General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 106 Sefton Road, Litherland, LIVERPOOL, Merseyside, L21 9HQ

Pharmacy reference: 1034602

Type of pharmacy: Community

Date of inspection: 08/07/2019

Pharmacy context

This is a community pharmacy located amongst other retail units on a parade of shops. It is situated in the residential area of Litherland, north of 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. 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	The pharmacy team complete learning 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 to help make sure it 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 chances of similar mistakes happening again. The pharmacy keeps 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 current set of standard operating procedures (SOPs) which had been recently updated by the head office. Various members of the pharmacy team said they were in the process of reading the updated procedures.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). The most recent error involved the incorrect supply of paroxetine 20mg tablets instead of pantoprazole 20mg tablets. The manager investigated the error and discussed it with the pharmacy team. To help reduce the risk of similar errors, the pharmacy team had moved medicines onto separate shelves.

Near miss errors were recorded on a paper log by the accuracy checker. Records were reviewed to help identify any possible trends. This was usually completed at the end of each month but had not been done since January 2019. So there may be a delay in identifying learning. The accuracy checker would highlight mistakes to staff at the point of accuracy check and staff were asked to rectify their own errors. The pharmacy team said when there was a repeated picking error, they would have a discussion and place an alert sticker in the medicine’s location e.g. pregabalin and gabapentin capsules.

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 and store it in the patient safety folder.

Roles and responsibilities of the pharmacy team were documented on a matrix. The technician was able to describe what her responsibilities were and was also 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 responsible pharmacist (RP) had their notice displayed prominently.

The pharmacy had a complaints procedure. A sign in the retail area advised people to make direct contact with 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 on display in the pharmacy. Controlled drugs (CDs) registers were maintained with running balances recorded and balances were checked monthly. The balances of two random CDs 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 had completed IG training and had signed confidentiality agreements. When questioned, the technician was able to describe how confidential information was segregated to be removed and destroyed by a waste carrier. A leaflet was available to provide information to people about how the company handles patient data.

Safeguarding procedures were available in the dispensary, and the pharmacy team said they had read and understood these. The pharmacist said she had completed level 2 safeguarding training. Contact details of the local safeguarding board were available. The technician 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. The pharmacy team complete learning modules to help them keep their knowledge up to date. They get regular feedback from their manager to help them improve.

Inspector's evidence

The pharmacy team included a pharmacist, four pharmacy technicians – two of whom were trained to accuracy check, four dispensers and a driver. All members of the team had completed the necessary training for their roles.

The normal staffing level was a pharmacist, a pharmacy manager – who was an accuracy checking technician and three staff. The volume of work appeared to be generally managed. Staffing levels were maintained by part-time staff and a staggered holiday system. A member of the pharmacy team had experienced a number of absences due to sickness. The manager said they would request relief staff, but they could not always be provided.

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

The technician 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 she felt able to exercise her professional judgement, and this was respected by the pharmacy manager and pharmacy team. The technician said she felt she received a good level of support from the company and pharmacy manager. And was able to ask for extra help if she needed it.

Appraisals were conducted annually by the pharmacy manager. A technician said she was required to complete a pre-appraisal rating sheet, which was used later to discuss her work with the manager. She felt the appraisal was a good chance to receive feedback about her work.

Staff were aware of the whistleblowing policy and said that they would be comfortable escalating any concerns to the SI. There were targets set by the company for MURs and NMS. The pharmacist said she 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

Parts of the dispensary were cluttered and presented a tripping hazard for staff – particularly the medicines which were stored on the staircase. The premises appeared adequately maintained. A cleaning rota was in place.

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 counter area was screened to help maintain privacy of conversations.

The temperature was controlled by the use of air conditioning units. Lighting was sufficient. The staff had access to a kitchenette area with 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 easy to access. And it manages them to help make sure that they are provided safely. The pharmacy gets its medicines from appropriate sources, stores them appropriately and carries out some 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 wheelchair access to the consultation room. Posters and 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. If the pharmacy did not provide a particular service staff were able to refer patients using a signposting folder. 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 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. 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 not routinely highlighted. So the pharmacy team may not be aware when they are being handed out in order to check that the supply is 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 technician said they had completed an audit and the pharmacist had spoken to any patients who were at risk and make them aware of the pregnancy prevention programme. This was recorded on their PMR.

Some prescriptions were dispensed by an automated hub as part of the company's off-site dispensing service (ODS). This had commenced within the last week. A leaflet was provided to people informing them about the service. But people were automatically opted-into the service without formal consent. So people may not always be aware that their information is being shared in this way. Medicines were labelled electronically against the prescription. Only staff who had been specifically trained were able to

label ODS 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 on the items; which was auditable. There was no audit trail of who had labelled the prescriptions. This may prevent identifying who was involved in this stage of the process to help them learn from any mistakes.

Prescriptions were received within 48 hours from the hub in a sealed crate that clearly identified that it contained dispensed medicines. Medicines were dispensed into sealed bags with the patient's name and address on the front. These did not need to be accuracy checked by the pharmacy unless they opened the bag, in which case the responsibility for the final accuracy check fell onto the pharmacy rather than the hub. When the dispensed medicines were received in branch they were matched up against the prescription, and any other bags from the ODS or medicines dispensed at the pharmacy.

Some medicines were dispensed into multi-compartment compliance aids at another site. 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.

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 a member of staff at the branch was ‘accredited’ by reviewing 125 submissions without making any errors. Once a member of staff 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 and their location of dispensing. Patient information leaflets (PILs) were supplied with the medicines.

Prescriptions sent to be dispensed at another site were clinically checked by the branch 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.

The pharmacy offered a medication dispensing service to care homes. A re-order sheet was provided to the pharmacy and it contained details about the medicines required. A copy of the prescription was sent to the care home and the care home would chase up any outstanding queries with the GP surgery. Some medicines for care homes were dispensed into disposable compliance aids, which were assembled elsewhere in the company. They contained the required labelling information and a dispensing signature. A delivery sheet was used and signed by the care home.

The pharmacist performed a clinical check of all prescriptions dispensed by the pharmacy, and then signed and stamped the prescription form to indicate this had been completed. This would allow an accuracy checker to perform the final accuracy check.

Prescriptions for dressings and ostomy supplies were sent to be dispensed by an external appliance contractor. The staff 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 personal information is being shared.

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

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 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. Liquid medication did not always have the date of opening written on, including a bottle of Morphine sulphate oral solution which expired three months after opening. So members of the pharmacy team may not know how long the medicines had been open or whether they remained fit for purpose.

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 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 three months. Patient returned medication was disposed of in designated bins for storing waste medicines.

Drug alerts were received electronically by email. 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.

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 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.

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.

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.