

# Registered pharmacy inspection report

**Pharmacy Name:** Rowlands Pharmacy, 59 Parr Lane, Unsworth,  
BURY, Lancashire, BL9 8JR

**Pharmacy reference:** 1033292

**Type of pharmacy:** Community

**Date of inspection:** 15/01/2024

## Pharmacy context

The pharmacy is situated in a small parade of shops next to a medical centre within a residential area. The pharmacy dispenses NHS prescriptions and supplies some people with medicines in multi-compartment compliance packs to help them manage their medicines. It also provides a seasonal flu vaccination service and a blood pressure check service.

## 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
<b>1. Governance</b>	Standards met	1.2	Good practice	The pharmacy is good at recording and reviewing mistakes that happen during the dispensing process. And it uses this information to help make its services safer and reduce any future risk.
<b>2. Staff</b>	Standards met	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	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 completes the records that it needs to by law. They record their mistakes so that they can learn from them, and they make changes to help stop the same type of mistakes from happening again. Members of the pharmacy team work to professional standards and are clear about their roles and responsibilities. The pharmacy team keep people's private information safe. And team members understand how they can help to protect the welfare of vulnerable people.

### Inspector's evidence

Standard operating procedures (SOPs) were available electronically on an e-learning portal and were assigned to team members to read depending on their roles. They completed a quiz after reading each SOP which helped to make sure they understood them. Team members were up to date with their training for the SOPs. SOPs were issued and reviewed by the head office team. Members of the team were sent an email when new SOPs were launched to ensure they completed the required training.

Dispensing mistakes which were identified before a medicine was supplied to people (near misses) were highlighted to the team member involved in the dispensing process and recorded in a near miss log. The pharmacy technician, who worked as an accuracy checker, (ACT) kept the log near her checking bench to help make sure any near misses were recorded. Near misses picked up by the pharmacists were also recorded. The ACT reviewed the records at the end of each month to identify any trends or patterns. Findings from the review were discussed at a monthly team meeting. As a result of past reviews, warning labels had been stuck on the drawers to remind the team to check medicines before picking them. Any medicines with similar packaging was highlighted to the team whilst stock was being put away. Medicines which looked-alike and sounded-alike were also discussed at the meetings. Any instances where a dispensing mistake had happened, and the medicine had been supplied (dispensing errors) it was investigated and reported on the electronic system. A copy of this was sent to the superintendent pharmacist (SI). The SI's team would contact the pharmacy if they felt any further action needed to be taken. Following an incident where medicines were delivered to the wrong address, the driver was given a separate log with addresses recorded to try to reduce the chance of a similar mistake happening again. The team were also sent emails from head office about commonly occurring near misses or incidents which may have occurred in other branches. These were discussed with the team by the managers. The pharmacy team also completed annual patient safety reviews. These helped to identify trends and patterns over a longer period of time. Information from this review was shared with the head office team.

The pharmacy manager completed monthly professional standards audits and checked to make sure tasks were being completed to uphold professional standards. For example, the checks included to see if SOPs were up to date and had been read by team members, if the safety folder was up to date, if fridge temperatures were being checked and recorded.

An incorrect Responsible Pharmacist (RP) notice was initially displayed which was changed during the inspection. When questioned, team members were aware of the tasks that could and could not be carried out in the absence of the RP. The pharmacy had current professional indemnity insurance. A complaints procedure was in place and team members tried to resolve complaints in the pharmacy where possible. Any matters which could not be resolved were escalated to head office.

Private prescription records, emergency supply records, records for unlicensed medicines dispensed, RP records and controlled drug (CD) registers were well maintained. Running balances for CDs were recorded and regularly checked against physical stock held in the pharmacy. A random balance was checked and found to be correct. CDs that people had returned to the pharmacy were recorded in a register and appropriately destroyed.

Assembled prescriptions, which were ready to collect, were stored in the dispensary and not visible to people using the pharmacy. The pharmacy had an information governance policy available, and its team members had completed training about it. Refresher training was completed on an annual basis. The pharmacy stored confidential information securely and separated confidential waste which was then shredded. Pharmacists had access to National Care Records and obtained verbal consent from people before accessing it.

The RP and ACT had completed level two safeguarding training. All other team members, including the delivery drivers, had completed level one safeguarding training. A safeguarding policy was available, and the team had details of local safeguarding boards available. When questioned, team members were able to explain the signs to look out for which may indicate a safeguarding concern. And they would refer any concerns to the RP or speak to the SI's office.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

There are enough team members to manage the pharmacy's workload and they receive appropriate training to carry out their roles safely. The pharmacy helps its team members to keep their knowledge and skills up to date. Team members get regular feedback to help improve their performance. And they can provide feedback and concerns relating to the pharmacy's services.

### Inspector's evidence

The pharmacy team comprised of the RP, who was one of two regular pharmacists, an ACT and four qualified dispensers. A pharmacy student also worked on Saturdays and a new team member was due to start who was a trained dispenser. The pharmacy also had a delivery driver. Team members described how they occasionally felt there were not enough staff particularly when additional services were being provided. The team were working on changing shifts to help make sure there was adequate cover at all times. Team members said it had been particularly difficult when providing the flu and covid vaccination services as both the pharmacist and ACT were busy vaccinating people. The team were observed working effectively together and were up to date with the workload.

Team members had annual appraisals and were also provided with ongoing feedback by the pharmacists. Feedback received highlighted what the team member had done well or what could have been done differently. Team members were able to raise concerns and give feedback.

Team members asked appropriate questions and counselled people before recommending over-the-counter medicines. They were aware of the maximum quantities of medicines that could be sold over the counter. Team members completed training modules online to keep up to date. Team members occasionally did not have time to complete training at work and completed this at home. The pharmacy manager also briefed the team on new services that were to be provided or being launched. There was a plan in place to brief the team on the NHS Pharmacy First Service to ensure the team were knowledgeable and able to answer any questions when providing the service.

Meetings with members of the team were held monthly, however as the team was small and worked closely together, any new information, issues or concerns were discussed as they arose. One member of the team attended weekly conference calls with the area manager and other branches. Relevant operational information related to the pharmacy from the call was cascaded to team members. The company had an electronic application where colleagues could post any comments or feedback. As the regular RP only worked one day a week she was briefed on any important information by the team when she was next in. Head office set targets for the services provided by the pharmacist, but the RP confirmed that they did not allow the targets to compromise their professional judgement.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available so people using the pharmacy can have a private conversation with its team members.

### Inspector's evidence

The pharmacy was clean, tidy, and organised. The dispensary was large and had ample workspace which was allocated for specific tasks. A clean sink was available for the preparation of medicines before they were supplied to people. Cleaning was done by members of the team. The room temperature and lighting were appropriate. The premises were kept secure from unauthorised access. A clean, signposted consultation room was available and suitable for private conversations.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy offers a range of service which are accessible and well managed. The pharmacy obtains its medicines from licensed sources and manages them appropriately. And it takes the correct action in response to safety alerts so that it supplies people with medicines and medical devices that are safe to use.

### Inspector's evidence

The pharmacy was easily accessible from the street. A ramp was available, the shop floor was clear of any trip hazards and the retail area was easily accessible. Team members assisted people who needed help entering the pharmacy and the pharmacy provided a medicine delivery service. A hearing loop was available, and leaflets were displayed at the front of the store for people to access additional health information if needed. When it was necessary, the pharmacy team used the internet to find out the details of local services so that they could signpost people who needed services that the pharmacy did not provide.

The team including the RP felt that the blood pressure check service had a positive impact on the local population. People were referred to the pharmacy from local surgeries and team members identified people who would benefit from a blood pressure check when dispensing medicines. All team members had been trained on how to provide the service. On occasions where a high blood pressure reading was discovered, people were referred to their GP. There had been several instances where people had been referred to their GP and then prescribed medicines for the treatment of high blood pressure.

Prescriptions were mainly received by the pharmacy electronically. These were either sent to the off-site Rowlands dispensing hub or dispensed in store. The off-site dispensing hub was used by pharmacy branches within the same company to assemble prescriptions. The hub then delivered the prescriptions back to the pharmacy so they could be supplied to people. All prescriptions were clinically checked by the pharmacist before either being sent to the hub or passed on to the dispensing team to assemble. Approximately 90% of prescriptions were sent to the hub to dispense. The ACT accuracy checked most of the prescriptions, however, there were some classes of medicines she did not check, in line with the SOP, which included Schedule 2 and 3 CDs, cytotoxic medicines, and fridge lines. The pharmacist separated out any prescriptions that were not to be checked by the ACT. 'Dispensed by' and 'checked by' boxes were routinely signed on dispensing labels, to create an audit trail showing who had carried out each of these tasks. Baskets were used to separate prescriptions, preventing the transfer of medicines between different people.

Sodium valproate was stored in a separate drawer and a warning label was attached to the front of the drawer, to remind the team about the additional checks that needed to be carried out. Team members were aware that the original pack could not be split and made sure warnings were not covered when attaching the dispensing label. All team members had completed the required training on the guidance for dispensing sodium valproate as well as an updated version of the training. The RP was aware of the guidance for dispensing sodium valproate and the associated Pregnancy Prevention Programme (PPP) and had a consultation with people who fell in the at-risk group and were supplied with this medicine. Additional checks were carried out when people were supplied with medicines which required ongoing monitoring. Some medicines such as insulin were triple checked by team members before being supplied to people to help make sure people received the correct medicine.

Some people's medicines were supplied in a sealed medicine pouch to help them take their medicines at the right time. Prescriptions were labelled on site and were prepared at the hub. The RP checked the dispensing labels once they were generated. Assembled pouches seen in store were labelled with product descriptions and mandatory warnings.

Deliveries were carried out by the delivery driver. Signatures were obtained when medicines were delivered, and the driver annotated the record with the time and date of delivery. In the event that someone was not home, medicines were returned to the pharmacy.

Medicines were obtained from licensed wholesalers and were stored appropriately. Fridge temperatures were monitored daily and recorded; these were within the required range for the storage of cold chain medicines. Team members were able to describe the actions they would take if the temperature was outside of the required range. CDs were kept securely. Expiry dates were checked routinely, the dispensary had been split into sections which were assigned by head office to team members and sections were checked in accordance with this. An updated date checking matrix was seen. No date expired medicines were found on the shelves. Obsolete medicines were disposed of in appropriate containers which were kept separate from stock and collected by a licensed waste carrier. Drug recalls were received from head office by email. They were printed, shared with the team, and actioned.



## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment it needs to provide its services. Equipment is maintained and kept clean so that it is safe and ready to use.

### Inspector's evidence

The pharmacy had calibrated glass measures. Tablet counting equipment was available. Separate measures were available for liquid CD preparations to avoid cross-contamination. Equipment was clean and ready for use. Two medical fridges were available. A blood pressure monitor was used for some of the services provided and was calibrated. Up-to-date reference sources were available. The pharmacy's computers were password protected and screens faced away from people using the pharmacy. A cordless telephone was also available to ensure conversations could not 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.