General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 55 Westgate, SKELMERSDALE, Lancashire, WN8 8LP

Pharmacy reference: 1033935

Type of pharmacy: Community

Date of inspection: 30/04/2019

Pharmacy context

This is a community pharmacy inside a small shopping centre. It is situated in the residential area of Westgate in the town of Skelmersdale, West Lancashire. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services, including substance misuse supplies, seasonal flu vaccinations, and emergency hormonal contraception. A number of people receive their medicines inside multi-compartment compliance aids.

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	2.2	Good practice	Members of the pharmacy team complete regular training modules to learn new skills and keep their knowledge up to date.
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 team follows written procedures to help make sure the pharmacy provides services safely and effectively. Members of the pharmacy team record things that go wrong and discuss them to help identify learning and reduce the chance of the same mistake happening again. The pharmacy keeps most of the records it needs to by law. People who work in the pharmacy are given training about the safe handling and storage of data. This helps to make sure that they know how to keep private information safe.

Inspector's evidence

There was a set of standard operating procedures (SOPs) which had recently been updated by the head office. The pharmacy team had signed to say they had read and accepted the SOPs.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). The most recent error involved a picking error between Calcichew D3 and Calcichew D3 Forte. The pharmacist investigated the error and action was taken to help reduce the risk of further errors including informing the staff and placing an alert on the patient's PMR.

Near misses were recorded on a paper log and were reviewed monthly by the pharmacist. The pharmacist would highlight mistakes to staff at the point of an accuracy check and staff were asked to record their own errors on the log. The pharmacist would discuss errors and the reviews with the pharmacy team to share the learning identified. But only anecdotal evidence of the action taken was provided.

The company shared learning between pharmacies by intranet or email messages. Amongst other topics they covered common errors. The pharmacy team would discuss the information when it was received. Action was taken to prevent a similar error occurring in the pharmacy e.g. by segregating stock with similar names such as omeprazole and olanzapine.

Roles and responsibilities of the pharmacy team were described in individual SOPs. The dispenser was able to describe what their responsibilities were and was also clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore a standard uniform and had badges identifying their name and role.

The pharmacy had a complaints procedure and it was described in the practice leaflet. It advised customers how to make direct contact with members of the pharmacy team or with the company's head office. Complaints were recorded and sent to the head office to be followed up.

A current certificate of professional indemnity insurance was supplied prior to inspection.

The responsible pharmacist (RP) had their notice displayed prominently and was signed in to the RP register. The responsible pharmacist left the premises for lunch each day when a second pharmacist was on the premises. But they did not record their absence. This does not meet legal requirements for the pharmacy record and may prevent the company from accurately identifying when the responsible pharmacist was present in the event of a query or concern.

Controlled drugs (CDs) registers were maintained with running balances recorded and checked monthly.

Records for private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

An information governance (IG) policy was available. The pharmacy team received annual IG training and had signed confidentiality agreements. When questioned, the dispenser was able to describe what information was considered confidential waste and how it was segregated to be destroyed using the on-site shredder. A leaflet provided information about how the company handled and stored peoples information.

Safeguarding procedures were available which the pharmacy team had used for their training. The two pharmacists said they had completed level 2 safeguarding training. Contact details of the local safeguarding board were on display. The dispenser said she would initially report any concerns to the pharmacist on duty.

Principle 2 - Staffing ✔ Standards met

Summary findings

There are enough staff to manage the pharmacy's workload and they are properly trained for the jobs they do. Members of the pharmacy team complete regular training modules to learn new skills and keep their knowledge up to date.

Inspector's evidence

The pharmacy team included a pharmacist manager, two pharmacy technicians, one of whom was employed as an accuracy checking technician (ACT) and eight dispensers – two of whom were in training. The pharmacy team were appropriately trained or in accredited training programmes.

The normal staffing level was a pharmacist, an ACT, three other dispensary staff and two counter staff. A second pharmacist also worked between 10am to 4pm.

The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff could be requested but they were not always provided, which meant there was sometimes more workplace pressure during staff absences.

The company provided the pharmacy team with a structured e-learning training programme. And the training topics appeared relevant to the services provided and those completing the e-Learning. Training records were kept showing ongoing training was up to date. Staff were allowed learning time to complete training.

The dispenser gave an example of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse co-codamol sales she felt were inappropriate and refer to the pharmacist if needed.

The locum pharmacist said she felt able to exercise her professional judgment and this was respected by the staff and the other pharmacist.

The dispenser said she received a good level of support from the pharmacy team and felt able to ask for additional help. Members of the pharmacy team had not been provided with appraisals. They said they would feel able to raise any concerns they had to the pharmacist manager.

Staff were aware of the whistleblowing policy in place and said that they would be comfortable to escalate any concerns to the head office.

The pharmacist said he was set targets for MURs and NMS. But he did not feel under pressure to achieve these.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are suitable for the services provided. A consultation room is available to allow private conversations.

Inspector's evidence

The pharmacy was clean and tidy, and adequately maintained.

The size of the dispensary was sufficient for the workload. A sink and washing facilities were available within the dispensary. Customers were not able to view any patient sensitive information due to the position of the dispensary and access was restricted by the position of the counter.

The counter area was screened to help maintain privacy of conversations. The temperature was controlled in the pharmacy by the use of thermostatic air conditioning units in both the retail and dispensary areas. Lighting was sufficient. The staff had access to a kettle, microwave, separate staff fridge, and WC facilities.

A consultation room was available with access restricted by use of a lock. The space was clutter free with a computer, desk, seating, adequate lighting, and a wash basin. The patient entrance to the consultation room was clearly signposted.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to most people. And they are suitably managed to help make sure that they are provided safely. The pharmacy gets its medicines from appropriate sources, manages them safely and carries out regular checks to help make sure that all its medicines are in good condition.

Inspector's evidence

Access to the pharmacy was level via an automatic door and was suitable for wheelchair users. The consultation room was wheelchair friendly and the PMR system was capable of producing large print font. A poster and pharmacy practice leaflets gave information about the services offered. There was also information available on the company's website. Pharmacy staff were able to list and explain the services provided by the pharmacy.

The pharmacy opening hours were displayed at the entrance of the pharmacy and a range of leaflets provided information about various healthcare topics. There were local restrictions in the area which prevented the pharmacy from ordering prescriptions on behalf of people.

The pharmacy had a delivery service. Deliveries were segregated after their final accuracy check and a delivery book was used to obtain patient signatures on receipt of the medication. Unsuccessful deliveries would be returned to the pharmacy and a card posted through the letterbox indicating the pharmacy had attempted a delivery.

Dispensed by and checked by boxes on dispensing labels were initialled to provide an audit trail. Dispensing baskets were used for segregating individual patient prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. Owing slips were in use to provide an audit trail if the full quantity could not be immediately supplied.

Dispensed medicines awaiting collection were segregated away from the dispensing area on a collection shelf using an alphabetical retrieval system. Prescription forms were retained, and stickers were used to clearly identify prescriptions when fridge or CD safe storage items needed to be added. Staff were seen confirming the patient's name and address when medicines were handed out.

Fridge items awaiting collection were stored in clear bags so that the patients could easily be shown them when they were handed out, to confirm they were correct.

Schedule 3 CDs stored on collection shelves were highlighted so that staff could check prescriptions were still valid at the time of supply. Schedule 4 CDs were not highlighted, so there was a risk that they could be supplied after the prescription had expired.

High-risk medicines (such as warfarin, lithium and methotrexate) were not routinely highlighted. This means the pharmacy team may not know the medicines are being supplied. So they may miss opportunities to check that the prescription remains suitable for the patient.

The staff were aware of the risks associated with the use of Valproate during pregnancy. Educational

material was available to hand out when the medicines were supplied. The pharmacist said he had completed an audit and spoken to relevant patients about the pregnancy prevention programme. Details about this counselling were recorded on their PMR.

Some medicines were dispensed in multi-compartment compliance aids. A record sheet was kept for all compliance aid patients containing details of current medication. Any medication changes were confirmed with the GP surgery before the record sheet was amended. Hospital discharge information was sought, and previous records were retained for future reference. Disposable equipment was used to provide the service, and the compliance aids were labelled with medication descriptions and a dispensing check audit trail.

Patient information leaflets (PILs) were not routinely provided with compliance aids. This is a legal requirement and without the leaflets people may not always have all the information they might need.

Some medicines were dispensed off-site at the company's NuPAC automated dispensing hub pharmacy. These prescriptions were clinically checked by the pharmacist the first time they were dispensed and then every six months; or if there was a change in medication or circumstances. Otherwise repeat prescriptions were not normally clinically checked, which means there may be a risk that some important information could be overlooked. Prescriptions were labelled on the PMR system, and the information was transmitted to the hub. A cover sheet containing the patient details was also transmitted alongside a patient profile sheet about the medicines. The hub used an automated robot to dispense the medicines into pouches on a roll. Each pouch contained the medicines to be taken at specific dosage time (e.g. at breakfast), and the roll was in time and date order.

When the pharmacy began sending prescriptions to the hub the information they sent was validated by a team in the head office to ensure it was accurate before dispensing. This carried on until the pharmacist at the branch was 'accredited' by reviewing 125 submissions without making any errors. Once the pharmacist was 'accredited' they were able to send the information directly to the dispensing robot at the hub. If an error was made the process was reset so that head office would review the submissions until the pharmacist had reviewed a further 125 without error. The dispensed medicines were returned to the pharmacy labelled with patient information, their location of dispensing and a security seal. Patient information leaflets (PILs) were supplied with the medicines.

Prescriptions for dressings and ostomy supplies were sent to be dispensed by an external appliance contractor. The pharmacist said that consent was not obtained from the patient for the prescription to be dispensed by another contractor. So people may not always be aware that their information is being shared.

Medicines were obtained from licensed wholesalers, with unlicensed medicines source via a special's manufacturer.

The pharmacy was not yet meeting the safety features of the Falsified Medicines Directive (FMD), which is now a legal requirement. Equipment was installed but the pharmacy team had yet to commence routine safety checks of medicines.

Stock was date checked on a three month rotating cycle. A date checking matrix was signed by staff and shelving was cleaned as part of the process. Short dated stock was highlighted using a pen and liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinet, with clear segregation between current stock, patient returns and out of date stock. CD denaturing kits were available for use.

There was a clean medicines fridge with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed it had been in range for the last three months.

Patient returned medication was segregated from current stock in designated bins for storing weaste medicines located away from the dispensary. Some returned medicines were waiting to be processed and were being kept outside of the bins.

Drug alerts were received electronically. Alerts were printed, action taken was written on, initialled and signed before being filed in the patient safety folder.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy team has access to the equipment they need for the services they provide.

Inspector's evidence

The staff had access to the internet for general information. This included access to medicine information on the BNF, BNFc and drug tariff resources. All electrical equipment appeared to be in working order. According to the stickers attached, all electrical equipment had been PAT tested in April 2019.

There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for CDs. The pharmacy also had counting triangles for counting loose tablets including a designated tablet triangle for cytotoxic medication.

Computers were password protected and screens were positioned so that they weren't visible from the public areas of the pharmacy. A cordless phone was available in the pharmacy which allowed the staff to move to a private area if the phone call warranted privacy.

The consultation room was used appropriately in the services provided by the pharmacy; patients were offered its use when requesting advice or when counselling was required.

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.