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: 29/10/2024

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. This was a re-inspection as the pharmacy had previously failed the last one in July 2024.

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	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 manage the risks associated with its services. It has written procedures available for its team members to follow to help make sure tasks are completed safely and effectively. Records of mistakes are made, and team members review them to learn and improve processes. The pharmacy keeps the records it needs to by law. Team members are aware of how to correctly keep people's private information safe, and they take appropriate steps to safeguard people that may be vulnerable.

Inspector's evidence

The pharmacy took relevant steps to adequately identify and manage the risks associated with its services. Mistakes identified as part of the accuracy check, also known as near misses, were recorded on an electronic platform and it contained details to show what had happened along with learning points to improve practices. A review of the previous months near misses was conducted to help establish the root cause of errors and any trends. For example, the person reviewing the near misses had found that one team member was involved in a number of picking errors. They provided some additional training to help mitigate this. Records for three 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. The pharmacy had improved the level of detail that it included when recording errors. The entries seen contained the team members involved and the specific action taken as a result of the errors.

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 superintendent (SI) subsequently addressed this and provided evidence that the driver had read the delivery procedures. 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 responsible pharmacist (RP) was absent. A correct RP notice was prominently displayed. Professional indemnity insurance was in place and covered the services provided.

The pharmacy 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. The pharmacy had improved on the recording of CDs that had been returned to the pharmacy. These were logged electronically to help maintain an audit trail of what stock was held. 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 offered 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. The pharmacy had recently installed additional security measures to make sure confidential waste was being held securely in a storeroom within the premises.

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 ongoing training is not provided so there may be gaps in their skills and knowledge.

Inspector's evidence

There were four 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 four dispensing assistants, two were qualified and two were enrolled on to a training course, two 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. 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 pharmacy had recently installed extra security measures to prevent unauthorised access to the room.

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 met

Summary findings

The pharmacy sources medicines from licensed suppliers and it stores them safely and securely. 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 the team carries out checks to make sure medicines are still safe to supply to people. The pharmacy provides a supervised consumption of medicines service effectively.

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.

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. Pharmacy team members had recently received some additional training to understand how additional dispensing labels can be printed from the automated dispensing machine. Tablets formulations were also provided, and these were dispensed each morning and they were stored safely in line with requirements.

A medicines delivery service was available for people in the local area. A record sheet was maintained to show when delivered had been scheduled but there was no record of what time the delivery was made and no signatures to confirm safe receipt of the medicines. This was not in line with the SOP for the delivery of medicines. The SI subsequently provided additional information to confirm signatures

were being captured. The pharmacy provided the NHS Pharmacy First service. The RP confirmed that they had received training to deliver the service and had signed the patient group directives (PGDs) which provided them the authority to treat the health conditions covered as part of the service. But these could not be located. The RP confirmed that they would keep a record in the pharmacy.

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, one detailed the descriptions of the medicines within them so that people could identify the medicines. However, one pack which contained three different white tablets only stated 'white tablets' which may make it harder to identify them. The risk of this was discussed and an assurance was provided to include more detail going forwards. Patient information leaflets were supplied so up to date information about the medicines could be accessed.

Medicines and medical devices were obtained from licensed wholesalers. Medicines were stored appropriately on the shelves and pharmacy medicines were stored securely behind the retail counter. 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. Records of the checks were maintained electronically but some recent alerts had not been actioned. The SI provided an assurance they would check them against the stock being held as a matter of urgency.

Medicines requiring cold chain were stored in a large fridge and the temperature was seen to be in range when checked. However, the maximum temperature had exceeded the required range. The RP reset the thermometer when this was highlighted to them and monitored the temperature over the course of the inspection. Records of the fridge temperatures were created daily. CDs were stored in a large CD cabinet and were stored in an organised manner. Patient returned CDs had been clearly separated from stock medicines to reduce the risk of them being supplied to people. Unwanted medicines were accepted by the pharmacy and were stored securely.

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.