General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 62 High Street, Great Wakering, SOUTHEND-ON-SEA, Essex, SS3 0EQ

Pharmacy reference: 1031418

Type of pharmacy: Community

Date of inspection: 08/02/2023

Pharmacy context

The pharmacy is on a high street in a village near Southend-on-Sea. It provides a range of services, including the New Medicine Service, flu vaccination service, blood pressure checks and weight management service. And it provides medicines as part of the Community Pharmacist Consultation Service. The pharmacy supplies medications in multi-compartment compliance packs to a large number of people who live in their own homes to help them manage their medicines. And it receives most of its prescriptions electronically.

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 identifies and manages the risks associated with its services to help provide them safely. And it learns from mistakes that happen during the dispensing process to help make its services safer. The pharmacy protects people's personal information. And people can provide feedback about the pharmacy's services. The pharmacy largely keeps its records up to date and accurate. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) and team members had signed to show that they had understood them and agreed to follow them. Dispensing errors, where a dispensing mistake had reached a person, were recorded on a designated form and a root cause analysis was undertaken. The pharmacist said that there had not been any recent dispensing errors. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. And once the mistake was highlighted, team members were responsible for identifying and rectifying them where possible. Near misses were recorded and reviewed regularly for any patterns. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And the outcomes from the reviews were discussed openly within the team.

Team members' roles and responsibilities were specified in the SOPs. One of the dispensers said that the pharmacy would not open if the pharmacist had not turned up in the morning. Team members knew which tasks should not be undertaken if there was no responsible pharmacist (RP) signed in. And they knew that they should not sell any pharmacy-only medicines or hand out dispensed items if the pharmacist was not in the pharmacy. A task matrix was displayed next to the counter for team members refer to if needed.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. Baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was clearly displayed, and the RP record was completed correctly. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. The recorded quantity of one CD item checked at random was the same as the physical amount of stock available. The private prescription records were mostly completed correctly, but the correct prescriber details were not always recorded. And the nature of the emergency was not routinely recorded when a supply of a prescription-only medicine was supplied in an emergency without a prescription. The pharmacist said that he would ensure that these records were completed properly in future.

Confidential waste was shredded, people using the pharmacy could not see information on the computer screens and computers were password protected. Team members used their own smartcards to access the NHS electronic prescription system, and these were stored securely when not in use. People's personal information on bagged items waiting collection could not be viewed by people using

the pharmacy. And team members had completed training about protecting people's personal information.

The complaints procedure was available for team members to follow if needed and details about how people could complain was displayed in the shop area. The pharmacist said that there had not been any recent complaints. And he explained that if someone complained via the pharmacy's website, the pharmacy's head office would contact the pharmacy and carry out an investigation where necessary.

The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. The pharmacist had completed the Centre for Pharmacy Postgraduate Education training about protecting vulnerable people. Other team members had undertaken some training about safeguarding provided by the pharmacy's head office. They could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist said that there had not been any safeguarding concerns at the pharmacy.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. Team members are provided with ongoing training to support their learning needs and maintain their knowledge and skills. And they can raise any concerns or make suggestions and have regular meetings. Team members can take professional decisions to ensure people taking medicines are safe. These are not affected by the pharmacy's targets.

Inspector's evidence

There was one pharmacist and two trained dispensers working during the inspection. Team members wore smart uniforms with name badges displaying their role. They worked well together throughout the inspection and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. One of the team explained that team members in the dispensary had to cover the medicines counter which created distractions during the dispensing processes. And the pharmacy was a parcel collection point which also added to the workload and distractions.

Team members appeared confident when speaking with people. One of the dispensers when asked, was aware of the restrictions on sales of medicines containing pseudoephedrine. And said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She asked relevant questions to establish whether the medicines were suitable for the person they were intended for. A list of 'red card' substances (where a referral to the pharmacist was needed before team members were allowed to make a sale) was displayed near the medicines counter.

Team members undertook regular ongoing training modules provided by the pharmacy's head office. And they were allowed time during the day to complete the modules. They could also access these at home if they wanted. The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And he felt able to make professional decisions. He had recently completed the face-to-face training about the flu vaccination service. Other recent training included he had undertaken was about blood pressure, inhaler technique and stop smoking. The pharmacist said that he had completed declarations of competence and consultation skills for the services offered, as well as associated training.

The team members had worked together for many years at the pharmacy. They had a good working relationship with each other and discussed any issues as they arose. The dispensers felt comfortable about making any suggestions to the pharmacist. And they had yearly appraisals and performance reviews. There were regular meetings to discuss any issues, and how to improve services and work better as a team. During these meetings, they also discussed any near misses or dispensing errors. Targets were set for the New Medicine Service. The pharmacist said that he provided the service for the benefit of people using the pharmacy and he did not feel under pressure to meet the targets.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind the counter and there was a clear view of the medicines counter from the dispensary. This mean that the pharmacist could hear conversations at the counter and intervene when needed. Air conditioning and heaters were available and the room temperature on the day of the inspection was suitable for storing medicines. Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

There were two chairs in the shop area for people to use while waiting. These were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard. There was a counter area away from the main counter which could be used to create a little more privacy if someone wanted to discuss something. The pharmacy's consultation room was accessible to wheelchair users and was in the shop area. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

Principle 4 - Services ✔ Standards met

Summary findings

People with a range of needs can access the pharmacy's services. And the pharmacy provides its services safely and manages them well. It gets its medicines from reputable suppliers and stores them properly. And it responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. The pharmacy clearly advertised its services and opening times and it had a variety of health information leaflets available. It could produce large print labels for people who needed them.

The pharmacist said that he checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin if available. And he kept a record of some people's blood test results. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. Prescriptions for Schedule 3 and 4 CDs were highlighted to help to minimise the chance of these medicines being supplied when the prescription was no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. One of the dispensers said they checked CDs and fridge items with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people. And he ensured that anyone in the at-risk group was on a Pregnancy Prevention Programme if needed. And he would refer people to their GP if they needed to be on one and weren't. The pharmacy had relevant patient information leaflets, warning cards available and warning stickers for use with split packs.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Short-dated items were marked and items that had expired at the end of January 2023 had been removed from dispensing stock. One of the dispensers explained that these would be disposed of appropriately. There were no date-expired items found in with dispensing stock. Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and it was not overstocked. CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. And CDs that people had returned, and expired CDs were clearly marked and kept separate from dispensing stock. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Team members said that part-dispensed prescriptions were checked frequently. People were given 'owings' notes if their prescription could not be dispensed in full, and they were kept informed about any supply issues. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. And prescriptions for alternate medicines were requested from prescribers where needed. The pharmacist said that prescriptions waiting collection were checked regularly, and people were sent a text message reminder if they had not collected their items after around six weeks. Uncollected prescriptions were returned to the NHS electronic system or to the prescriber and the items were returned to dispensing stock where possible.

The pharmacist said that people had assessments carried out by their GP to show that they needed help to manage their medicines. The pharmacy obtained consent from people before sending prescriptions to a centralised dispensing hub that made the pouches. The pharmacist said that he carried out a clinical check on the prescription before it was sent to the hub. And prescriptions for people receiving their medicines in these pouches were ordered in advance so that any issues could be addressed before people needed their medicines. The pharmacy did not routinely request prescriptions for 'when required' medicines. The dispenser said that the pharmacy contacted people to ask if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication, and they also kept any hospital discharge letters for future reference. Packs were suitably labelled, and medication descriptions were put on the packs to help people and their carers identify the medicines. And patient information leaflets were routinely supplied.

Deliveries were made by a delivery driver. The pharmacy obtained people's signatures for deliveries where possible, and these were recorded in a way so that another person's information was protected. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. And a card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the pharmacy's head office and the NHS. The pharmacist explained the action the pharmacy took in response to any alerts or recalls. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The blood pressure monitor was replaced at regular intervals by the pharmacy’s head office. The weighing scales and the shredder were in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed.

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.