General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Rowlands Pharmacy, 56-58 CoppleHouse Lane, Fazakerley, LIVERPOOL, Merseyside, L10 0AF

**Pharmacy reference:** 1034443

**Type of pharmacy:** Community

**Date of inspection:** 25/09/2019

## Pharmacy context

This is a community pharmacy situated in the residential area of Fazakerley in Liverpool. The pharmacy dispenses NHS prescriptions, private prescriptions and sells over-the-counter medicines. It also provides a range of services including seasonal flu vaccinations and a smoking cessation service. A number of people receive their medicines in multi-compartment compliance aids.

## 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 | 2.2 | Good practice | Members of the pharmacy team complete regular training modules to help them 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, and this helps to maintain the safety and effectiveness of the pharmacy's services. They are given training so that they know how to keep private information safe. Members of the team record things that go wrong and discuss them to help identify learning and reduce the chances of similar mistakes happening again. The pharmacy keeps the records it needs to by law.

### Inspector's evidence

There was a current set of standard operating procedures (SOPs) which were recently updated. 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 the supply of an additional instalment of methadone outside of a valid prescription. The pharmacist had investigated the error and found it was due to the quantity on the prescription being for less than usual. Action was taken to help reduce the likelihood of a similar mistake by placing a note on the person's PMR record and marking the prescription to indicate no more supplies were to be made. Near miss errors were recorded on a paper log and the records were reviewed monthly by the pharmacist. But the pharmacist was not able to produce the monthly review documents. So the pharmacy could not demonstrate what had been learned. The pharmacist said he discussed the review with staff each month and would also highlight mistakes to staff at the point of accuracy check and ask them to rectify their own errors. He gave examples of action taken to help prevent similar mistakes, which included placing alert stickers in dispensary locations of common picking errors. For example, in the location of ramipril tablets and capsules. The company shared learning between pharmacies by intranet. Amongst other topics they covered common errors. The pharmacy team would discuss the information when it was received. There was evidence of action being taken to prevent similar errors occurring, for example, by moving quetiapine away from quinine tablets.

Roles and responsibilities of the pharmacy team were documented on a matrix. The dispenser was able to describe what her responsibilities were and was clear about the tasks which could or could not be conducted during the absence of a pharmacist. Staff wore standard uniforms and had badges identifying their names and roles. The pharmacy had a complaints procedure. This was described in the practice leaflet and it advised people they could give feedback to members of the pharmacy team. Complaints were recorded and sent to the head office to be followed up. A current certificate of professional indemnity insurance was seen prior to inspection.

An incorrect responsible pharmacist (RP) notice was on display for a pharmacist who had not been present for at least a week. This may not meet current legal requirements and may cause confusion about who the RP was at a particular point in time. Controlled drugs (CDs) registers were maintained with running balances recorded and checked weekly. Two random balances were checked, and both found to be accurate. Patient returned CDs were recorded in a separate register. Records for the RP, 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 confidentiality agreements in their contracts. When questioned, the dispenser was able to correctly describe how confidential information was segregated and destroyed using the on-site shredder. A leaflet was available that described how people's information was handled.

Safeguarding procedures were included in a procedure and the pharmacy team are provided with safeguarding e-learning. The pharmacist said he had completed level 2 safeguarding training. Contact details of the local safeguarding board were available. 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 appropriately trained for the jobs they do. Members of the pharmacy team complete regular training modules to help them keep their knowledge up to date

### Inspector's evidence

The pharmacy team included a pharmacist manager, an accuracy checking technician (ACT), and four dispensers – two of whom were in training. The pharmacy team were appropriately trained or on accredited training programmes. The normal staffing level was a pharmacist, ACT and two or three dispensers. The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff from local branches could also be requested. A dispenser, who worked 30 hours per week, had recently ceased employment and the pharmacy was not planning to replace the role.

The pharmacy 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 that ongoing training was up to date. Staff were allowed learning time to complete training.

The dispenser gave examples of how she would sell a pharmacy only medicine using the WWHAM questioning technique, refuse sales she felt were inappropriate and refer people to the pharmacist if needed. The pharmacist said he felt able to exercise his professional judgement and this was respected by the pharmacy team and the company. The dispenser said she felt a good level of support from the pharmacist and was able to ask for further help if she needed it.

Appraisals were conducted by the pharmacy manager. Staff were aware of the whistleblowing policy and said that they would be comfortable reporting any concerns to the head office. There were service based targets for MURs, NMS and Flu. The pharmacist said 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 enable private conversations.

### Inspector's evidence

The pharmacy was clean and tidy, and appeared adequately maintained. The size of the dispensary was sufficient for the workload. A sink was 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 use of a gate. The temperature was controlled by the use of electric heaters. 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 provides a range of services which are easy to access. And it manages and provides them safely. It gets its medicines from appropriate sources, stores them appropriately and carries out regular checks to help make sure that they are in good condition.

### Inspector's evidence

Access to the pharmacy was level via a single door and was suitable for wheelchair users. There was also wheelchair access to the consultation room. Pharmacy practice leaflets gave information about the services offered. There was also information available on the 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.

The pharmacy had a delivery service. Deliveries were segregated after their accuracy check and a delivery book was used to obtain signatures from the recipient to confirm delivery. 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 were initialled on dispensing labels to provide an audit trail. Dispensing baskets were used for segregating individual patients' prescriptions to avoid items being mixed up and the baskets were colour coded to help prioritise dispensing. The pharmacist performed a clinical check of all prescriptions and then signed the prescription form to indicate this had been completed. When this had been done, an accuracy checker was able to perform the final accuracy check. 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 when fridge or CD safe storage items needed to be added. Staff were seen to confirm the patient's name and address when medicines were handed out.

Schedule 3 and 4 CDs were highlighted so that staff could check prescription validity at the time of supply. High-risk medicines (such as warfarin, lithium and methotrexate) were also highlighted and patients were counselled on their latest results. 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 had spoken to any patients who were at risk and made them aware of the pregnancy prevention programme, which was recorded on their PMR.

Some prescriptions were dispensed at an automated hub known as Medi-PAC. People were automatically enrolled onto the service and formal consent was not obtained. So they may not always be aware that this was happening. Medicines were labelled electronically against the prescription then the information was transmitted to the hub where the medicines were assembled. Only staff who had been specifically trained were able to label Medi-PAC prescriptions. The PMR would tell the dispenser if any item could not be dispensed at the hub. Once all the prescriptions were labelled, the pharmacist was required to complete the accuracy check to make sure the information was correct, and this was

auditable. But there was no audit trail of who had produced the labels. This may make it difficult to identify who was involved in this stage of the process to help them learn from any mistakes. Dispensed medicines were received back from the hub within 48 hours, packed in a sealed crate that clearly identified what it contained.

Medicines were packed in sealed bags for each individual person's prescription, with the patient's name and address on the front. These were not accuracy checked by the pharmacy unless they opened the bag, in which case the responsibility for the final accuracy check transferred to the pharmacy rather than the hub. When the dispensed medicines were received in branch they were matched up against the prescription form, and any other bags from the Medi-PAC or medicines dispensed at the pharmacy.

Some medicines were dispensed into multi-compartment compliance aids at a hub. The pharmacy would order prescriptions for these patients and staff contacted the GP surgery in the event of a discrepancy. Hospital discharge sheets were sought, and records kept for future reference. 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 assembled medicines into disposable compliance aids and patient information leaflets were routinely supplied.

Prescriptions which were dispensed off-site were clinically checked by the pharmacist the first time they were dispensed and then every 6 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.

The pharmacy provided a seasonal flu vaccination service. A checklist had been completed by the pharmacist to check the required documents and equipment were present before he commenced vaccinations. Current patient group directions were available to reference. The pharmacist had completed a declaration of competence to indicate his training and knowledge was sufficient to commence the service.

Medicines were obtained from licensed wholesalers, with unlicensed medicines sourced from a special's manufacturer. The pharmacy was not yet meeting the safety features of the falsified medicine 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 12-week rotating cycle. A date checking matrix was signed by staff as a record of what had been checked, and shelving was cleaned as part of the process. Short dated stock was highlighted using a sticker and liquid medication had the date of opening written on.

Controlled drugs were stored appropriately in the CD cabinets, with clear segregation between current stock, patient returns and out of date stock. There were clean medicines fridges, each with a thermometer. The minimum and maximum temperatures were being recorded daily and records showed they had been in range for the last 3 months. Patient returned medication was disposed of in designated bins located away from the dispensary. Drug alerts were received by email from the head office and the MHRA. 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's team members have access to the equipment they need for the services they provide. And they maintain the equipment so that it is safe to use.

### Inspector's evidence

The staff had access to the internet for general information. This included access to 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 June 2019. There was a selection of liquid measures with British Standard and Crown marks. Separate measures were designated and used for methadone. The pharmacy also had counting triangles for counting loose tablets. Equipment was kept clean by the pharmacy team.

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; patients were offered its use when requesting advice or when counselling was required. Substance misuse clients were directed to the use of the consultation room to provide 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. |