General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rosemary Street Pharmacy, Rosemary Street, MANSFIELD, Nottinghamshire, NG19 6AB

Pharmacy reference: 1115749

Type of pharmacy: Community

Date of inspection: 12/08/2024

Pharmacy context

The pharmacy is next to a health centre in the market town of Mansfield, Nottinghamshire. It is open late into the evening, seven days a week. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. It provides NHS services including Pharmacy First, the New Medicine Service (NMS), contraception and blood pressure checks. And it also offers a private ear care service. The pharmacy supplies some medicines in multi-compartment compliance packs, designed to help people remember to take their medicines. And it offers a medicine delivery service.

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 effectively identifies and manages the risks for providing its services. It mostly keeps the records it needs to by law. And it uses the feedback it receives to help inform improvements to the way it delivers its services. Pharmacy team members treat people's confidential information with care. They know how to recognise, and report concerns to help protect vulnerable people. And they behave openly and honestly by engaging in regular reviews designed to reduce risk following the mistakes they make during the dispensing process.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) to support it in operating safely and effectively. Its superintendent pharmacist (SI) had reviewed these within the last year. Overall, the SOPs reflected the processes observed. But some information, such as how to report a mistake identified following the supply of a medicine, known as a dispensing incident, had not been updated to reflect changes to current practice. A roles and responsibilities matrix helped team members to identify the SOPs relevant to their role. And training records showed they had mostly read these SOPs to support them in working safely. A pharmacy technician, working in an accuracy checking role (ACPT) demonstrated how the responsible pharmacist (RP) physically marked prescriptions to show they had carried out a clinical check of them. ACPTs only undertook accuracy checks of medicines following this check. An ACPT discussed feeling confident in referring any queries during the checking process to the RP.

The pharmacy had a business continuity plan and it provided useful contact information to its team members in the event urgent assistance was required to resolve a maintenance, utilities, or IT issue. The pharmacy effectively managed the risks of introducing new services. For example, it had a documented risk assessment for its new ear care service. And had developed a SOP to support the effective management of the service. The pharmacy had contacted its professional indemnity insurance provider about the change in services to ensure appropriate cover was in place prior to the service commencing. The service was provided by a nurse, the pharmacy had reviewed their training certificates and professional registration as part of the service implementation process.

The pharmacy had processes for managing mistakes its team members made and identified during the dispensing process, known as near misses. Following a mistake being identified, team members checked their work and corrected their mistake. The pharmacy had used safety reviews to help promote the importance of reporting near misses. Near miss reporting was consistent with team members acting openly and honestly by reporting their own mistakes. A manager reviewed the near miss records for trends, and they shared learning from these reviews with all team members through a secure messaging application. Team members provided examples of recent improvements to the storage of medicines by labelling shelves in the dispensary. The pharmacy manager demonstrated how dispensing incidents were reported, and records of these incidents were kept. The team demonstrated how it acted to reduce risk following these types of incidents. For example, two medicines with similar names had been segregated from each other within the main dispensary to reduce the risk of a similar mistake occurring.

The pharmacy had a complaints procedure. It advertised how people could make comments or raise concerns about its services on its website. But there was no notice explaining to people visiting the pharmacy how they could do this. A team member explained how they would take details of a concern and aim to resolve it themselves, with escalation to the RP or a manager if required. The pharmacy had experienced a difficult period of a few months within the last year which had resulted in a sharp rise in the feedback it received. It had used this feedback effectively to inform a series of changes. This included improvements to the way it managed the process for ordering medicines not readily available to dispense, known as owings. It had also used feedback from a GPhC assurance visit at the beginning of the year to inform change.

Pharmacy team members had completed learning to support them in managing confidential information with care. The team stored all confidential information in staff-only areas of the premises. The pharmacy had recently completed its NHS data security toolkit and it was registered with the Information Commissioner's Office. It followed secure processes when disposing of its confidential waste. Pharmacy team members had completed learning to help them recognise and report a safeguarding concern. And contact information for safeguarding teams was accessible to the team. Team members had some general awareness of what to do if somebody attended the pharmacy asking for access to a safe space. But the team had not engaged in any specific learning about safety initiatives promoted by domestic violence charities to help them recognise how these requests might be made.

The pharmacy had current professional indemnity insurance arrangements. The RP notice displayed the correct details of the RP on duty. And the RP record was completed in full. A sample of records made in the private prescription register found team members did not always enter the date of prescribing when entering the supply of a medicine against a private prescription. And the team frequently used dispensing labels in the register. This meant that some information could potentially be removed or fade over time, making it more difficult for the pharmacy to answer any queries that may arise following dispensing. The pharmacy kept its controlled drug (CD) register electronically. It completed regular balance checks of physical stock against its register. A random check of the physical stock of two controlled drugs matched the balance recorded in the register. The pharmacy held a separate record of the patient-returned CDs it received, and it entered return in the register at the point of receipt.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough appropriately trained and knowledgeable staff to deliver its services safely and effectively. It supports team members in developing their skills by encouraging regular learning. Pharmacy team members are happy in their roles, and they work together well. They feel able to provide feedback at work and they engage in regular reviews to help share learning and manage risk.

Inspector's evidence

The pharmacy had two managers. The general manager provided overarching support to the pharmacy to help ensure it was operating safely and effectively. They completed administrative duties and did not have any direct role in tasks requiring specific pharmacy training. The pharmacy manager was an ACPT and led the multi-compartment compliance pack dispensary as part of their role. An ACPT working in the main dispensary supported the management team in day-to-day tasks such as authorising leave.

On duty during the inspection was the RP, who was the SI. Both managers, a medicine counter assistant (MCA), three dispensers and an ACPT were also present. Another two dispensers joined the team shortly before the inspection concluded. The pharmacy also employed another ACPT, five dispensers, two MCAs, a trainee dispenser and two permanent delivery drivers. It had employed a temporary delivery driver to support it in covering some unplanned leave. The SI worked two to three days a week in the pharmacy with regular locum pharmacists covering the remaining days. The pharmacy had processes to monitor its staffing levels and skill mix effectively over its extended opening hours. And it regularly reviewed its staffing levels and planned for upcoming changes effectively. The team was up to date with its workload and team members appeared enthusiastic in their roles. The SI discussed how they were supported in providing consultation services and targets did not impact on their professional judgement when providing these services. Pharmacy team members took regular opportunities to engage in learning relevant to their role. This included mandatory learning such as safeguarding requirements and learning to support the effective delivery of the pharmacy's services. Team members were supported by a structured appraisal process to help them develop within their roles. Two MCAs were currently enrolled on formal training programmes to support them in safely completing stock management tasks within the dispensaries.

Team members engaged in frequent discussions to help manage workload. They took regular opportunities to share feedback about safety events. In addition to sharing learning from patient safety reviews through the secure messaging application, the pharmacy used the application to update all team members on any changes to processes or to make them aware of any current issues and all team members could contribute within this group forum. The pharmacy had an employee handbook which provided details of the standards and behaviour expected of its team members. The handbook provided information to team members about how they could provide feedback at work. And team members understood how they could raise and escalate a concern at work. A manager explained how feedback was used to trial changes to processes, these were then reviewed to ensure they were effective before being permanently adopted. For example, the introduction of barcode technology to support the team in identifying which stage a prescription or medicine was at during the dispensing and delivery process.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is secure and well maintained. It provides a clean and professional environment for delivering healthcare services. People visiting the pharmacy can speak to team members in confidence in a private consultation room.

Inspector's evidence

The pharmacy was secure, very clean and maintained to a good standard. A maintenance person completed regular maintenance work. A contracted cleaner undertook cleaning tasks in the presence of pharmacy team members. And a cleaning and waste checklist was used to monitor cleanliness and hygiene standards. The pharmacy was subject to health and safety audits and there was a health and safety risk assessment in place. Lighting was bright throughout the premises and air conditioning effectively controlled the temperature throughout the premises. Pharmacy team members had access to sinks equipped with handwashing supplies and hand sanitiser was available for use.

The premises consisted of a largely open plan public area leading to a medicine counter. The public area provided access to the pharmacy's consultation room and to a customer toilet. The main dispensary was beyond the medicine counter. The dispensary was a modest size for the level of activity carried out and workflow was managed well. Workbenches were free of clutter and floors were free from trip hazards. Team members accessed the pharmacy's consultation room through a door to the side of the dispensary, the public facing door was locked between use. The first floor consisted of a good size second dispensary used to managing dispensing tasks for the multi-compartment compliance pack service, a stock area, office space and a staff break area. The pharmacy had a website which it used to provide helpful information about its services to people. It did not provide any services through its website. The website provided the pharmacy owners details. But it did not provide details of the pharmacy's GPhC registration number or the details of its SI.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy ensures its services are easily accessible for people. It works well with other local healthcare providers to support people in accessing support and treatment in a timely manner. And it provides people with the information they require to help them take their medicines safely. The pharmacy obtains its medicines from reputable sources. It stores its medicines safely and securely. Its team members apply a series of checks to ensure medicines are safe to supply to people.

Inspector's evidence

People accessed the pharmacy through either an automatic door from street level or through an internal door between the pharmacy and health centre. The pharmacy advertised its opening times to people. And it provided information about its services on noticeboards within the public area. Ample seating was available for people waiting in the public area. Team members had a good awareness of other local pharmacies and healthcare organisations. And they knew to signpost people to these if the pharmacy was unable to provide a medicine or a service. Several team members spoke a second language and they used their language skills to communicate with people visiting the pharmacy. The team identified specific communication needs on people's patient medication record (PMR) to support team members in acknowledging these.

The pharmacy provided a range of consultation services. Pharmacists providing these services had access to service specifications, procedures, and current Patient Group Directions to help them provide the service safely. The nurse providing the ear care service had access to the procedures and risk assessment for the service. The pharmacy worked well with the neighbouring GP practice and had established a process to triage referrals received for the treatment of minor ailments through the Pharmacy First Service. This involved the RP reviewing the referral form and conducting a telephone triage call with the person in the first instance to ensure the pharmacy could provide the support the required. If the referral was appropriate people were asked to attend the pharmacy for a consultation. If the pharmacy was not able to support the person, the RP contacted the GP surgery so a GP appointment could be arranged. This supported people in accessing timely treatment and advice from the right healthcare professional.

The pharmacy stored Pharmacy (P) medicines behind the medicine counter. The RP had appropriate supervision over the medicine counter and public area. Team members shared information with each other about repeat requests for P medicines liable to abuse and they referred these requests to the RP. The RP discussed how they managed these requests and had refused sales and signposted people to see their GP when a request was not appropriate. Pharmacy team members generally understood the requirements of the valproate Pregnancy Prevention Programme (PPP). And the pharmacy had recently received some tools to support it in complying with the topiramate PPP. The RP discussed how they would make appropriate checks and counselling when supplying medicines requiring compliance with PPPs to people. But the team did not fully understand all recent legal changes about supplying valproate in original packs. A discussion about these changes led the team to review how the pharmacy supplied valproate to ensure it supplied the medicine as the changes required. The pharmacy had a process for flagging prescriptions to inform team members of the need to refer to a pharmacist for further counselling. And the RP discussed some of the counselling they provided when handing out

medicines. But the team did not routinely record these types of verbal interventions on people's medication records to support continual care.

The pharmacy team used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. Team members took ownership of their work by signing their initials within the 'dispensed by' and 'checked by' boxes on medicine labels. Team members were seen logging off the PMR system when they had completed tasks, this prevented shared use of their individual profiles and meant that the audit trail for the generation of medicine labels was accurate. They provided relevant safety information when supplying medicines, such as patient information leaflets. The pharmacy kept an audit trail of the medicines it owed to people, and it demonstrated how the changes made to the way it processed owings worked effectively. It made a series of checks on stock availability. It contacted people if a medicine was likely to be unavailable for some time to help ensure they had enough time to discuss this with their prescriber, and to obtain a prescription for an alternative medicine before their current supply ran out. The pharmacy kept audit trails of the medicines it delivered to people.

The pharmacy supplied medicines in multi-compartment compliance packs to a large number of people. The pharmacy team used a work schedule and individual patient records to support it in providing the service safely. It identified changes clearly on the individual record sheets, along with the date of the change. But team members did not routinely document the checks they made to support them in applying changes. This meant it may be more difficult for team members to answer any queries related to the changes made. A sample of compliance packs examined were labelled clearly with handwritten descriptions of the medicines inside the compliance pack provided. The pharmacy delivered some multi-compartment compliance packs to people living in a care home. It provided medicine administration record (MAR) sheets alongside the compliance packs to support care home staff in administering medicines. And it had regular communication with care staff to support it in providing this service.

The pharmacy obtained its medicines from licensed wholesalers, and it stored them neatly and within their original packaging. The team followed a series of checks when dispensing medicines, which included checking the expiry date of medicines to help ensure medicines were safe to supply. It identified medicines with short expiry dates through its regular checks of stock medicines and it recorded these checks. Team members explained there was a current focus on ensuring these checks remained up to date. A random check of dispensary stock found two out-of-date medicines. These were brought to the direct attention of the RP for safe disposal. The team marked liquid medicines with details of their opening dates to ensure they remained safe to supply. The pharmacy kept CDs securely in cabinets, there was designated space within the cabinets for holding assembled medicines, date-expired and patient-returned CDs. The pharmacy's medicine fridges were an appropriate size for the medicines they held. The team generally monitored and recorded the operating range of the fridges daily. Records showed the temperature had remained within the required range of two-eight degrees Celsius. The pharmacy had appropriate medical waste receptacles to support the safe disposal of medicine waste. And medicine waste awaiting processing was clearly held away from stock medicines. The pharmacy received medicine alerts electronically and it demounted the checks it made in response to these alerts.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs to provide its services. Its team members regularly check equipment to ensure it remains in safe working order. And they use the equipment in a way which protects people's confidentiality.

Inspector's evidence

Pharmacy team members had access to paper-based reference resources such as the British National Formulary. They also used a range of digital resources online to help them resolve queries and obtain up-to-date information such as the Specialist Pharmacy Service website. Team members used password-protected computers and NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicines on designated shelving within the dispensary, and out of line of sight of the public area.

Pharmacy team members had a range of equipment for providing its consultation services, this was from recognised manufacturers. Equipment for measuring and counting medicines was standardised and separate equipment was used when counting cytotoxic medicines to avoid the risk of cross contamination. Specialist equipment was available to support team members in removing medicines from the manufacturers foil packaging when supplying them in multi-compartment compliance packs. A team member demonstrated how the equipment worked and explained the need to assess the suitability of the medicine and foil packaging prior to using it. The team routinely cleaned equipment between use, and it checked equipment regularly to ensure it was free from wear and tear. Electrical equipment was in working order and portable appliance testing took place at scheduled intervals.

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.