General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Hilton Pharmacy, Welland Road, Hilton, DERBY, DE65 5GZ

Pharmacy reference: 1110209

Type of pharmacy: Community

Date of inspection: 26/06/2024

Pharmacy context

This community pharmacy is situated in Hilton, Derby. It is adjacent to a health centre. NHS dispensing is the main activity, and the pharmacy provides a number of other services such as the NHS Pharmacy First Service and a private prescribing service for minor illnesses. A medicine delivery service is available, and some people's medicines are provided in multi-compartment compliance packs to help them take their medicines correctly. An optician service is located inside the pharmacy. This service was not inspected.

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 largely identifies and manages the risks associated with the services that it provides. But its risk assessments for its private prescribing service do not fully address the risks involved, which means it may not always operate effectively. And the consultation notes maintained by the pharmacist prescriber do not always contain sufficient information which may make it harder to respond to any queries. Team members follow written procedures so that they can carry out tasks safely. The pharmacy generally keeps the records that are needed by law. Team members take appropriate action to protect people's information and take the opportunity to learn from mistakes that occur.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) that had been reviewed in January 2024. Pharmacy team members had signed most of the SOPs to state that they have read and understood them. Two team members had not signed some SOPs that were important to their roles and responsibilities. And the delivery driver had not signed the SOPs specific to the delivery of medicines. 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 what they could and could not do if the responsible pharmacist (RP) had to take a short leave of absence. The pharmacy had professional indemnity insurance in place to cover the services they were providing.

The pharmacy offered a pharmacist led private prescribing service which was managed by the superintendent pharmacist (SI). The SI was qualified as an independent prescriber, and they had completed training in acute illnesses. They mainly prescribed medicines suitable to treat minor infections such as chest and skin infections. A risk assessment was available for the prescribing service which covered some of the risks, but it didn't include all the potential risks that were associated with the service. For example, it didn't cover the risk of not following the local antimicrobial formulary or not calibrating diagnostic equipment specifically used for the service. This meant that the pharmacy may not always have the correct mitigations in place to minimise risk to help make sure that the service is provided safely. The SI provided an assurance they would review the risk assessment and identify other risks. An SOP was available which covered the prescribing service and a formulary had been created which detailed the medicines that the SI had complete training for to prescribe competently. They also used national guidance to help make prescribing decisions. The SI kept records that were associated with the prescribing service. This included consultation notes and copies of the prescriptions issued. However, some of the notes did not contain all the information that had been discussed during the consultation with the person. For example, red flags and safety netting advice had not been included. This would make it difficult for the pharmacy to demonstrate that this advice was provided in the event of a query or mistake. The SI subsequently amended the consultation notes template and provided this as evidence. An assurance was provided that they would capture this information going forwards.

Pharmacy team members made electronic records of mistakes that occurred when dispensing medicines also known as near misses. The pharmacist highlighted the mistake to the team member involved and they made a record in a near miss log so that they could reflect on it. Some action had been taken to reduce the chance of similar mistakes from happening again. For example, team

members had physically separated amlodipine, amitriptyline, and allopurinol due to the look alike sound alike nature in order to reduce them being picked in error during the dispensing process. Near misses were not reviewed as a collective which meant team members may be missing out on opportunities to identify common or emerging trends. 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.

The RP record was kept electronically and was complete. 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 prescriber details did not match the prescription. The pharmacy kept appropriate records of any unlicensed medications that they dispensed. Records for controlled drugs (CD) were also appropriately maintained. The records were in line with legal requirements and running balances were recorded. Balance checks of these medicines were completed frequently. A few of the balances were checked against the physical stock held in the CD cabinet and were found to be accurate. 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 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 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 the pharmacy provides support 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 pharmacist who was also the SI, six qualified dispensers and a delivery driver. One of the dispensing assistants was also training to complete accuracy checks of assembled prescriptions (ACD). Another team member worked at the opticians which was based inside the pharmacy. Their primary role was to support people using the optometry services but, on some occasions, they also helped serve people on the pharmacy retail counter, including handing out assembled prescriptions and selling medicines over-the-counter. They were not trained for this role and the risk of this was discussed with the SI. The team member was subsequently enrolled on to an accredited medicines counter assistant course.

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.

Team members received an appraisal every six months which helped them understand their progress and allowed them to talk about development opportunities. 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 processes, keeping up to date with pharmacy news and discussing workload. Team meetings were also held each quarter to review any errors and discuss team performance.

Members of the team understood when they would need to refer to the pharmacist for advice. A dispensing assistant explained they referred 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 clean and tidy which helps to maintain a professional appearance. A consultation room is available for the confidential provision of pharmacy services, including a pharmacist led prescribing service.

Inspector's evidence

The pharmacy was clean and tidy, and its team members managed the space well to help make sure that the workload was completed safely and effectively. Pharmacy team members were responsible for cleaning and shared the duties equally. Fixtures and fittings were well maintained and suitable for the storage of medicines. There was a clean sink with hot and cold water available which was used when preparing medicines that require mixing before being supplied to people.

The pharmacy had a consultation room which was suitable for the services that were being provided. The room was clearly signposted and was secure from unauthorised access. An optician was situated inside the premises and an area was dedicated for eye tests and selling associated products. 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 generally provides its services safely and effectively. Medicines are sourced from licensed suppliers and team members complete checks to make sure they are safe for people to use. The pharmacy occasionally offers a private prescribing service to treat minor illnesses, and it carries out some checks to make sure that medicines are being prescribed safely. But a record of these checks is not always maintained, and the pharmacy does not routinely communicate with people's regular doctor when prescribing and supplying medicines which may result in a lack of care continuity.

Inspector's evidence

The entrance to the pharmacy was step free and an automatic door led into a large retail area. It was easily accessible for those with wheelchairs or a pram. The opening hours and services provided were displayed on the doors and windows. A consultation room was clearly signposted and could be easily accessed by those with mobility issues. The pharmacy offered a prescription delivery service for people that wanted their medicines delivered to their home. A record of deliveries completed was maintained and signatures were obtained when medicines were delivered.

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 the prescription was assembled, the pharmacist would then carry out a clinical and accuracy check. And they signed 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. Some medicines were accuracy checked by one of the dispensing assistants who was qualified to complete the checks. Before this happened, the pharmacist on duty clinically checked the prescription and initialled it to show they had completed this part of the process. The accuracy checking dispensing assistant explained that they would not accuracy check any medicines if the prescription had not been initialled. And they did not check any CD items or if the person had been started on a new medicine.

Medicines that were waiting to be collected were stored securely and out of sight from people waiting in the retail area to maintain confidentiality. 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 3 and 4 CDs were also highlighted so that they were not handed out beyond their legal limit of 28 days. 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 team members were aware of the advice to provide when supplying valproate containing medicines. 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 carried out.

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 the regular pharmacist also knew how to make the packs in case they needed to help. A record sheet was maintained which contained details of the medicines people were on so that new prescriptions for the

compliance packs could be checked for accuracy against the record. Changes to medicines were confirmed with the person's doctor and a record of the change was kept. Some completed compliance packs were checked and included both the description of the medicines and patient information leaflets allowing people to identify their medicines and access up to date information about them. However, the backing sheets that had been applied to the packs were not securely attached. This meant there was a risk of them becoming misplaced and therefore difficult to identify who the compliance pack belongs to and the medicines that had been dispensed in the event of a query or a hospital admission. An assurance was provided to secure the backing sheets to the packs.

The pharmacy offered a private prescribing walk-in clinic for minor illnesses allowing people to be treated for chest infections and other acute infections. The volume of people using the service was low and this had reduced further with the introduction of the NHS Pharmacy First service. The service was not actively advertised to people. The SI explained they opportunistically offered the service when people found it difficult to see their regular doctor or if there was an NHS 111 referral. The SI accessed people's National Care Records (NCR) to help validate their medical history and check for any drug allergies. But a record of the check was not kept which would be useful if a query arose following a consultation. Notification of any treatment provided to the person's regular doctor was not routinely sent which meant there could be a lack of care continuity or risk of over prescribing. This was discussed with the SI who subsequently created a GP notification letter and provided an assurance that it would be sent after each completed consultation.

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 and were found to be in range. The expiry dates of medicines and devices was said to be checked every three months and a record made on a date checking matrix. However, the record had some gaps where checks may not have been completed. A sample of medicine stock was checked and found to be within its expiration date. Stock that was short dated was highlighted so that it could be picked up during the dispensing process. CD stock that had expired or was returned to the pharmacy was clearly marked and separated from the normal stock so that it was not mixed up during the dispensing process.

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

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. Its team members use the equipment in a way to help maintain privacy.

Inspector's evidence

The pharmacy had clean, calibrated conical measures available for measuring liquids when needed. Some measures were 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 and 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 looked to be in good working order.

The pharmacy had a range of healthcare equipment that was being used to provide the services on offer. This included a blood pressure monitor, a stethoscope and an otoscope. The RP was aware of how to calibrate the equipment so that it was accurate and safe to use. A range of information resources such as the BNF and NICE guidelines were accessed online.

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.