General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 86 Waddicar Lane, Melling, LIVERPOOL, Merseyside, L31 1DY

Pharmacy reference: 1034624

Type of pharmacy: Community

Date of inspection: 20/06/2019

Pharmacy context

This is a community pharmacy located next door to a GP surgery. It is situated in the small village of Melling, near Kirkby in Merseyside. The pharmacy dispenses NHS prescriptions, private prescriptions, sells over-the-counter medicines and provides a seasonal flu vaccination service. A number of people receive their medicines inside multi-compartment compliance aids. The pharmacy was piloting the company's 'off-site dispensing' service; where medicines were assembled at a central hub location.

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	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 chance of the same mistake 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 recently been updated by the head office. The pharmacy team had read and accepted the SOPs. An internal compliance audit was conducted every year by the company. On the last occasion it identified some areas of improvement e.g. missing SOP signatures, and date checking records. The pharmacist manager said these areas had been addressed.

Dispensing errors were recorded electronically and submitted to the superintendent (SI). A recent error involved the incorrect supply of Laxido sachets instead of Laxido paediatric sachets. The pharmacist investigated the error and made the pharmacy team aware of it.

Near miss errors were recorded on a paper log and were reviewed monthly by the pharmacist. The pharmacist said she would consider underlying factors such as the time of day as part of her review. Action was taken in response to any risk factors identified in the reviews, to help prevent similar mistakes e.g. segregating ramipril tablets away from the capsule formulations.
Reviews had not been completed for errors made since March 2019. So this may delay identifying improvements. The pharmacist said she would highlight mistakes to staff at the point of the accuracy check and staff were asked to rectify their own errors.

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. To help prevent a similar mistake, the pharmacy team had moved quetiapine to a different dispensary location.

Roles and responsibilities of the pharmacy team were documented on a matrix. The dispenser 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 and it was described in the practice leaflet. It advised people how to report concerns to the pharmacy team or the company's head office. Any 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. Records for the RP, private prescriptions, emergency supplies and unlicensed specials appeared to be in order.

Controlled drugs (CDs) registers were maintained with running balances recorded and checked monthly. The balance of two random CDs were checked and both found to be accurate. Patient returned CDs were recorded in a separate register.

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 describe what information was considered confidential and how it was segregated to be destroyed using the on-site shredder. A leaflet provided information about how patient data was handled.

Safeguarding procedures were available, and the pharmacy team had completed safeguarding training. The pharmacist said she had completed level 2 safeguarding training. Contact details of the local safeguarding board were on display in the dispensary. 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. 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 two pharmacist managers, and three dispensers. All members of the team had completed the necessary training for their roles. The normal staffing level was a pharmacist and two dispensers; except for on a Tuesday and Friday when the second dispenser worked reduced hours between 10am to 3pm.

The volume of work appeared to be managed. Staffing levels were maintained by part-time staff and a staggered holiday system. Relief staff would provide cover during 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. 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 she felt able to exercise her professional judgment and that this was respected by the company. The dispenser said she received a good level of support from the pharmacist and felt able to ask for further help if she needed it.

Appraisals were conducted annually by the pharmacy manager. A dispenser said she would complete a pre-appraisal form about her work, before discussing it with the manager in private. She felt that the appraisal process was a good chance to have an open discussion about her work.

Staff were aware how to escalate any concerns to the head office. A poster was displayed which encouraged staff to raise concerns. There were targets set for services such as MURs and NMS. The pharmacist said she did not feel under pressure to achieve targets.

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 appeared adequately maintained. The dispensary was small. The pharmacist explained the system they had in place to help manage the workload to make best use of the available space. 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 in the pharmacy by the use of 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’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 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 wheelchair access to the consultation room. 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. 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 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 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.

The pharmacist said she would highlight schedule 3 and 4 CDs 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 counsel 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 she would speak to any patients who were at risk and make them aware of the pregnancy prevention programme, and this would be recorded on their PMR.

Some prescriptions were dispensed by an automated hub as part of the company's off-site dispensing (ODS) service. This was new and had started about two weeks ago. A sign in the retail area indicated that some prescriptions were dispensed off-site at another location. The staff said they would inform people about the service if they enquired about the differences in the presentation of the medicines,

but formal consent was not obtained. 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 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 tote 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 for people who required them in multicompartmental compliance aids were dispensed off-site at the company's NuPAC automated dispensing hub pharmacy. 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 submissions 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 sent to the ODS hub or the NuPAC hub 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.

Prescriptions for dressings and ostomy supplies were sent to be dispensed by an external appliance contractor. A sign was on display in the retail area about this. But 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 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 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 minimum and maximum thermometer. The minimum and maximum temperature was being recorded daily and records showed they had been within the required range for the last three months.

Patient returned medication was disposed of in designated bins for storing waste medicines located away from the dispensary.

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 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 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 2018.

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; 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.