

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 244 Bath Road, Leckhampton, CHELTENHAM, Gloucestershire, GL53 7NB

Pharmacy reference: 1031482

Type of pharmacy: Community

Date of inspection: 15/10/2019

Pharmacy context

This is a community pharmacy in a popular, vibrant residential shopping area close to the centre Cheltenham. A wide variety of people use the pharmacy. The pharmacy dispenses NHS and private prescriptions and sells over-the-counter medicines. It also supplies medicines in multi-compartment compliance aid to help vulnerable people in their own homes to take their medicines.

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	2.4	Good practice	The staff are encouraged to keep their skills up to date and they do this in work time.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards met	4.2	Good practice	The pharmacy team members make sure that people have the information that they need to use their medicines safely and effectively. They intervene if they are worried or if people are suffering from side effects.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✓ Standards met

Summary findings

The pharmacy's working practices are generally safe and effective. The working area is organised. The pharmacy keeps the up-to-date records that it must by law. It is appropriately insured to protect people if things go wrong. The pharmacy team keeps people's private information safe and they know how to protect vulnerable people. But, they could learn more from mistakes to prevent them from happening again. And, they could be better at acting on the feedback given to them to improve their services.

Inspector's evidence

The pharmacy team identified and managed most risks. All dispensing errors and incidents were recorded, reviewed and appropriately managed. There had been a recent strength error where Symbicort 100 had been given against a prescription calling for Symbicort 200. A full root cause analysis of the error had been done and all the dispensary staff were aware of the error. A prominent alert had been placed on the patient's prescription medication record about the error. Near misses were recorded but most included insufficient information to allow any useful analysis, such as, two recent quantity errors with Octasa 400mg. No learning points or actions taken to reduce the likelihood of similar recurrences were recorded. General trends however were identified, such as, in August 2019, where the most common mistakes were with 'look alike, sound alike' drugs. These had been discussed with the staff.

The dispensary was organised with labelling, assembly and checking areas. A small bench at the back of the dispensary was used for the assembly of the multi-compartment compliance aids. The pharmacist was newly appointed, three months, and he planned to re-organise the dispensary in order to make better use of the available space. He reported that this was possible because the pharmacy had just started using an off-site dispensary hub in Runcorn (six weeks prior to the visit), mainly for regular repeat prescriptions. This meant that the pharmacy could reduce its stock holding which would free-up some shelves. These could then be utilised, for, for example, prescriptions that were waiting to be checked. This would then keep the dispensary benches clear.

Coloured baskets were used and distinguished prescriptions for patients who were waiting, those calling back, those for collection and those for delivery. There was a clear audit trail of the dispensing process and all the 'dispensed by and checked by' boxes on the labels examined had been initialled. In addition, currently about 30% of the pharmacy's prescriptions were being sent for off-site dispensing. Prior to them being sent to the hub, they were all clinically checked by the pharmacist and there was an electronic audit trail demonstrating that this was the case.

Up-to-date, signed and relevant standard operating procedures (SOPs), including SOPs for services provided under patient group directions were in place and these were continually reviewed by the superintendent pharmacist. The roles and responsibilities were set out in the SOPs and the staff were clear about their roles. The company's sales protocol was displayed and included questions to be asked of customers requesting to buy medicines and when customers should be referred to the pharmacist, such as, specific patient groups and those requesting multiple sales. The till flagged up certain items that should be referred to the pharmacist, such as, fluconazole capsules. The medicine counter assistant said that she would refer all medicine sale requests for patients who were also taking prescribed medicines, to the pharmacist. She was aware of 'prescription only medicine' (POM) to 'pharmacy only medicine' (P) switches, such as chloramphenicol eye drops and Ella One and also

referred requests for these to the pharmacist. The staff were not aware of the NFA-VPS (non-food animal – veterinarian, pharmacist, suitably qualified person) status of veterinary medicines. The pharmacist said that he would ensure that all the staff were trained on this.

The staff were clear about the complaints procedure and reported that feedback on all concerns was actively encouraged. The pharmacy did an annual customer satisfaction survey but they did not know the results of the latest survey. The survey displayed was dated 2017. However, a staff member said that most frequent feedback from customers was about the seating for patients who were waiting for their prescriptions. The pharmacy had two chairs and there had been no change to this over the last few years.

Public liability and indemnity insurance provided by Numark and valid until 31 March 2020 was in place. The responsible pharmacist log, controlled drug (CD) records, including patient-returns, private prescription records, emergency supply records, specials records, fridge temperature records and date checking records were all in order.

There was an information governance procedure and the staff had also recently completed training on the new data protection regulations. The computers, which were not visible to the customers, were password protected. Confidential information was stored securely. Confidential waste paper information was shredded. No conversations could be overheard in the consultation room.

The staff understood safeguarding issues and had all read the company policy on the safeguarding of both children and vulnerable adults. The pharmacist had also completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. Local telephone numbers were available to escalate any concerns relating to both children and adults. All the staff had completed 'Dementia Friends' training.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. And, they are able to help when team members are on holiday or off sick. The staff are encouraged to keep their skills up to date and they do this in work time. The team are well supported by their manager. And, they are comfortable about providing feedback to him to improve services.

Inspector's evidence

The pharmacy was in a popular, vibrant residential shopping area close to the centre Cheltenham. Most of the prescriptions that they dispensed were NHS prescriptions, with the majority of these, being repeats. Several domiciliary patients received their medicines in multi-compartment compliance aids. Few private prescriptions were dispensed.

The current staffing profile was one pharmacist, the manager, two part-time NVQ2 trained dispensers, one NVQ2 trained dispenser on a zero hours contract, one part-time NVQ2 trainee dispenser and one part-time medicine counter assistant. The part-time staff were flexible and generally covered any unplanned absences. The dispenser with a zero hours contract added further flexibility. Planned leave was booked well in advance and only one member of the dispensary staff could be off at one time. A staffing rota was used to ensure appropriate staffing levels with the desired skill mix.

The staff clearly worked well together as a team. Staff performance was monitored, reviewed and discussed informally throughout the year. The manager was newly appointed, three months previously. He said that the company's performance appraisals were behind schedule. He planned to re-instate these as soon as possible. A trained dispenser seen, had not had a formal appraisal for eight years.

The staff were encouraged with learning and development and completed e-Learning, such as recently on winter flu and the company's Medi-PACs. The staff reported that they spent about 60 minutes each month of protected time learning. Staff enrolled on accredited courses, such as the NVQ2 trainee dispenser said that she was well supported by the pharmacist but that she did not have any dedicated learning time towards her course. The manager said that he would introduce this. All the dispensary staff reported that they were supported to learn from errors. The pharmacist said that all learning was documented on his continuing professional development (CPD) records. He was currently doing the Bath University clinical diploma.

The staff knew how to raise a concern and said that they felt able to raise any issues. But, there were no formal staff meetings. The newly appointed manager said that he would implement these. The pharmacist reported that he was encouraged to do Medicines Use Reviews (MURs) and the New Medicine Service (NMS) in line with the community pharmacy contract. He said that he only did clinically appropriate reviews and did not feel unduly pressured .

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy generally looks professional. The consultation room is well signposted so it is clear to people that there is somewhere private for them to talk. But, the room is small and it is difficult for people to sit face-to-face which may hinder some conversations. Some areas of the pharmacy would benefit from re-decoration and repair.

Inspector's evidence

The pharmacy generally presented a professional image. But, some ceiling tiles in the retail area were damaged following previous ingress of water, an area in the retail area had paint peeling off and the medicine counter had marks left from cello tape. The dispensing benches were largely uncluttered and the floors were clear. The premises were clean.

The consultation room was small but well signposted. The door opened outwards and so should not impede access by the emergency services, if necessary. It contained a computer and a sink.

Conversations in the consultation room could not be overheard but the design made it difficult to sit face-to-face. The pharmacy computer screens were not visible to customers. The telephone was cordless and all sensitive calls were taken in the consultation room or out of earshot.

The temperature in the pharmacy was below 25 degrees Celsius. There was good lighting throughout. Most items for sale were healthcare related.

Principle 4 - Services ✓ Standards met

Summary findings

Most people can access the services that the pharmacy offers. But, some people with specific mobility needs may have difficulty entering the pharmacy. The pharmacy services are effectively managed to make sure that they are provided safely and effectively. The team members make sure that people have the information that they need to use their medicines safely and effectively. They intervene if they are worried or if people are suffering from side effects. The pharmacy gets its medicines from appropriate sources. The medicines are stored and disposed of safely. The team make sure that people only get medicines or devices that are safe.

Inspector's evidence

There was wheelchair access to the pharmacy and the consultation room but no bell on the door to alert the pharmacy team to anyone who may need assistance. There was no access to Google translate on the pharmacy computers for use by non-English speakers. The pharmacist said that he had to use his personal mobile phone recently for a gentleman who spoke Arabic. The pharmacy could print large labels for sight-impaired patients.

Advanced and enhanced NHS services offered by the pharmacy were Medicines Use Reviews (MURs), New Medicine Service (NMS), emergency hormonal contraception (EHC), urgent repeat medicines and seasonal flu vaccinations. The latter was also provided under a private scheme. The services were well displayed and the staff were aware of the services offered.

The pharmacist had completed suitable training for the provision of seasonal flu vaccinations including face to face training on injection technique, needle stick injuries and anaphylaxis. He had also completed suitable training for the provision of the free NHS EHC service.

Several domiciliary patients received their medicines in compliance aids (blister packs). These were assembled on a four-week rolling basis and evenly distributed throughout the week to manage the workload. The assembly space was small and the trays for one patient at a time were assembled and then immediately checked in order to keep the space as clear as possible. The blister packs were assembled during quiet times. There were dedicated poly-pockets for these patients where all the relevant information such as hospital discharge sheets and changes in dose were kept. These were referred to at the checking stage. The pharmacy had a good working relationship with the local surgeries. Some surgeries sent the pharmacy written confirmation of dose changes or other issues and some telephoned.

There was a good audit trail for all items ordered on behalf of patients by the pharmacy and for all items dispensed by the pharmacy. All prescriptions sent for off-site dispensing had been clinically checked by the pharmacist prior to this. No controlled drugs, items requiring refrigeration, special obtain items or split packs were assembled off-site. There was a two day turn-around time for the off-site dispensing. Patients were told to order their medicines one week in advance to ensure continuity of supply. The medicines were scanned into the computer when they were received at the pharmacy. The bag labels were aligned with the scanner used to check for falsified medicines.

Interventions were recorded on the patient's prescription medication record. The pharmacist routinely counselled patients prescribed high-risk drugs such as warfarin and lithium. INR levels were recorded.

He also counselled patients prescribed amongst others, antibiotics, new drugs and any changes. CDs and insulin were packed in clear bags and these were checked with the patient on hand-out. All the staff were aware of the new sodium valproate guidance.

All prescriptions containing potential drug interactions, changes in dose or new drugs were highlighted to the pharmacist. Signatures were obtained indicating the safe delivery of all medicines and owing slips were used for any items owed to patients. Potential non-adherence or other issues were identified at labelling and ordering. Any patients giving rise to concerns were targeted for counselling. The pharmacist reported that his patients were generally well informed about their medicines. He sometimes identified side effects, such as, ankle oedema with patients prescribed felodipine. He referred one such patient back to their doctor and the felodipine was changed to perindopril.

Medicines and medical devices were obtained from Phoenix, Alliance Healthcare and AAH. Specials were obtained from Phoenix Specials. Invoices for all these suppliers were available. A scanner was used to check for falsified medicines as required by the Falsified Medicines Directive (FMD). CDs were stored tidily in accordance with the regulations and access to the cabinet was appropriate. There were several patient-returned and out-of-date CDs. These were clearly labelled and separated from usable stock. Appropriate destruction kits were on the premises. Fridge lines were correctly stored with electronic records. Date checking procedures were in place. Designated bins were available for medicine waste and used. There was no separate bin for cytotoxic and cytostatic substances, but there was a list of the substances that should be treated as hazardous for waste purposes. The staff said that any of these substances would be appropriately labelled and separated.

There was a procedure for dealing with concerns about medicines and medical devices. Drug alerts were received electronically, printed off and the stock checked. They were signed and dated by the person checking the alert. Any required actions were recorded. The pharmacy had received an alert on 9 October 2019 about Zantac products. The pharmacy had none in stock and this was recorded.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the appropriate equipment and facilities for the services it provides. And, the team members make sure that they are clean and fit-for-purpose.

Inspector's evidence

The pharmacy used British Standard crown-stamped conical measures (10 - 100ml). There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. There were up-to-date reference books, including the British National Formulary (BNF) 76 and the 2017/2018 Children's BNF. There was limited access to the internet.

The fridge was in good working order and maximum/minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and any sensitive calls were taken in the consultation room or out of earshot. Confidential waste information was shredded. The door was always closed when the consultation room was in use and no conversations could be overheard.

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.