General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, Folly Lane, WARRINGTON, Cheshire, WA5 0LZ

Pharmacy reference: 1029819

Type of pharmacy: Community

Date of inspection: 27/11/2019

Pharmacy context

The pharmacy is next to a medical centre close to the centre of Warrington. It mainly dispenses NHS prescriptions, including dispensing methadone to some people. It sells a range of over-the-counter medicines. The pharmacy delivers medicines to people's homes. It provides NHS services such as the new medicines service (NMS). And it provides a seasonal flu vaccination service. The pharmacy provides some medicines in multi-compartment compliance packs. And dispenses prescriptions for people living in two care homes.

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 appropriately manages the risks to its services. It has up-to-date written procedures relevant to its services. And the team members have read them. The team members keep people's private information secure. And they mostly maintain the records they must by law. They understand the importance of acting upon concerns to help protect the welfare of children and vulnerable people. The pharmacy team uses the information recorded about mistakes during dispensing to learn. But could analyse the information in greater detail to improve ways of working. And to further reduce the risks of mistakes in the future.

Inspector's evidence

The pharmacy was large and airy with a high roof. The retail area and main dispensing area was open plan. The pharmacy counter ran the width of the premises. And there was a barrier to one side of the pharmacy counter to allow access to the dispensary and staff only areas. This barrier was opened using a latch, so it provided a good deterrent to prevent unauthorised people entering the dispensary. The dispensing and checking bench faced outwards into the retail area. So, there was good visibility into the shop. It was far enough away from the pharmacy counter that the team could discuss confidential matters in the dispensary without being overheard. The pharmacist could easily oversee pharmacy sales and the advice the team gave. The pharmacist had recently started as the manager in the pharmacy. He described how the team was concentrating on improving professional standards. And providing a good dispensing service. There had been a period of time without a manager and this had been a difficult time for the whole team. The pharmacy had transferred the multi-compartment compliance packs to another pharmacy for a short time. So, the team could concentrate on its dispensing services and providing other services for people.

The pharmacy held a set of up-to-date standard operating procedures (SOPs) electronically. And it had paper copies of the SOPs printed off. The most recent addition to the SOPs seen was for the Community Pharmacist Consultation Scheme (CPCS). The training record had been signed by team in November 2019. The team were in the process of reading and signing off the most current SOPs. And there were training records available. The pharmacy had a document entitled " Who needs to read each SOP". This listed all the SOPs and detailed which role was required to read which SOP. This helped make clear the roles and responsibilities in the team. The SOPs were relevant to the services provided. They included SOPs for controlled drug (CD) management, responsible pharmacist (RP) regulations and dispensing procedures relating to the company's offsite dispensing programme.

The pharmacy had a SOP relating to near miss errors and another for the management of dispensing incidents. The pharmacist described how he identified a near miss error and discussed the error with the team member at the time. So, it was easier to identify why the error had occurred. The pharmacist described how the number of near miss errors had decreased since the introduction of offsite dispensing. The team recorded some near miss errors each month. The records were checked from April 2019. The records didn't contain details of why the error occurred, any learning or any actions taken as a result. The pharmacy had attached one handwritten alert message next to pregabalin, which alerted the team to check the strengths on selection. However, since the message had been attached there had been another similar near miss error. This was discussed during the inspection with ideas of how another error could be prevented. The team had completed training in relation to look-alike and

sound-alike medicines (LASA) and this had raised awareness. But the team members hadn't really analysed if they could take any further action to minimise the risks of errors with these medicines. The pharmacy recorded dispensing errors electronically. And the pharmacist produced a copy of a recent submitted report. All details had been added and some action had been taken. But there could have been more information with regard to learnings and actions taken. The pharmacy team had informal meetings to discuss patient safety rather than regular planned and recorded meetings.

The pharmacist displayed the correct RP notice. And the pharmacy team members understood their roles and responsibilities. The team members described what tasks they could and couldn't complete in the absence of the RP. They were seen completing tasks associated with their roles throughout the inspection. This included the pharmacist completing clinical checks and an accuracy checking technician (ACT) completing accuracy checks. During the inspection it was clear that the pharmacist completed the clinical check on prescriptions before dispensing. And then the ACT completed the accuracy check. The pharmacist was seen signing the bottom of prescriptions for people that were waiting for them, to indicate they had been clinically checked. But he didn't always refer to the person's medication record when completing these checks. This was discussed during the inspection. And the records were checked for all prescriptions following this. There wasn't a complete audit trail on all prescriptions checked by the ACT. Although there was a stamp available, it wasn't being used as part of the dispensing and checking process. For the prescriptions processed for offsite dispensing the pharmacy team used a series of labelled baskets. So, it was clear whether prescriptions were waiting for data entry, for the clinical check or for the accuracy check to be completed. But there wasn't a robust audit trail on the prescription to indicate these checks had been completed as the stamp wasn't used. The clinical and accuracy checks for repeat prescriptions were completed electronically. There was no requirement for the pharmacist or ACT to individually log on to the system to complete these checks. The person completing the check entered their own registration number to complete the check. This potentially could be completed by another team member, but the processes being followed in the pharmacy were robust enough to prevent this. The pharmacist explained how not all prescriptions were highlighted for a clinical check on the system on each occasion. This was due to the safety profile of the medicines. And the fact people's medicines hadn't changed. But he didn't have full details of exactly how the system identified which medicines were not selected for the clinical check each time. No risk assessment or protocol for which medicines this included was seen during inspection.

The pharmacy had a complaints procedure. And it had a practice leaflet that people could pick up, so people knew how to make a complaint or provide feedback. The pharmacy displayed a poster with the same information near the counter. The pharmacist manager and team members described the pharmacy's complaint procedure. They were confident to deal with concerns and knew when to escalate to the manager or area manager if necessary. The pharmacy asked people for feedback using an annual questionnaire. And the pharmacy had some blank questionnaires on the counter at the time of the inspection. The pharmacy displayed the results of a past survey in the consultation room. But these results were from 2017. And not all people could see this information in the consultation room. The team couldn't give any details of changes made following feedback.

The pharmacy had up-to-date professional indemnity insurance. Records for private prescriptions and emergency supplies complied with requirements. The pharmacy held records of certificates of conformity for unlicensed medicines. It kept up-to-date CD register entries. Not all the register inserts were securely attached. The pharmacy kept completed and archived register inserts in the same folder. This made it more difficult to access the current register. And it increased the risk of the inserts not being securely attached. Prior to September the CD balance checks against the physical stock had been ad hoc. But these were now completed regularly and mostly weekly. A physical balance check of MST 30mg tablets and Longtec 10mg tablets matched the balances in the register. Not all headers in the

registers were fully completed as required. And the wholesaler's address was not always completed. The pharmacist's name and registration number was not always entered. This is not a legal requirement but helps with accountability. There was evidence that the pharmacy investigated CD discrepancies. And annotated the register accordingly.

The pharmacy team members were aware of the importance of keeping people's information safe. And they had completed some training relating to information governance (IG) and recently General Data Protection Regulation (GDPR) training. The pharmacy shredded most of its confidential waste as part of the dispensing process at the time to prevent build-up of waste. If the team members were busy, they stored the confidential waste in a basket and shredded it when it was quieter. The pharmacy had several confidential waste sacks stored in a room off the dispensary. These bags were full but hadn't been sealed. They were awaiting collection to be destroyed securely. The pharmacy had NHS leaflets explaining how people's data mattered and was handled.

The pharmacy had a safeguarding policy and procedure, which detailed the pharmacy's processes. The team members had read this policy. The pharmacist had completed level two training from the Centre for Pharmacy Postgraduate Education (CPPE) relating to safeguarding in 2019. The team members understood their responsibilities to protect the welfare of children and vulnerable people. They had not needed to apply their knowledge. A team member described how she would escalate any concerns to the pharmacist.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough skilled and qualified people working to provide its services and to manage its workload effectively. The pharmacy provides some training time during the working day. And it engages team members to complete learning relevant to their roles. Pharmacy team members work well together to achieve common goals. They feel comfortable to share their ideas to improve ways of working. And they know how to raise professional concerns if they need to.

Inspector's evidence

During the inspection the pharmacist manager was the RP. He was supported by a full-time accuracy checking technician, a part-time trainee pharmacy technician, a part-time NVQ level two dispenser and a full-time NVQ level two dispenser. There was also another full-time NVQ level two dispenser, a part-time NVQ level two dispenser and a trainee medicines counter assistant (MCA) employed, but not working on the day. One of these team members was working at another local Rowlands pharmacy providing cover. The pharmacy had a part-time delivery driver.

The ACT had recently transferred from another pharmacy. This was to help with accuracy checking, so the pharmacist could increase the range of services offered and so the compliance pack workload could be transferred back to the pharmacy. The pharmacy had transferred the dispensing of the multi-compartment compliance packs to a nearby pharmacy whilst the team went through a period of change. This was to reduce workload pressure on the team. And help the team prioritise dispensing prescriptions and improve standards. The pharmacy team members were observed completing tasks competently. And managing the workload in an organised manner. They worked well together. They provided appropriate advice and answered queries competently within their expertise. They were seen referring queries appropriately to the pharmacist. After referring a query, the pharmacist went outside with a mother to assess her son who had fallen and to give her advice. He showed compassion to step outside so the boy didn’t need to be unnecessarily woken up, as he was in pain. A pharmacy team member described the questions she would ask when she received a request for the sale of a codeine-containing Pharmacy (P) medicine. And in which circumstances she would refer her concerns to the pharmacist.

The trainee technician had put her course on hold until the pharmacist manager had been appointed. And he was supporting her to complete the course by June 2020. The MCA was due to finish her course in January 2020. The pharmacy team members completed e-learning modules and ongoing learning. They received some time during the working day to complete training. And they completed some training at home free from distractions. The team members completed training relevant to their roles, for example information governance (IG) and dementia friends training. The pharmacist had completed safeguarding training and risk management training.

The pharmacy had a whistleblowing process that the team members could access. A team member described how she would escalate a professional concern. She felt comfortable speaking to the manager and escalating any concern further if needed. The team members worked together in an open and honest way. They described how they shared ideas to improve ways of working. The pharmacy set the team targets to achieve. The pharmacy team members felt at the moment some were unachievable due to circumstances in the pharmacy, such as transfer of the compliance pack dispensing to a local

branch. They continued to provide the services as they could to benefit the people using the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides its healthcare services in a professional environment. It maintains the premises to an appropriate standard. And people using the pharmacy can speak with a member of the team privately.

Inspector's evidence

The pharmacy premises were large and suitable for the services provided. It had a large main open plan dispensing area with enough bench space and storage space for medicines. And for people's medicines awaiting collection. There were several other rooms off this main dispensary, all maintained to a suitable standard. And some had additional bench space used on occasions for dispensing multi-compartment compliance packs. The pharmacy had a back door, that was a fire exit. At the start of the inspection the door was kept slightly ajar. And there was the risk of unauthorised access from the health centre car park outside. The pharmacist explained that a member of the team had just used this exit. The door was made secure. The heating and lighting were sufficient throughout the premises. The dispensary had a sink with hot and cold running water. And other hand washing facilities. The pharmacy had separate male and female toilets, with hand washing facilities. The pharmacy was clean and overall portrayed a professional appearance. There were some stains and marks on the floor and benches, just from use over time. And these detracted slightly from the overall appearance.

The pharmacy had a suitably soundproofed consultation room. And a privacy area to one side of the pharmacy counter. This was sectioned off from the main counter by a screen. The pharmacist was observed using both the privacy area and consultation room to provide services and speak with people about their medicines. The consultation room door was kept locked. The door was released using a button behind the counter. The pharmacy team member accessed the room from behind the counter. And the person accessing services entered from the public area. No confidential information was kept on show in the room. The team member could comfortably sit down with the person to discuss their health. And they could access people's medication history from the computer in the room. The sharps bin and other equipment required for services were stored on the staff side of the consultation room.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible. And the pharmacy provides a range of services to meet people's health needs. It generally manages its services effectively, so people receive an appropriate level of care. It obtains its medicines from licenced sources. And it generally stores and manages its medicines satisfactorily. But it has allowed the stock of some medicines to build up which may compromise stock management and introduce unnecessary risks.

Inspector's evidence

The pharmacy's premises had level access through a set of double doors. The pharmacy advertised its services and opening hours for people to see when the pharmacy was open. And it displayed its opening hours on the wall outside. This could be seen when the pharmacy was closed, and the shutters were down. The pharmacy had some posters on display in the retail area, detailing some of the services offered. For example, flu vaccinations. The team had attached a notice to the pharmacy counter informing people that the pharmacy dispensed some medicines at an offsite dispensary. The pharmacy had break out areas in the retail area where team members could speak to people away from the counter. It had space there for posters and leaflets. But there were no posters displayed. And few leaflets to pick up from these areas. There was no co-ordinated health promotion display. The pharmacy had a television advertising some of its services, for example flu vaccinations. And medicines for minor ailments. It had small information cards that people could pick up and take away. This gave people useful information on minor ailments. The pharmacy advertised the use of its working hearing loop.

The pharmacist provided several flu vaccinations during the inspection to staff from a local care home. The pharmacist had completed the required training. And he had the necessary equipment in the consultation room, for example a sharps bin and in-date adrenalin pens. The pharmacy had signed up to provide the Community Pharmacist Consultation Service (CPCS) and had relevant flow charts displayed in the consultation room to help provide the service. But the pharmacy hadn't received any referrals. The pharmacy team was completing an audit, asking people with diabetes whether they had received an eye and foot check up in the last twelve months. The team recorded the outcome and referred people to their GP if necessary. The pharmacy completed additional checks when people were taking high risk medicines. The pharmacist described how he requested people's blood test results before supplying warfarin. And how he often completed a medicine use review to ensure they were taking their medicines appropriately and not suffering any side effects. The pharmacy was completing an audit of people taking methotrexate. The pharmacist explained how he used the consultation room to sit down with people to discuss their regular blood tests and side effects of the medicine. The pharmacy was completing an audit over the next three months relating to people taking valproate. So far it hadn't highlighted anyone at risk if they became pregnant. The pharmacy team wasn't fully aware of the requirements of the safety alert. And didn't have any warning cards or guides to give to people. The pharmacist agreed to contact the manufacturer for a pack and use this as training for the team.

For prescriptions dispensed in the pharmacy, the team used baskets throughout the dispensing process, to reduce the risk of error. And it kept a dispensing audit trail as the team members signed the dispensed by and checked by boxes on the dispensing labels. The pharmacy had an organised workflow, with separate areas for labelling, dispensing and checking prescriptions. The pharmacy team members

ensured they utilised the offsite dispensing process as much as possible to reduce the workload pressure on the pharmacy team. They organised to complete the required checks as late as possible in the day to maximise the prescription information sent over to the hub before the cut off time. This ensured the pharmacy received all those prescriptions back in two days' time. The team members were seen explaining the system to people during the inspection. So, people had an awareness of when their prescription would be ready. The pharmacy had given leaflets to people when the service commenced. The pharmacy received people's medicines from the offsite hub in designated numbered totes, which could be tracked on the system. So, if someone came in early to collect their medicines they could easily be located. The team could also track prescriptions that hadn't been received back yet. There was the opportunity to dispense the prescription locally if it was urgent. Once the team members received the sealed medicine bags back from the hub, they matched them up with the prescriptions. The bags had one clear side, so the medicines inside could be viewed without breaking the seal. The pharmacist described the quality assurance process at the hub where a team of pharmacists and ACTs made checks to confirm accuracy of the systems used at the hub. The pharmacy dispensed items such as CDs, fridge lines, needles and urgent items locally. The pharmacy dispensed prescriptions for methadone to a small number of people. It dispensed the methadone in advance to reduce workload pressure when the person came to collect. The team stored the doses securely and in an orderly way to reduce the risk of errors.

The pharmacy had a driver to deliver medicines to the care homes and to people's homes. And he collected any prescriptions required from nearby surgeries. The driver worked across several of the Rowlands pharmacies in the area. The pharmacy had recently changed the delivery system. And it required people to contact the pharmacy to arrange a delivery each time. This helped organise the workload. And ensure people were available to receive their medicines. The driver obtained signatures from people on receipt of their medicines. Each person signed on a separate page to ensure people's private details were kept secure.

The pharmacy had good facilities and space to provide medicines to people in multi-compartment compliance packs. At the time of the inspection it was supplying a few packs per week. And it was dispensing medicines for two care homes. The care home staff ordered the prescriptions and they faxed the orders to the pharmacy. So, the team members could check this information against the prescriptions when they received them. They contacted the care home staff with any queries, to make sure people received the correct medicines. The pharmacy provided medicine administration records (MAR) charts with the medicines. And one of the care homes received their medicines in the original manufacturer's packs. The pharmacy team ordered the prescriptions for people living at home, who received their medicines in multi-compartment compliance packs. They ordered the prescription approximately two weeks in advance to make sure they had time to deal with any queries and to dispense the medication into the pack. Each person had a master record sheet with the details of their current medicines and times of administration. The team member checked the prescriptions against this record sheet and contacted the prescriber with any queries. The team member after picking the stock asked another team member to check it before dispensing the medicines into the pack to reduce errors. They sometimes annotated the pack with the descriptions of what the medicines looked like. There was a discussion about how accurate descriptions could be useful in case of queries for example if the person was admitted to hospital. The team didn't always supply patient information leaflets each month with the packs.

The Pharmacy (P) medicines were stored behind the pharmacy counter, so the pharmacist could appropriately oversee sales. The pharmacy had two medical Labcold fridges located one on top of the other. The fridges were full of stock. The stock was arranged tidily in the fridges. The fridge temperature records indicated the temperatures were within the required range. The pharmacy had enough storage

space for its CDs and used suitable CD cabinets. And it stored its CD stock in an orderly manner with different strengths of products kept separate. The pharmacy had a large quantity of out-of-date CDs and patient returned CDs awaiting destruction. Some of the stock and patient returns had been stored for several years. And the records indicated this. This practice could increase the risk of errors and make good CD management difficult. Recently the out-of-date stock and patient returned medicines had been segregated and sealed in separate bags. These were stored neatly at the bottom of the CD cabinet. The pharmacist manager had highlighted the issue and a member of the head office team had come to support. They were due to return to complete the destruction. And check the stock and registers for any discrepancies. The importance of completing this task in a timely manner and reporting any discrepancies to the Accountable Officer was discussed. The pharmacy stocked CD denaturing kits for suitable destruction of its CDs.

The pharmacy had a SOP for date checking and a completed date checking schedule. The team split the pharmacy into zones for the retail area and dispensary. The team members completed date checking according to the schedule every 3 months. And they highlighted short-dated stock. No out-of-date stock was found in the sample checked. The pharmacy had the systems to comply with the Falsified Medicines Directive (FMD). And the pharmacist described the process where the patient medication record (PMR) system produced a barcode during the labelling process. And this was used to decommission medicines at hand out. Barcodes were seen being printed. But it was difficult to see the end to end process during the inspection. The pharmacist explained how the offsite dispensing hub was also compliant for FMD. The pharmacy received safety alerts and medicine recalls by email. A team member printed the alert and actioned it. They signed and dated the alert and stored it in a file for reference.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it provides. It maintains its equipment to the required standard and uses it in a suitable way to protect people's privacy.

Inspector's evidence

The pharmacy had equipment suitable for the services provided. It had resources available such as the British National Formulary (BNF) and access to the internet to obtain up-to-date clinical information. The electrical equipment had regular safety testing. There was no sign of any wear and tear. The pharmacy had two fridges in the dispensary and an additional medical fridge in the room designated for dispensing compliance packs. All were in good working order. The pharmacy had a separate fridge for staff food items. The pharmacy team used a range of glass crown stamped measures for measuring liquids.

The pharmacy stored people's medicines awaiting collection in sections of the dispensary on hangers. These were out of view of the public area. There was a large number of medicines awaiting collection in the retrieval areas. The computers were password protected. And they were positioned in a way to prevented disclosure of confidential information. It held its private information in the dispensary. The pharmacy had cordless telephone handsets. These allowed the team members to have telephone conversations in private areas of the dispensary.

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.