector's evidence

The pharmacy had clean, calibrated conical measures available for measuring liquids when needed. One measure was clearly marked for use with higher risk medicines to reduce the risk of cross-contamination. Counting triangles were also available. The pharmacy had a set of patient medical record (PMR) systems, one of which was available in the consultation room. Access to these systems were restricted using a username and password. Computer screens were kept out of the visibility of people using the pharmacy to maintain confidentiality. Electrical equipment had been tested last year.

The pharmacy also had a range of healthcare equipment that was being used to provide the services on offer. This included an ambulatory blood pressure monitor, a stethoscope, pulse oximeter and an otoscope. The equipment was regularly checked by the SI and calibrated. The otoscope was also sent to an external company for cleaning alongside a regular clean after each use. The pharmacist was able to access a range of resources online such as the BNF, NICE guidelines and prescribing formulary for Derbyshire.

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.