General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rosehill Pharmacy, 299 Normanton Road, DERBY, Derbyshire, DE23 6UU

Pharmacy reference: 1091033

Type of pharmacy: Community

Date of inspection: 23/07/2024

Pharmacy context

This extended hours pharmacy is open seven days per week. It is located on a busy main road in Derby. Its main activity is dispensing prescriptions, but it also provides some other NHS pharmacy services such as Pharmacy First, the New Medicine Service and the supervised consumption of medicines. It supplies some medicines in multi-compartment compliance packs to help people take them correctly. And it offers a medicine home delivery service.

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	1.2	Standard not met	Team members do not make appropriate records of mistakes that happen to help to identify further learning opportunities and make improvements to help the reduce the risk of errors happening again. They do not record and review near miss errors. And records of dispensing errors do not contain sufficient detail of the action taken to learn from them, and the RP is not always stated which may make it harder to identify who was responsible.
		1.6	Standard not met	The pharmacy does not keep records of returned CDs which means there is no audit trail of when these medicines were returned and the quantity. This means that pharmacy cannot demonstrate the effective management and safe disposal of these medicines.
		1.8	Standard not met	Confidential information is not always stored securely to prevent unauthorised access.
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 not all met	4.3	Standard not met	Controlled drugs are not always stored in accordance with safe custody requirements. And the pharmacy does not store unwanted medicines securely away from unauthorised access
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 always identify and manage the risks associated with its services. Records of mistakes are not always made, and they are not reviewed so its team members may miss out on opportunities to learn and improve. The pharmacy does not always keep the records it needs to by law. It does not effectively record when controlled drugs are returned to the pharmacy so it may make it harder to demonstrate that these have been safely and appropriately disposed of. Team members are largely aware of how to keep people's private information safe but some confidential information is not stored safely.

Inspector's evidence

The pharmacy did not adequately identify and manage the risks associated with its services. Mistakes identified as part of the accuracy check, also known as near misses, were said to be recorded on an electronic platform but there was no evidence of the records when checked. This meant the pharmacy team could not effectively review near miss errors to identify common mistakes and emerging trends. The lack of recording also meant its team members missed out on opportunities to learn from their mistakes. The responsible pharmacist (RP) explained that some near misses were discussed when they occurred and was able to give one example of action taken following a near miss. Due to their look alike sound alike properties, azathioprine and azithromycin had been physically separated on the shelf. Records for three recent dispensing errors were available. This is when a mistake is identified after a medicine has been supplied to the person. The details of the errors had been included so it was clear what the mistake was. But details of the actions taken to reduce the risk of similar mistakes from happening again were not sufficient in all three records. This meant team members may not have fully reflected on the mistake and put in appropriate safeguards to reduce the chance of errors. And details of the RP had not been recorded in two of the entries which may make it harder for the pharmacy to respond to any subsequent queries or concerns.

Electronic standard operating procedures (SOPs) were available, and a training record was maintained which showed most team members had read and acknowledged them. The delivery driver had not read the SOPs relevant to their role which meant they may not fully understand the procedures that underpin the safe delivery of medicines. The RP provided an assurance that they would address the oversight. Roles and responsibilities of team members were set out in SOPs, and they were aware of the tasks that could and couldn't be completed if the RP was absent. An RP notice was displayed but the details of the pharmacist on duty was incorrect. A team member promptly corrected it when this was pointed out. Professional indemnity insurance was in place.

The pharmacy largely kept the records it needed to by law. Electronic controlled drug (CD) registers were maintained with running balances which were checked each month. The physical stock of three CDs were checked against the running balance and were found to be correct. However, the pharmacy had not recorded the receipt of several CDs that people had returned to the pharmacy for disposal. This meant there was no audit trail available to show when the CDs has been returned and how much had been returned which heightened the risk of medicine diversion. RP records were also held electronically and were generally completed in full apart from a couple of times where the RP has forgotten to sign out. This may make it harder for the pharmacy to demonstrate which RP was responsible in the event of a query or mistake. Records for private prescriptions and unlicensed medicines were completed as per

the requirements.

A safeguarding SOP was available and team members were able to correctly explain what action they would take if a concern was identified. In the first instance they would refer to the pharmacist but also offer to have a private conversation with the person in the consultation room. The details of the local safeguarding leads were available, and the pharmacist had completed training on safeguarding to help support vulnerable people. Team members had a confidentiality clause within their employment contracts and verbal training was provided to help them understand how to protect people's information. There were no written procedures in place to underpin this, but they were able to explain some of the steps they take to help keep private information safe. For example, confidential waste was separated into clearly marked baskets and shredded. And they had quiet conversations in the dispensary when discussing prescriptions so not to be overheard. However, some confidential information was being stored in a stock room which was not secure and there was risk of it being accessed by people who were not part of the pharmacy team.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough team members to effectively manage the workload. Members of the team work well together and they ask for help if they need it. They are appropriately trained for their roles or are enrolled onto recognised training courses. However, additional training is not provided so there may be gaps in their skills and knowledge.

Inspector's evidence

There were three regular pharmacists who worked across the week to cover the opening hours of the pharmacy. One of the pharmacists was also the SI. The pharmacy also employed five dispensing assistants, two were qualified and three were enrolled on to a training course, three trainee medicines counter assistants and one delivery driver. Those on training courses felt well supported by members of the team and the RP was available to help with any queries. Additional ongoing training was not provided so team members may miss out on opportunities to further develop their skills and knowledge. Members of the team were observed working well together and supported each other with queries. The RP was seen providing advice to trainee members to help with their learning.

Meetings with the team members were held informally every two to four weeks where they discussed the performance of the pharmacy and provided an opportunity to raise any concerns or provide feedback. Appraisals were held annually although only one team member has received one because the rest of the team had been employed for less than one year.

A trainee medicines counter assistant was observed asking questions when selling medicines to make sure they were appropriate to supply. They explained that there had been some people trying to make repeated purchases of codeine containing products, but most customers were known to the team and the pharmacist would be informed if there were any concerns. They felt comfortable refusing the sale of a medicine they didn’t feel was appropriate and referred to the RP in these instances.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, and it provides a suitable environment for healthcare. It is generally tidy and organised, but some areas of the pharmacy are cluttered which may detract from a professional image.

Inspector's evidence

The retail area of the pharmacy was large with seating which helped to create a suitable waiting area. The size of the dispensary was adequate for the workload undertaken and its team members utilised the space effectively to help manage the number of prescriptions that were being assembled. There was a storage area at the back of the dispensary which was cluttered and short of space. This area was being used to store excess medicine stock as well as a staff rest area and WC. The pharmacy also had access to a residential flat above the pharmacy. One room had been allocated for storing consumables and excess paperwork. The room had not been secured and so could be accessed by people residing in the flat. The risk of this was discussed with the RP who provided an assurance that additional security measures would be installed.

A consultation room was available which was clean and suitable for the services that were being provided. But it was untidy which detracted from a professional appearance. The room was clearly signposted so that people knew a private area was available if they needed to receive a service or speak to a member of the team.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy sources medicines from licensed suppliers but it doesn't always store them safely and securely. And it doesn't keep unwanted medicines safe from unauthorised access. The pharmacy's services are accessible to most people but those with mobility issues may find it difficult. Medicines are supplied in an effective manner, and it carries out checks to make sure medicines are still safe to supply to people. The pharmacy provides a supervised consumption of medicines service safely.

Inspector's evidence

There was a small step and manual door at the entrance of the pharmacy which led into a large retail area. As the pharmacy was on a main road, it was not possible to use a portable ramp to help people with mobility issues enter the premises. However, team members explained they helped people access the pharmacy when needed and a home delivery service was available. Records of deliveries were maintained. The services provided were clearly displayed in the pharmacy window along with the opening hours. Members of the team were multi-lingual which helped to meet the language needs of the local population.

The pharmacy's main activity was dispensing NHS prescriptions, most of which were received electronically. Members of the team used baskets to separate different people's prescriptions to avoid them getting mixed up. 'Dispensed-by' and 'checked-by' boxes were initialled on the dispensing labels to help create a record of who was involved in the prescription assembly process in the event of a query. Stickers were applied to bag to indicate if a fridge or CD item needed to be added when a person presented to collect their medicine. And the pharmacist wrote the date the prescription expires if it was for a CD to prevent it being supplied after the 28-day limit. However, higher-risk medicines were not routinely marked so that additional advice could be given. This meant the pharmacy was unable to demonstrate that it takes sufficient action to help make sure higher-risk medicines are taken safely. Team members were aware of the requirements of having a pregnancy prevention programme in place for people taking valproate containing medicines. Educational material was supplied, and the medicine was dispensed in its original container. One person still received valproate containing medicines in a multi-compartment compliance pack. The RP had confirmed this with the person's GP as there was a risk of them not taking the medicine as prescribed if it was not dispensed into the pack. But a record of the conversation, or risk assessment, was not made which may make it harder for the pharmacy to justify why the medicine was not supplied in the original container.

A large number of people who use drugs received medicines from the pharmacy. A supervised consumption service was provided along with needle syringe provision. People were given their doses in the consultation room to help protect their privacy. An automated measuring system was used to dispense the doses of medicines. Before this, team members entered details from the prescription into the system so that the prescribed amount could be accurately dispensed. The prescription was initialled to help show which team member has entered it on to the system and the RP completed a second check to make sure the information was correct. Tablets formulations were also provided, and these were dispensed each morning. But the assembled prescriptions were not kept securely as per the requirements which heightened the risk of medicines going missing.

Medicines were provided to some people in multi-compartment compliance packs. An electronic record

of the medicines, doses and timings were held on each person's patient medication record (PMR). New prescriptions were checked against the record and any discrepancies were followed up with the GP before a record was made on the PMR to state a change had been made. Two completed packs were checked, and both detailed the descriptions of the medicines within them so that people could identify the medicines. But patient information leaflets were not available and so up to date information may not be easily accessed. The RP agreed that the leaflets should be supplied going forwards.

Medicines and medical devices were obtained from licensed wholesalers. Medicines were largely stored appropriately but some loose blisters were found on the shelf. The blisters had been cut so key information such as the name, strength, formulation, batch number, expiry date or brand was missing. This may make it harder for the pharmacy to identify the medicine and demonstrate that it is safe to supply. The blisters were taken off the shelf for disposal. Checks were carried out on sections of the dispensary every month to make sure they were within the expiry date and any short-dated stock was highlighted with a sticker. Records of the checks in the dispensary were not maintained so some areas of the pharmacy may be overlooked. A random check of some medicines was carried out and no expired stock was found. Alerts about defect medicines was received by email and these were checked against the stock being held. But there was no record of who carried out the check, when it was completed and what action was taken which may make it harder to show that this has been done effectively.

Medicines requiring cold chain were stored in a large fridge and the temperature was seen to be in range. Records of the fridge temperatures were created daily. CDs were stored in a large CD cabinet and were stored in an organised manner. However, some patient returned CDs had not been clearly separated from stock medicines so there was a risk that these could be used. This heightened the risk of unsafe medicines being used as the pharmacy would not be able to demonstrate how they had been stored. The RP agreed to separate these and mark them as patient returns. Unwanted medicines were accepted by the pharmacy, but they were not being stored safely to prevent unauthorised access. There was a risk that these medicines could be accessed and either misused or sold.

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. Equipment is appropriately maintained so that it is safe to use, and it is used in a way that protects privacy.

Inspector's evidence

The pharmacy used the internet to access reference sources, including the BNF and NICE guidelines. Crown stamped measures were used to measure liquids. An automated measuring system was used to dispense doses of methadone and it was calibrated regularly with records available to demonstrate this. Electrical equipment appeared to be in good working order. Equipment for the NHS Pharmacy First service was available, and the calibration information was known to the RP.

The dispensary was screened to provide privacy for the dispensing operation. The consultation rooms were used for services that required privacy and for confidential conversations and counselling. Pharmacy computers were password protected and screens were positioned so that they were not visible to the public. Team members used cordless phones to enable private conversations with people.

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.