General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rushden Pharmacy, Rushden Medical Centre, Adnitt Road, RUSHDEN, Northamptonshire, NN10 9TR

Pharmacy reference: 1091462

Type of pharmacy: Community

Date of inspection: 27/11/2024

Pharmacy context

This community pharmacy is situated in a residential area of Rushden, in Northamptonshire. It is located within a medical centre. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu and COVID vaccinations, and the NHS Pharmacy First service. The pharmacy supplies medicines in multi-compartment compliance packs to some people to help them take their medicines at the right time.

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 team members follow written procedures, and this helps them to provide services safely and effectively. They know how to keep people's information safe. And they keep the necessary records as required by law. Members of the team discuss and record when things go wrong. And they review the records to help identify further learning opportunities.

Inspector's evidence

The pharmacy had written standard operating procedures (SOPs) which were updated in January 2024. Members of the team had signed to say they had read and accepted the SOPs.

The pharmacy had systems in place to identify and manage risk, such as the recording of dispensing errors and details of the subsequent learning outcomes. Near miss incidents were recorded on a paper log before being uploaded onto electronic software. The pharmacist had recently conducted a review of the errors and completed a monthly patient safety report. This was the first patient safety report to have been completed for some time. But most of the learning points which had been identified related to non-specific actions such as reminding members of the team to take extra care. So, the pharmacy may not be able to show it is doing all it can to learn from its mistakes.

The roles and responsibilities for members of the team were documented within the SOPs. A dispenser explained what their responsibilities were and was clear about the tasks that could or could not be conducted in the absence of a responsible pharmacist (RP). The correct RP notice was on display. The pharmacy had a complaints procedure. Any complaints were recorded and followed up by a member of the team. A current certificate of professional indemnity insurance was available.

Records for the RP and private prescriptions appeared to be in order. Controlled drug (CD) registers appeared to be in order. Running balances were routinely recorded and had been recently reviewed. Two CD balances were checked, and both were accurate. A separate register to record patient-returned CDs was available.

An information governance procedure was available. When questioned, a dispenser described how confidential information was separated and removed by a waste carrier for destruction. Safeguarding procedures were available. The pharmacist and pharmacy technician had both completed level 2 safeguarding training. Members of the team explained they would refer any concerns to the pharmacist in the first instance.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has fallen behind with the workload, but they are managing it safely. And they complete the necessary training for their role. Ongoing learning is available to team members, but the new pharmacy manger does not know what had been done previously. So it is not known whether ongoing learning needs are being met.

Inspector's evidence

The pharmacy team included a pharmacist manager, a pharmacy technician who was trained to accuracy check medicines, three dispensers, a medicine counter assistant, and a delivery driver. All members of the pharmacy team were appropriately trained. The pharmacy had previously been without a pharmacist manager for six months and a new pharmacist manager started around four weeks ago. Since commencing their post, the pharmacist manager had prioritised a number of routine tasks to complete, such as the recording of near miss incidents, and date checking.

The team had fallen behind with their dispensing work by around three days due to absences in the pharmacy team. During this time the team were prioritising the workload to dispense any acute prescriptions, such as urgent antibiotics. And they communicated to people who were waiting to set expectations and prioritise the workload. The team were not aware of any incidents about people going without medicines. To help and provide cover, part-time staff were working extra hours and some relief team members were providing cover from other pharmacy branches.

Members of the pharmacy team had completed online training packages, such as counter medicines training packages. Records of training were kept, but the pharmacist manager had not yet reviewed where members of the team were up to. So they may not be aware whether learning needs were being met. A dispenser provided examples of selling a pharmacy only medicine using the WWHAM questioning technique, refusing sales which they felt were not appropriate, and referring people to the pharmacist when needed.

Members of the team felt well supported by each other. They were seen working well together and assisted each other with any queries they had. Team members were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the SI. There were targets for professional based services such as flu vaccinations and Pharmacy First referrals. The team did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available for people to have a private conversation with a member of the team.

Inspector's evidence

The pharmacy was situated inside a medical centre, with its own independent entrance. It appeared adequately maintained. The premises were able to be secured. There were a large number of boxes in the dispensary, and these were stacked high. The boxes contained a bulk order of medicines which had been ordered incorrectly. The pharmacist acknowledged the boxes could impact the effectiveness of the dispensary and may present a hazard to members of the team. During the inspection, the boxes were moved to a storage room which corrected the potential hazard and enabled sufficient space for the workload. The room temperature was controlled by the central heating and lighting was sufficient. Team members had access to WC facilities.

A consultation room was available. It appeared to be clean, and it was clearly advertised to make people aware of its availability.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easy to access. And it manages and provides them effectively. It gets its medicines from licensed sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition. But members of the pharmacy team do not always know when they are handing out higher-risk medicines. So they might not always be able to check that the medicines are still suitable, or give people advice about taking them.

Inspector's evidence

The pharmacy and consultation room were easily accessible to those with additional mobility needs. Information was on display about the services offered. The pharmacy opening hours were also on display. The pharmacy had a medicines delivery service, and delivery records were kept. Unsuccessful deliveries were returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

The pharmacy team initialled dispensed by and checked by boxes on dispensing labels to provide an audit trail. They used dispensing baskets to separate individual patients' prescriptions to avoid items being mixed up. The baskets were colour coded to help prioritise dispensing. The pharmacist clinically checked each prescription and signed the prescription to show it had been checked. This enabled the accuracy checking technician (ACT) to perform the final accuracy check in line with the pharmacy's SOP. Owing slips were used to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were kept on a shelf using an alphabetical retrieval system. Prescription forms were retained, and stickers were used to clearly identify when fridge or CD safe storage items needed to be added. Team members were seen to confirm the patient's name and address when medicines were handed out. Members of the team used a CD date checking matrix to ensure 28-day prescriptions, such as schedule 3 and 4 CDs, were in-date for supply. The pharmacist would use 'speak to pharmacist' stickers to provide counselling advice when she identified a need. But there was no process to routinely speak to people who were taking higher-risk medicines (such as warfarin, lithium and methotrexate). So this was a missed opportunity. Members of the team were aware of the updated guidance for valproate-containing medicines and the risks. They supplied these medicines in their original packs. The pharmacist provided counselling advice and recorded the advice on the PMR. But some of the team were not aware of the updated drug safety alert for topiramate-containing medicines. The pharmacist acknowledged this was important information and would discuss it with the team following the inspection.

Some medicines were dispensed into multi-compartment compliance packs. A record was kept for each patient, containing details about their current medication. Any medication changes were confirmed with the GP surgery before the record was updated. Hospital discharge information was sought and kept for future reference. The compliance packs were supplied with patient information leaflets (PILs) and medication descriptions.

Medicines were obtained from licensed wholesalers. Any unlicensed medicines could be sourced from a specials manufacturer, but the pharmacy had not needed to do this for some time. The team had fallen behind with their process to check the expiry dates of medicines. Members of the team had recently

completed a check of the dispensary stock to catch up, but this had not been recorded. A spot check did not find any out-of-date medicines. Some liquid medicines did not have the date of opening written on. The team acknowledged this was important and they would review the stock present following the inspection. CDs were stored in CD cabinets. There were two medicines fridges, each equipped with a thermometer. Fridge temperature records were kept, and the temperatures had been in range for the past three months. Patient-returned medication was disposed of in designated bins. Drug alerts were received from the MHRA by email. The alerts were printed, action taken was written on, and filed away.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have access to the equipment they need for the services they provide. And they keep the equipment in a manner expected of a healthcare setting.

Inspector's evidence

Team members accessed the internet for general information. This included access to the British National Formulary (BNF), BNF for Children and Drug Tariff resources. All electrical equipment appeared to be in working order. There was a selection of liquid measures with British Standard and Crown marks. A tablet triangle for counting loose tablets was also present. Equipment appeared clean.

Computers were password protected and screens were positioned so that they weren't visible to external delivery drivers. A cordless phone was available in the pharmacy which allowed team members to move to a private area if the phone call warranted privacy.

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.