General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 228 Chorley New Road, Horwich, BOLTON, Lancashire, BL6 5NP

Pharmacy reference: 1033136

Type of pharmacy: Community

Date of inspection: 09/12/2019

Pharmacy context

This community pharmacy is located on a main road opposite to a medical centre. Most people who use the pharmacy are from the local area. The pharmacy dispenses mainly NHS prescriptions and sells a range of over-the-counter medicines. It supplies a large number of medicines in multi-compartment compliance aid packs to help people take their medicines at the right time. Around 40% of prescriptions are sent to the company's hub to be dispensed.

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	1.2	Good practice	The pharmacy records and analyses adverse dispensing incidents to identify learning points which it incorporates into day to day practice to help manage future risks.
2. Staff	Good practice	2.2	Good practice	The team members have the appropriate skills, qualifications and competence for their role and the pharmacy supports them to address their ongoing learning and development needs.
		2.4	Good practice	Openness, honesty and learning is embedded throughout the organisation.
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 effectively manages risks to make sure its services are safe, and it keeps the records required by law. Members of the pharmacy team are clear about their roles and responsibilities. They record their mistakes so that they can learn from them and take steps to help stop the same sort of mistakes from happening again. They have written procedures on keeping people's private information safe and complete training so they know how to protect children and vulnerable adults.

Inspector's evidence

The pharmacy had up-to-date standard operating procedures (SOPs) for the services provided, with signatures showing that members of the pharmacy team had read and accepted them. A locum pharmacist and locum dispenser were working and they both stated that they were required to read the SOPs as part of the process when accepting work at the pharmacy. Roles and responsibilities were set out in SOPs and the pharmacy team members were performing duties which were in line with their role. They were wearing uniforms and name badges indicating their role. A 'model day' checklist was completed each day to ensure all the required tasks were carried out. A business continuity plan was in place which gave guidance and emergency contact numbers to use in the case of systems failures and disruption to services. The name of the responsible pharmacist (RP) was displayed in the dispensary but it could not be seen from the retail area. So, people might not know which pharmacist was responsible and this might cause confusion in the event of a problem or query.

There was a near miss SOP and a 'patient safety incident recording and investigation' SOP. Dispensing incidents were reported on the company's intranet system and learning points were included. Following an incident when the incorrect type of diabetes testing strips were supplied, they had been better separated in the drawer to avoid a re-occurrence. Near misses were recorded and discussed with the pharmacy team. Comments such as ' staff told to go slower when dispensing' and 'double check work' had been recorded. Some monthly analysis had been completed. Clear plastic bags were used for assembled CDs and insulin to allow an additional check at hand out. There was a notice on the fridge showing the company's insulin policy. This had been implemented when the pharmacist superintendent (SI) identified that a high number of errors occurred with insulin prescriptions. A third accuracy check was required before handing out insulin and a check made with the person collecting the insulin to confirm they recognised it and it was what they were expecting. Quetiapine and quinine had been separated following incidents in other pharmacy's when these two medicines were confused. Annual patient safety reports were completed. Patient safety objectives were displayed on a notice board and included a reminder that patients' medical profile sheets for compliance aid packs should be rewritten when changes occurred rather than crossing out or altering them to avoid confusion. The team were in the process of working through all patient's profile sheets and had introduced a communication book to record any information about their compliance aid packs.

'How to make a complaint' or give feedback was outlined on various notices which included the address of the company's complaint's manager. A customer satisfaction survey was carried out annually. Insurance arrangements were in place. Private prescription and emergency supply records, the RP record, and the controlled drug (CD) register were appropriately maintained. Records of CD running balances were kept and these were regularly audited. Two CD balances were checked and found to be

correct. Patient returned CDs were recorded and disposed of appropriately.

There was an information governance (IG) and confidentiality policy, and a data handling and data protection policy which were filed in the IG file. Team members had completed General Data Protection Regulation (GDPR) and IG training on the company's online training system. Confidential waste was shredded. A dispenser correctly described the difference between confidential and general waste. Details of what information was recorded and shared, the patient's rights under the Data Protection Act, and a statement that the pharmacy complied with the NHS Code of Confidentiality was given in 'safeguarding your information' leaflets. A notice containing information about the Freedom of Information Act was on display. The delivery driver knew what it meant to maintain patient confidentiality. Assembled prescriptions awaiting collection were not visible from the medicines counter. Explicit consent was not obtained from the patient before sending their prescription details to the hub, although if patients asked about the process it was explained to them and they could opt out.

The pharmacist had completed the Centre for Pharmacy Postgraduate Education (CPPE) level 2 training on safeguarding. The delivery driver said they would voice any concerns regarding vulnerable people to the pharmacist working at the time. There was a safeguarding policy and the contact numbers of who to report concerns to in the local area were on display, along with Royal Pharmaceutical Society (RPS) guidance. There was a chaperone policy which was on the company's Intranet, but it was not clearly highlighted to the public and some members of the pharmacy team were not aware of it. The team confirmed that they would offer a chaperone to a patient if it seemed appropriate, and would allow a patient's representative to join them in a consultation if this was requested. Members of the pharmacy team had completed Dementia Friends training, so had a better understanding of patients living with this condition.

Principle 2 - Staffing ✔ Good practice

Summary findings

The pharmacy team members have the right qualifications for the jobs they do. They work well together and communicate effectively. They are comfortable providing feedback to their manager and receive feedback about their own performance.

Inspector's evidence

There was a pharmacist, three NVQ2 qualified dispensers (or equivalent) and a delivery driver on duty at the time of the inspection. The staffing level was adequate for the volume of work during the inspection and the pharmacy team were observed working collaboratively with each other and the patients. Planned absences were organised on a holiday chart. There were two absences due to sickness at the time of the inspection, one of which was long-term, and this was being covered by a locum dispenser.

Members of the pharmacy team carrying out services had completed the appropriate training and used the company's online training system 'Moodle' to ensure their training was up to date. A record of the completed training could be viewed on their personal profile. Training on sepsis, risk management, oral health, dementia, look-alike and sound-alike drugs (LASAs) and Community Pharmacist Consultation Service (CPCS) had been completed. Members of the pharmacy team did not always have regular protected time to complete training, especially with the recent issues with absences. They had one-to-one discussions with the pharmacy manager where performance and development were discussed, annual objectives were set and then reviewed after six months. Other day to day issues were discussed within the team as they arose. A dispenser said she felt there was an open and honest culture in the pharmacy and said she would feel comfortable talking to the pharmacy manager about any concerns she might have. She said the team could make suggestions or criticisms informally. There was a staff briefing area with lots of notice and information for the team. This included a 'retail steering wheel' showing performance against targets for a variety of things, the details of a recent conference call and a reminder about the audits taking place. There was a whistleblowing policy and a notice on display highlighting a confidential helpline to report concerns about incidents or suspicious behaviour to the business integrity team.

The pharmacist said she felt empowered to exercise her professional judgement and could comply with her own professional and legal obligations. For example, refusing to sell a pharmacy medicine containing codeine, because she felt it was inappropriate. She said she recorded the number of Medicines Use Reviews (MURs) and New Medicine Service (NMS) she had completed on her locum invoice but did not receive additional salary for these. She said she tried to complete these when appropriate but didn't feel under any pressure.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises generally provide a professional environment for people to receive healthcare. The pharmacy has a private consultation room that enables it to provide members of the public with the opportunity to have confidential conversations.

Inspector's evidence

The pharmacy premises including the shop front and facia were clean and in an adequate state of repair. The retail area was free from obstructions, professional in appearance and had a waiting area with six chairs. A cleaning rota was used. The temperature and lighting were adequately controlled. The pharmacy had been fitted out to a good standard and the fixtures and fittings were in good order. Maintenance problems were reported to head office and the response time was appropriate to the nature of the issue.

There was a separate stockroom in the basement where excess stock was stored. It was not in a good state of repair and was not very tidy but it was heated and there were no signs of damp. The WC was in an out-building in the yard behind the pharmacy. It was heated and had a wash hand basin and antibacterial hand wash. There was a separate dispensary sink for medicines preparation with hot and cold running water. Hand washing notices were displayed above the sinks. Hand sanitizer gel was available.

The consultation room was equipped with a sink, and was uncluttered, clean and professional in appearance. The availability of the room was highlighted by a sign on the door. The pharmacy team used this room when carrying out the services and when customers needed a private area to talk. An area of the counter was partially screened which allowed a degree of privacy when prescriptions were being handed out. Patients usually received supervised medication here, which potentially breached their privacy and dignity. Team members said the consultation room was offered but they preferred not to use it. There was a partial barrier to prevent unauthorised access into the dispensary area and security mirrors were used to increase visibility around the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy offers a range of healthcare services which are effectively managed, so people receive appropriate care. The pharmacy team members give advice and make extra checks when people are receiving higher-risk medicines, to make sure they take them in the right way. The pharmacy sources, stores and supplies medicines safely. And it carries out appropriate checks to ensure medicines are in good condition and suitable to supply.

Inspector's evidence

There was a step up to the front door of the pharmacy, but it was possible for customers to enter with prams and wheelchair users with assistance. There was a bell at the door and staff said they would always be ready to serve customers at the door if necessary. There was a hearing loop in the pharmacy and a sign showing this.

A list of the services provided by the pharmacy was displayed in the window of the pharmacy along with the opening hours. There was a TV-style screen advertising products for smoking cessation, cough and cold, incontinence, and erectile dysfunction (ED) as well as promoting services such as flu vaccination. The pharmacy team were clear what services were offered and there was a folder containing relevant signposting information which could be used to inform patients of services and support available elsewhere. A patient was referred to another pharmacy or their GP as the locum pharmacist was not accredited to carry out emergency hormonal contraception (EHC). There was a range of healthcare leaflets and information cards showing common conditions and their treatment. There was a healthy living desk which contained information on suicide prevention and prostate cancer.

The pharmacy offered a repeat prescription ordering service and patients were required to contact the pharmacy before their prescriptions were due each month, to confirm their requirements. This was to reduce stockpiling and medicine wastage. There was a home delivery service with associated audit trail. This was limited to ten patients each day. Each delivery was recorded, and a signature was obtained from the recipient. A note was left if nobody was available to receive the delivery and the medicine was returned to the pharmacy. The delivery driver described the delivery process which was in line with the SOP.

Space was quite limited in the dispensary, but the work flow was organised into separate areas with a designated checking area. The dispensary shelves were well organised, neat and tidy. Dispensed by and checked by boxes were initialled on the medication labels to provide an audit trail. Different coloured baskets were used to improve the organisation in the dispensary and prevent prescriptions becoming mixed up. The baskets were stacked to make more bench space available.

Stickers were put on assembled prescription bags to indicate when a fridge line or CD was prescribed. ‘See Pharmacist’ stickers were used to highlight counselling was required and high-risk medicines such as warfarin, lithium and methotrexate were targeted for extra checks and counselling. INR levels were requested and recorded when dispensing warfarin prescriptions. A reminder of this was on the shelf in front of warfarin. The team were aware of the valproate pregnancy prevention programme. A note was

in front of Epilim highlighting this to ensure people in the at-risk group were given the appropriate information and counselling. An audit had been carried out and two patients in the at-risk group had been identified. These patients had discussions with their GP about pregnancy prevention and there was a note on their patient medication record (PMR) confirming this. The valproate information pack and care cards were available. Several audits were taking place, including one for patient with diabetes. One patient had been referred to their GP for foot or retinopathy eye checks as they had not had either one within the last year. We would like a chat' notes were attached to prescriptions to be delivered when the pharmacist wanted to include them in the audit.

A large number of patients received their medication in multi-compartment compliance aid packs. They were divided into four weekly groups to effectively manage the workload. There was a partial audit trail for changes to medication in the packs, but it was not always clear who had confirmed these and the date the changes had been made, which could cause confusion in the event of a query. A dispensing audit trail was completed, and medicine descriptions were usually included on the labels to enable identification of the individual medicines. Packaging leaflets were included so patients and their carers had easy access to all the required information about their medicines. Disposable equipment was used. There was a SOP for new people requesting a compliance aid pack. An assessment was made by the pharmacist as to the appropriateness of a pack or if other adjustments might be more appropriate to their needs.

A dispenser knew what questions to ask when making a medicine sale and when to refer the patient to a pharmacist. She was clear which medicines could be sold in the presence and absence of a pharmacist and understood what action to take if she suspected a customer might be abusing medicines such as a codeine containing product.

CDs were stored in CD cabinets which were securely fixed to the floor and fitted with digital locks. Both dispensers had individual codes to open the CD cabinets and access could be tracked if necessary. The locum pharmacist had been issued with an individual code to use whilst she was working there. The CD key for one of the cabinets, which did not have a digital lock, was stored securely. Date expired, and patient returned CDs were segregated and stored securely. Patient returned CDs were destroyed using denaturing kits. Pharmacy medicines were stored behind the medicine counter so that sales could be controlled.

Recognised licensed wholesalers were used to obtain medicines and appropriate records were maintained for medicines ordered from 'Specials'. No extemporaneous dispensing was carried out. The pharmacy was compliant with the Falsified Medicines Directive (FMD) and were scanning medicines to verify and decommission them. Medicines were stored in their original containers at an appropriate temperature. Date checking was carried out and short dated stock was highlighted. Dates had been added to opened liquids with limited stability. Expired medicines were segregated and placed in designated bins.

Alerts and recalls were received via e-mail messages from the SI office and from the NHS area team. These were read and acted on by a member of the pharmacy team and then filed. The action taken was recorded so the team was able to respond to queries and provide assurance that the appropriate action had been taken.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Members of the pharmacy team have the equipment and facilities they need for the services they provide. They maintain the equipment so that it is safe and use it in a way that protects privacy.

Inspector's evidence

Recent versions of the British National Formulary (BNF) and BNF for children were available and the pharmacist could access professional website via the intranet for the most up-to-date information. For example, the Electronic Medicines Compendium. There were three clean medical fridges. The minimum and maximum temperatures were being recorded regularly and had been within range throughout the month. All electrical equipment appeared to be in good working order and had been PAT tested.

There was a selection of clean glass liquid measures with British standard and crown marks. Separate measures were marked and used for methadone solution. The pharmacy had a range of clean equipment for counting loose tablets and capsules, with a separately marked tablet triangle that was used for cytotoxic drugs. Medicine containers were appropriately capped to prevent contamination.

Computer screens were positioned so that they weren't visible from the public areas of the pharmacy. Patient medication records (PMRs) were password protected. Individual electronic prescriptions service (EPS) smart cards were used appropriately. Cordless phones were available in the pharmacy, so staff could move to a private area if the phone call warranted privacy.

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.