General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 2-3 The Chestnuts, High Street, Bourton-on-Water, CHELTENHAM, Gloucestershire, GL54 2AN

Pharmacy reference: 1031491

Type of pharmacy: Community

Date of inspection: 28/10/2020

Pharmacy context

This is a community pharmacy in the popular Cotswold town of Bourton-on-Water. A wide variety of people use the pharmacy, including tourists, but most are elderly. The pharmacy team members dispense prescriptions, sell over-the-counter medicines and give advice. They also supply several medicines in multi-compartment compliance packs to help vulnerable people in their own homes to take their medicines. Some pharmacists offer additional services such as seasonal flu vaccinations. The inspection was carried out during the COVID-19 pandemic.

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's working practices are generally safe and effective. It has made changes to its written procedures as a result of COVID-19. And, some physical measures are in place to reduce the risk of transmission of coronavirus. The pharmacy is appropriately insured to protect people if things go wrong. It keeps the required records. The pharmacy team members keep people's private information safe and they know how to protect vulnerable people. But they could be better at recording and learning from their mistakes to prevent them from happening again.

Inspector's evidence

The pharmacy team members identified and managed most of the risks associated with providing its services. They had put some physical changes in place, as a result of the COVID-19 pandemic, to reduce the risk of transmission of coronavirus (see under principle 5). The pharmacy had updated its standard operating procedures (SOPs) with changes relating to the pandemic. All the team members had read and signed the new SOPs. The pharmacy had also updated its business continuity plan but the team members were unsure of the details to accommodate any potential issues relating to the current NHS 'test and trace' scheme. They did not know who they should liaise with to ensure that there was no disruption in the supply of medicines to their patients if they had to close. The pharmacy was the only pharmacy in the town. The manager said that she would look into this as a matter of urgency. She had conducted risk assessments of the premises and occupational risk assessments of all the staff. The team members were asked about any potentially vulnerable people in their households and also about their mental health. The manager reviewed the risk assessments every two weeks. The pharmacy team members were aware that they needed to report any COVID-19 positive test results.

The pharmacy team members recorded some near miss mistakes, that is, mistakes that were detected before they had left the premises. But none had been recorded in October 2020. They did not document learning points and actions to prevent future recurrences. General trends could be identified but there was no documented evidence that the log in September 2020 had been reviewed. The manager said that there had not been an error, where the incorrect medicine had left the pharmacy, for a long time.

The dispensary was relatively spacious but there was no clear marked checking area. This could increase the risk of mistakes. The manager said that she would implement this. A separate bench was used for the assembly of the multi-compartment packs. The staff assembled these in the mornings when it was quiet to reduce the risk of mistakes. The dispensary team members placed the prescriptions and their accompanying medicines into baskets. This reduced the risk of errors. But only the baskets for people who were waiting were distinguished by a different colour. This meant that it may be difficult for the pharmacist to prioritise the workload.

All the staff knew their roles and responsibilities. The team members reported an increased demand for codeine-containing medicines since the outbreak of the pandemic. They all new that such medicines should only be sold for three days use. The till flagged up any items, such as, sumatriptan, fluconazole and steroid creams, where the pharmacist should be consulted before they were sold to people. A NVQ2 trainee dispenser would refer anything she was uncertain of, to the pharmacist.

The pharmacy team were clear about their complaints procedure. They had received a few recent complaints from people about delays in receiving their medicines. These were largely due to the pharmacy sending a large proportion of its prescriptions to be dispensed off-site. If the hub branch ran out of medicines, the pharmacy only knew this on the day that the medicines were due back at the branch. The medicines then had to be ordered by the branch and this sometimes led to delays in people getting them. Some people complained that the pharmacy could not order special items such as probiotics. However, most people using the pharmacy were extremely grateful for the hard work and dedication of all the staff since the outbreak of the pandemic.

The pharmacy had current public liability and indemnity insurance. It kept the required up-to-date records: the responsible pharmacist (RP) log, controlled drug (CD) records, private prescription records, emergency supply records and specials records. The pharmacy also had fridge temperature records, date checking records, patient-returned CD records and cleaning rotas.

All the staff understood the importance of keeping people's private information safe. They stored all confidential information securely. The computers, which were not visible to the customers, were password protected. The correct NHS smartcards were seen in the appropriate computers. The pharmacy team members shredded all confidential wastepaper. The pharmacy offered face-to-face services. These were done in the consultation room. People could not be overheard or seen in the consultation room.

The pharmacy team understood safeguarding issues. The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) module on safeguarding. The pharmacy had local telephone numbers to escalate any concerns relating to both children and adults.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough staff to manage its workload safely. The team members do their best to cover anyone who is sick or on holiday. They are encouraged to keep their skills and knowledge up to date. And they are kept informed about any changes relating to COVID-19. The pharmacy team work well together and they are comfortable about providing feedback to their manager to improve their services and she acts on this.

Inspector's evidence

The pharmacy's current staffing profile was: one pharmacist, two full-time NVQ2 qualified dispensers, one of whom was the manager, one full-time NVQ2 trainee dispenser, one part-time NVQ2 qualified dispenser and one delivery driver. The pharmacy had had several staff changes in the past year. It had no current regular employed pharmacist. One was due to start work in November 2020. It also had had several locum dispensers in this time. The manager said that the staffing was now stable but that not all the previous locum staff had been replaced with employed staff. Only one part-time member was employed and so there was limited flexibility to cover both planned and unplanned absences. Some help was available from other branches. Planned leave was booked well in advance and only one team member could be off at one time.

The staff worked well together as a team. The manager monitored the performance of the team members. They had an annual appraisal with a six-monthly review where any learning needs could be identified. Review dates would be set to achieve this. The team members had 'ad hoc' staff meetings. They all felt able to raise any issues or concerns with their manager and that she would act on these, if appropriate. The NVQ2 trainee dispenser had raised a concern about the procedures for medicines that were owed to people. Because of this, the pharmacy now had a dedicated box where these were kept. They were checked every day. As soon as the pharmacy received the medicine, the prescription was completed. These procedures were safer, because the owed items were completed when the team members had adequate time rather than, as before, when the person came into the pharmacy to collect the owed item. And the new system was subsequently also more efficient.

The staff were encouraged with learning and development. They completed regular e-learning such as recently on the company's PilPouch system and on suicide awareness. However, due to workload constraints, the team members completed this learning at home. The workload also made it difficult for the manager to allocate dedicated learning time to those team members studying towards accredited qualifications. So, they too, did most of their learning at home. The team members were kept informed about any changes relating to COVID-19. Some team members had requested to further their education by doing the NVQ3 technician course. They had been told that the company was undergoing a re-structure and to date, they had not received an answer to their request. The pharmacist seen, a locum, documented all learning on his continuing professional development (CPD) records.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy looks professional and is suitable for the services it offers. It is clean, tidy and organised. The premises are thoroughly cleaned to reduce the likelihood of transmission of coronavirus. The pharmacy signposts its consultation room so it is clear to people that there is somewhere private for them to talk.

Inspector's evidence

The premises presented a professional image. The dispensing benches were mainly uncluttered and the floors were clear. The pharmacy was clean. As a result of COVID, it was thoroughly cleaned every day. The work tops and door handles were wiped over frequently throughout the day. The team members washed their hands regularly. They used alcohol gel or washed their hands after each interaction with people.

The consultation room was signposted. It was cleaned after each use. People could not be seen or overheard in the consultation room. The pharmacy's computer screens were not visible to customers. The telephone was cordless and the staff took all sensitive calls out of earshot. The temperature in the pharmacy was below 25 degrees Celsius and it was well lit.

Principle 4 - Services ✔ Standards met

Summary findings

People can access the services the pharmacy offers. It generally manages its services effectively to make sure that they are delivered safely. The team members make sure that people have the information they need to use their medicines properly. The pharmacy gets its medicines from appropriate sources. It stores and disposes of them safely. The pharmacy makes sure that people only get medicines or devices that are safe.

Inspector's evidence

People could access the pharmacy and the consultation room. But the pharmacy team members could not access an electronic translation application for any non-English speakers. They may need to do this because the pharmacy was located in the popular tourist town of Bourton-on-Water in the Cotswolds. They also did not have general internet access. The team members could print large labels for sight-impaired people.

Most of the pharmacy's prescriptions were electronically transferred from the local surgery and most were for local residents. Many prescriptions were dispensed off-site. This sometimes resulted in delays (see under principle 1). The dispensary staff initialled the 'dispensed by' and 'checked by' boxes on the labels of any prescriptions dispensed at the pharmacy, so providing a clear audit trail of the dispensing process.

The pharmacy had no employed regular pharmacist. Some locums were not accredited to provide services in addition to the essential NHS services. The pharmacy provided emergency supplies of medicines but was not using the Gloucestershire Urgent Repeat Medicine Service (URMS).

The locum pharmacists, who were accredited to provide flu vaccinations, wore type 2 fluid resistant masks, gloves and face shields. They used alcohol gel or washed their hands before and after each vaccination. Everyone who received the vaccine wore a face covering and they had all made prior appointments. The appointment slots were 30 minutes apart to allow the room to be thoroughly cleaned between appointments. The pharmacy had however run out of vaccine supplies, both for people over 65 and for those under 65. The staff believed they would get more stock in November but they were not sure. Because of this, the pharmacy was not making any appointments for the vaccine. Many elderly people in the town were anxious about not being able to have the vaccination.

The pharmacy had no substance misuse clients who usually had their medicines supervised. It did have several domiciliary people who had their medicines in compliance packs. These were done on a separate bench, usually in the mornings. The team members kept dedicated folders for these people where they recorded any changes in dose or other issues. The pharmacist referred to these when doing the final accuracy check. The assembled packs were stored tidily. The pharmacy was due to change from the traditional compliance packs to 'PilPouch' packs in January 2021. The pharmacy team had started to give advice and support to their patients about the use of these.

The dispensary team highlighted any prescriptions containing potential drug interactions, changes in dose or new drugs to the pharmacist. The locum pharmacist seen, routinely counselled people

prescribed high-risk drugs such as warfarin and lithium and also those prescribed antibiotics, oral steroids and any changes. All pharmacy team members were aware of the pregnancy protection programme regarding sodium valproate. The pharmacy currently had no ‘at risk’ patients who were prescribed sodium valproate.

The pharmacy delivered several medicines to people. Because of the pandemic, the delivery driver did not currently ask people to sign for their medicines to indicate that they had received them safely. He knocked or rang the doorbell and left the medicines on the doorstep. The driver retreated and waited until the medicines had been taken safely inside. The driver annotated the delivery sheets accordingly.

The pharmacy got its medicines from Phoenix, Alliance Healthcare and AAH. Invoices for all these suppliers were available. The pharmacy used a scanner to check for falsified medicines as required by the Falsified Medicines Directive (FMD). It stored its CDs in accordance with the regulations and access to the cabinet was appropriate. But it had many out-of-date and patient returned CD medicines. These were taking up valuable space in the cabinet and were not not clearly labelled. This could increase the risk of errors. Appropriate CD destruction kits were on the premises. The pharmacy stored its fridge lines correctly and it had date checking procedures. The pharmacy team members were accepting patient-returned medicines. These were double bagged. The staff member who accepted the returned medicines wore gloves and washed their hands after disposing of the medicines into a dedicated waste bag. The team members placed any medicines, considered hazardous for waste purposes, into a separate dedicated waste bin.

The pharmacy had procedures for dealing with concerns about medicines and medical devices. The pharmacy received drug alerts electronically. They were printed off and the stock was checked. The pharmacy had received an alert on 13 October 2020 about Epilim. It had none of the affected batches 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. The pharmacy has taken action to reduce the spread of coronavirus with the use of protective screens and equipment.

Inspector's evidence

The manager had done a risk assessment of the premises as a result of the pandemic. The pharmacy only allowed two people at a time to enter the premises. It had foot marks on the floor indicating where people should stand and a 'taped -off' area two metres from the medicine counter. The pharmacy had two small protective screens, suspended from the ceiling, on the medicine counter. But there were large gaps between these and people were seen to stand at the gaps. The medicine counter was circular in design and so, probably, only a bespoke protective screen, would afford better protection, both for the staff and for the people visiting the pharmacy. All the staff were wearing Type 2R fluid resistant face masks.

The pharmacy used British Standard crown-stamped conical measures. There were tablet-counting triangles, one of which was kept specifically for cytotoxic substances. These were cleaned with each use. The pharmacy had up-to-date reference books, including the British National Formulary (BNF) 78 and the 2019/2020 Children's BNF.

The fridge was in good working order and maximum and minimum temperatures were recorded daily. The pharmacy computers were password protected and not visible to the public. There was a cordless telephone and the staff took any sensitive calls out of earshot. The pharmacy team members shredded all confidential waste information.

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.