General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 99 North Road, DARLINGTON, County Durham, DL1 2PS

Pharmacy reference: 1029414

Type of pharmacy: Community

Date of inspection: 05/10/2022

Pharmacy context

The pharmacy is opposite a surgery on a main road leading into the centre of Darlington, County Durham. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. It 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 identifies and manages the risks associated with its services appropriately. It advertises how people can provide feedback. And it shares information with people about the availability of its services to help support it in managing feedback. The pharmacy keeps people's private information secure. And it mostly keeps the records it must by law. Pharmacy team members act swiftly to report concerns to protect the wellbeing of vulnerable people. And they engage in shared learning following mistakes they make during the dispensing process to reduce the risk of similar mistakes occurring.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) to support its safe and effective running. These covered responsible pharmacist (RP) requirements, controlled drug (CD) management, dispensary processes and services. It held SOPs electronically and reviewed them on a rolling two-year rota. Pharmacy team members could access the SOPs as required. And training records confirmed they had completed learning associated with the SOPs. Pharmacy team members on duty were observed completing tasks in accordance with SOPs, such as checking their work prior to signing medicine labels to provide a dispensing audit trail. They confidently discussed and demonstrated their roles and responsibilities. For example, one team member explained clearly what tasks could not be completed if the RP took absence from the premises.

Pharmacy team members engaged in some learning following mistakes made and identified during the dispensing process, known as near misses. This learning involved team members correcting their own mistakes, discussing them and recording them within a near miss record. But near miss reporting was inconsistent at times. For example, the last mistake in the record had been recorded around a month ago. The team reflected on some increased pressures over the last month which may have contributed to a gap in formal recording. This included staff absences due to sickness, annual leave, and training. A discussion highlighted the importance of recording mistakes to support continual shared learning opportunities. There was evidence of regular patient safety reviews taking place. And team members had recently changed the layout of the dispensary to help improve safety and efficiency when dispensing. The pharmacy had a clear process for reporting mistakes identified after a person received their medicine, known as dispensing incidents. Team members reported dispensing incidents electronically to its superintendent pharmacist's (SI's) team. And they retained a copy of the incident report within the pharmacy to help address learning points. Pharmacy team members demonstrated recent safety improvements when handing out bags of assembled medicines to people. This included highlighting information to prompt careful checks of names and addresses. And it supported team members in completing date-of-birth checks when people with the same name lived at the same address.

The pharmacy had a complaints procedure and this was advertised. Pharmacy team members recognised how they would manage feedback and understood how to escalate a concern when required. There was a clear notice displayed at the pharmacy's entrances and at the medicine counter explaining to people that flu vaccinations were currently out of stock. The notice provided details of the expected delivery date if people wished to attend for a vaccination. Team members explained how this had helped reduce feedback about the temporary unavailability of the service whilst waiting for more

stock. Pharmacy team members completed mandatory learning associated with safeguarding vulnerable people. The RP confirmed they had completed level two learning on the subject. A team member shared examples of how the team had supported people who had attended the pharmacy seeking urgent assistance. The pharmacy had provided a safe place for these people to wait until the police arrived. And pharmacy team members had been offered some support following these events due the potential impact on their own mental health and wellbeing.

The pharmacy stored personal identifiable information in staff-only areas of the premises. It held confidential waste in designated areas of the dispensary and shredded this at regular intervals. The pharmacy had up-to-date indemnity insurance. The RP notice displayed contained the correct details of the RP on duty. A sample of pharmacy records examined confirmed the pharmacy generally kept the records required by law in good order. But there were some gaps in the RP record where pharmacists had not signed out. The pharmacy maintained running balances in the CD register. And the team completed regular full balance checks of CD stock against the register, these were generally weekly. A random physical balance check of a CD conducted during the inspection complied with the running balance in the register. But the pharmacy team did not always enter the address of the wholesaler in the register when entering receipt of a CD as required.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has suitably skilled and knowledgeable people working to provide its services safely and effectively. Pharmacy team members complete regular learning relevant to their role. And they receive support and time at work to complete this learning. They understand how to raise concerns at work. And they engage in discussions relating to patient safety and risk management.

Inspector's evidence

The RP was a locum pharmacist who had worked at the pharmacy a number of times previously. They were supported by the pharmacy manager, who was a qualified dispenser, another qualified dispenser, and a trainee dispenser during the inspection. The pharmacy also employed a trainee medicine counter assistant. A company employed driver completing tasks associated with the medicine delivery service. The pharmacy did not employ a regular pharmacist, team members reported that regular locums provided cover. The team reported that its workload had increased in recent months. And there was evidence of staffing levels and skill mix being reviewed in response to these changes in workload. For example, the team had recently been notified of plans to advertise for an additional part-time team member. Pharmacy team members reported working flexibly to cover absences. And the pharmacy team reported receiving some support from the company's local relief team if it raised a need for additional cover.

Pharmacy team members engaged in ongoing learning relevant to their role. Trainees received some time at work to support the completion of their learning. And all team members received some ongoing support to help monitor their learning and development through an appraisal process. Each team member had their own e-learning training record. And this showed completion of courses relevant to working in a healthcare environment. The RP confirmed that specific targets had not been discussed when agreeing their shift at the pharmacy. The manager had commenced their role earlier in the year. It was their first management placement and they had been enrolled on a training course to support this career pathway. They discussed feeling supported by the pharmacy's area manager. And worked with the area manager towards meeting mini targets designed to support the ongoing safe running of the pharmacy. For example, the recent change in layout of the dispensary had formed a mini target. And the current mini target involved organising the patient safety folder to help team members access documents designed to share learning. Pharmacy team members communicated well with each other. They engaged in regular conversations at work about their ongoing learning, workload, and patient safety. But they did not always take the time to record details discussed in team meetings to help monitor the effectiveness of any changes they made. The pharmacy had a whistle blowing policy and details of a confidential support service was clearly advertised to team members. Team members understood how to raise and escalate a concern if needed.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure, and suitably maintained. People using the pharmacy can speak with a member of the pharmacy team in confidence in a private consultation room.

Inspector's evidence

The pharmacy was secure and appropriately maintained. There was a clear process for reporting any maintenance concerns. The pharmacy was clean, and generally free from clutter. Lighting and ventilation throughout the premises was appropriate. Pharmacy team members had access to sinks equipped with antibacterial hand wash and paper towels. Hand sanitiser was available for use. The public area was large and open plan. It was split between two levels by a step with a door on each level. The consultation room was accessible from the front entrance of the pharmacy. It was clean and professional in appearance. It offered a suitable space for holding private conversations.

A barrier deterred unauthorised access beyond the medicine counter. The dispensary was split between two rooms with stock medicines held in each. The front dispensary provided space for completing general dispensing tasks such as labelling, assembling, and checking prescriptions. The back dispensary provided some protected workspace for completing higher-risk tasks, such as managing the multi-compartment compliance pack service. There was also a small kitchen area in this dispensary. A small storeroom and staff toilet facilities led off this area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. It obtains its medicines from reputable sources. And it generally stores and manages its medicines safely and securely. Pharmacy team members engage people in conversations about their health and their medicines. But they do not always supply information leaflets for all medicines. This may limit the information some people have available to support them in taking their medicines safely.

Inspector's evidence

People could access the pharmacy through several entrances, one of these had a ramp with handrails leading from street level. The multiple entrances allowed people to access both levels of the public area with ease. The pharmacy's designated waiting area had seats available for people to sit down whilst waiting. And it had a good range of information leaflets available about the pharmacy's services and common health conditions. Pharmacy team members were aware of how to signpost a person to another pharmacy or healthcare provider if they required a service which the pharmacy could not provide.

The pharmacy held its Pharmacy (P) medicines behind the medicine counter and behind plastic screens opposite the counter. This protected them from self-selection and the RP was able to supervise activity in the public area. The pharmacy team was aware of counselling and monitoring checks when supplying higher-risk medicines. For example, checking if people attended for regular blood tests. But the team did not record the outcome of these types of interventions on people's medication records. Pharmacy team members understood dispensing requirements related to the valproate Pregnancy Prevention Programme (PPP), including ensuring the necessary safety information was included when supplying valproate to people. The pharmacy did not currently dispense to anybody within the at-risk group. The RP discussed the requirements of the PPP and understood the need to issue the patient card when dispensing valproate to people within the at-risk group. The pharmacy stored assembled cold-chain medicines in clear bags. This prompted additional checks when handing out the medicine.

The pharmacy had up-to-date patient group directions (PGDs) and equipment available to support the flu vaccination service when further stock of the vaccine became available. There was a clear process to support locum pharmacists in engaging with people enrolled on the NHS New Medicine Service (NMS). The process allowed pharmacists to see what follow-up consultations were required each day. The pharmacy was able to provide the NHS hypertension case-findings service. But team members reported that there had been no uptake of this service to date. The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. The pharmacy kept original prescriptions for medicines owing to people. Team members used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy maintained an audit trail of the medicines it delivered to people. This supported it in answering queries related to the delivery service.

The pharmacy sent some dispensing workload offsite to the company's hub pharmacy. It had a list of exception items which meant that it did not send prescriptions for some medicines requiring specific storage requirements or monitoring to the hub pharmacy. A team member demonstrated the process

for transferring details of these prescriptions to the hub pharmacy. This included the process for team members entering prescription data and the process for completing accuracy checks of this data. The clinical check of these prescriptions was recorded and completed every six-months. There was a process to ensure the clinical check was repeated when new medicines were prescribed, or when changes to current medicine regimens took place. Records examined identified appropriate clinical checks had taken place when medicine regimens had changed. The hub then dispensed these prescriptions and sent the medicines to the pharmacy for people to collect, or for the pharmacy to deliver. Pharmacy team members could demonstrate how they managed prescriptions when part was dispensed at the hub and part was dispensed in the pharmacy. This included ensuring those locally dispensed were assembled and checked in good time.

The hub pharmacy dispensed some people's medicines into a pouch system. The pouch system was designed in a way that allowed people to detach the pouch containing their medicines for specific times of the day. And the system contained 28 days' worth of medicine in date and time order. The system was designed to help people manage their medicines easier. And prior to people starting on the system a team member met with them to provide specific details of how the system worked. And to establish whether the person understood how to safely use the system to help them take their medicines. This meeting included demonstrating sample packaging and going through a specific guide relating to how to use the pouch system. Patient information leaflets (PILs) were supplied to some people. But there was an option on the patient medication record (PMR) to suspend the provision of PILs, and the pharmacy team did tick this for the majority of people.

The pharmacy supplied a small number of people with their medicines in multi-compartment compliance packs. The manager explained that the locally dispensed compliance packs were not offered routinely to people. But would be an option for people with specific requirements or when an assessment identified that they were unable to manage their medicines in original packs or the pouch system. Workload associated with this service was monitored by the SI's team to ensure the pharmacy had the capacity to cope safely in managing it. The pharmacy used individual patient record sheets to record people's medication regimens. A sample of assembled compliance packs contained full dispensing audit trails and descriptions of the medicines inside the packs. But the backing sheets did not contain adverse warnings associated with the medicines supplied within the compliance packs. The manager addressed this concern and sought assistance from the PMR software provider shortly after the inspection to rectify the issue. The pharmacy considered people's individual requirements when dispensing medicines in compliance packs. For example, a backing sheet attached to one pack was printed on coloured paper. This allowed the person receiving the pack to read the information more clearly. But the pharmacy did not routinely supply PILs alongside compliance packs.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner, within their original packaging, on shelves. The pharmacy stored CDs appropriately within secure cabinets. Medicines inside were stored in an orderly manner with baskets used to help prevent them becoming mixed up with similar looking medicines. The pharmacy stored medicines requiring refrigeration in appropriately sized fridges. It monitored fridge temperatures and these records confirmed they were operating within the correct temperature range of two and eight degrees Celsius.

The team regularly recorded the completion of date checking tasks. But random checks of stock found an out-of-date medicine in the dispensary and some out-of-date plasters in the consultation room. Pharmacy team members routinely checked expiry dates during the dispensing process which reduced the risk of supplying an out-of-date medicine and short-dated medicines were highlighted. The manager acted immediately to replace the plasters in the consultation room. A discussion highlighted the need

to ensure equipment and sundries within the room were date checked regularly. The pharmacy had appropriate medicinal waste bins and CD denaturing kits available. It was storing some excess medicine waste due to some delays in collections. And this issue had been escalated to ensure a collection was arranged. The waste was stored in a separate room to stock medicines and suitably secured in bins and boxes. The pharmacy received and actioned medicine alerts electronically with an audit trail showing the action taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to the equipment they require to provide the pharmacy's services safely. And they manage and use this equipment appropriately.

Inspector's evidence

The pharmacy had appropriate and up-to-date written and electronic reference resources available to its team members. Pharmacy team members had access to the internet and intranet to help them answer queries and keep up to date with information. The pharmacy protected its computers from unauthorised access through the use of passwords and NHS smart cards. It stored bags of assembled medicines on shelving within designated areas of the dispensaries. This protected details on bag labels and prescription forms from unauthorised view. Pharmacy team members used a cordless telephone handset when speaking to people over the telephone. This meant they could move out of earshot of the public area if the phone call required privacy.

The pharmacy team used calibrated measuring cylinders for measuring liquid medicines. Equipment for counting capsules and tablets was also available. There was separate equipment available for counting and measuring higher-risk medicines. This mitigated any risk of cross contamination when dispensing these medicines. Equipment used to support the delivery of pharmacy services was from reputable manufacturers. The pharmacy maintained its equipment to help ensure it remained fit for purpose. For example, electrical equipment was subject to regular portable appliance testing.

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.