General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 31 North End, BEDALE, North Yorkshire, DL8 1AF

Pharmacy reference: 1038913

Type of pharmacy: Community

Date of inspection: 17/04/2023

Pharmacy context

The pharmacy is on the main shopping street in the town of Bedale, North Yorkshire. Its main services include dispensing NHS prescriptions and selling over-the-counter medicines. It supplies some medicines in a disposable pouch system designed to help people remember to take their medicines. And it offers a medicine delivery service to people's homes.

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	N/A	N/A	N/A
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 identifies and manages the risks associated with its services effectively. It keeps people's confidential information secure, and it generally keeps the records it must by law. The pharmacy advertises how people can provide feedback about its services. And its team members respond to feedback appropriately. Pharmacy team members know how to recognise and report concerns to help keep vulnerable people safe. They share learning following mistakes made during the dispensing process. And they act to reduce the risk of repeat mistakes occurring.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs) to support its safe and effective running. It held these electronically and reviewed them on a rolling two-year rota. There was a defined process to support team members in identifying new or updated SOPs and completing relevant learning. Pharmacy team members on duty were observed completing tasks in accordance with SOPs. They understood what tasks could not take place should the responsible pharmacist (RP) take absence from the pharmacy. And they referred queries to the RP appropriately. The RP was a locum pharmacist who provided occasional cover at the pharmacy. They had access to the pharmacy's SOPs and training associated with them. This helped to ensure they remained up-to-date and familiar with the pharmacy's procedures.

The pharmacy had tools to support its team members in learning from mistakes. Pharmacy team members identified and corrected mistakes brought to their attention during the dispensing process, known as near misses. There was clear learning applied following mistakes. For example, warning labels attached to shelf edges within the dispensary prompted additional checks when picking a medicine. But the opportunity to record all near misses was not always taken. This risked some trends in near misses going unidentified when the records were analysed as part of a monthly patient safety review. This review involved team members reflecting on both near misses and mistakes reported following the supply of a medicine to a person, known as a dispensing incident. The pharmacy completed comprehensive incident reports following this type of mistake. These reports were submitted electronically and reviewed by the pharmacy's superintendent pharmacist's team. And team members acted to reduce risk by sharing learning both at the time the mistake was reported, and within its patient safety reviews. The company's hub pharmacy had on occasion fed back mistakes made with data entry relating to quantity errors. A team member explained how this had informed learning when inputting data to send to the hub pharmacy.

The pharmacy advertised its complaints procedure. A pharmacy team member explained how they would manage feedback, and escalate concerns to the pharmacy manager, a qualified dispenser. Team members provided examples of how they supported each other when people had occasionally been unhappy with the pharmacy's service. In response to feedback, the team had reviewed and streamlined the process for managing owed medicines to people. This had effectively reduced the time it took a team member to find a prescription when a person came to collect their medicine. The pharmacy displayed notices advising members of the public to treat staff with respect and team members were aware of what action to take if they felt threatened or unsafe at work.

Pharmacy team members completed mandatory learning associated with safeguarding vulnerable people. A trainee team member was in the process of beginning this learning. They identified that they would seek assistance from the manager, or another team member should they have any concerns about a person's health or wellbeing. The RP confirmed they had completed level two safeguarding learning through the Centre for Pharmacy Postgraduate Education. There was some awareness of the 'Safe Spaces' and 'Ask for ANI' safety initiatives, designed to provide people experiencing domestic violence with a safe space to go. The pharmacy manager discussed what steps would be taken to support a person requiring assistance in these circumstances.

The pharmacy stored personal identifiable information in staff-only areas of the premises. It displayed a privacy notice, and another notice informed people that some prescriptions may be dispensed by the company's hub pharmacy. The team shredded confidential waste at regular intervals. The pharmacy had current indemnity insurance. The RP notice displayed contained the correct details of the RP on duty. A sample of pharmacy records examined mostly complied with legal and regulatory requirements. This included records associated with private prescriptions and unlicensed medicines. There were some gaps in the RP record where pharmacists had not signed out.

On the day of inspection, the pharmacy held two current CD registers. There was a clear rationale for the pharmacy deviating from the legal requirement to hold one CD register. This was due to it implementing an electronic register within the last fortnight. It had a defined process of maintaining both its handwritten and its new electronic register for a brief period of time prior to a senior manager reviewing the registers to ensure entries in the electronic register were compliant. The team had an effective system for completing weekly physical checks of stock against the running balances recorded in the registers. This involved having specific days of the week assigned to specific medicines. Random physical balance checks of several CDs conducted during the inspection complied with the running balance in the registers. The pharmacy retained an up-to-date patient returned register; this was also in the process of being transferred to the electronic record.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy employs people with the appropriate knowledge and skills to provide its services effectively. Pharmacy team members are enthusiastic in their roles, and they work together well. They engage in regular conversations together to help minimise risk. And they understand how to raise concerns at work.

Inspector's evidence

On duty was the RP, two qualified dispensers and a trainee dispenser and the delivery driver. Another dispenser, and another trainee dispenser also worked at the pharmacy. The team had recently recruited a regular pharmacist who had not yet commenced their role. Regular relief and locum pharmacists had been providing RP cover for some months. The pharmacy had been short-staffed due to staff leaving the business. During this time, the team felt it had been supported well by colleagues from other pharmacies who attended to cover during periods of staff absence. The situation had recently improved with the recruitment of new team members. A dispenser with previous management experience had stepped into the role of manager. They expressed feeling well supported by the pharmacy's area and regional manager who regularly checked in with the team to ensure it was coping with workload. The pharmacy had some targets associated with the services it provided. The RP on duty explained these had not been specifically discussed with them. They were clearly able to apply their professional judgment when providing pharmacy services. And was observed taking the opportunity to engage with members of the public. The team managed workload effectively and was up to date with day-to-day housekeeping tasks.

The pharmacy enrolled its trainee team members on GPhC accredited learning courses following completion of their induction period. Trainee dispensers felt well supported in their learning roles, this included a good level of support from a regular relief pharmacist. Pharmacy team members engaged in a structured appraisal process to support their learning and development. They were able to take some time at work to complete regular e-learning associated with their roles. The pharmacy team engaged in some structured discussion relating to risk management. And it recorded learning points from these discussions to help reduce the risk of repeated mistakes occurring. The pharmacy had a whistleblowing policy. Its team members understood how to raise and escalate a concern at work. And they were confident at putting forward ideas designed to reduce risk following mistakes.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and secure. It offers a professional environment for delivering healthcare services. People using the pharmacy can speak with a member of the pharmacy team in private.

Inspector's evidence

The pharmacy was secure against unauthorised access, and it was maintained appropriately. The public area was fitted with wide spaced aisles, allowing people using wheelchairs and pushchairs to navigate the space. The dispensary was set back beyond the public area and was accessed up a step from a corridor leading off the public area. A large window at the front of the dispensary allowed team members to monitor activity in the public area. The dispensary provided adequate space to manage current workload. There was a room at the far-end of the corridor used to store stock such as dispensary sundries and retail lines. The driver used protected space in this room to complete tasks associated with the delivery service. Other rooms off the corridor included kitchen and bathroom facilities.

The pharmacy's consultation room was opposite the dispensary. The room was accessed off the corridor and was narrow. This meant it might be difficult for people using wheelchairs to access it. On occasion the team had screened off part of the public area to accommodate a person's privacy. This had always been done at the request of a person and with their full consent. There was also an option to telephone people to help protect their privacy. The pharmacy was clean and generally organised. Floor spaces remained free from trip and fall hazards. Sinks were equipped with antibacterial soap and paper towels and there was hand sanitiser available for use. Lighting and heating arrangements were appropriate.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are accessible to people. The pharmacy obtains its medicines from licensed sources. And it stores its medicines safely and securely. Pharmacy team members work effectively to manage the pharmacy's services. They engage people in conversations about the medicines they are taking. And they conduct regular checks to ensure medicines are safe and fit to supply to people.

Inspector's evidence

People accessed the pharmacy through a simple door from street level. An internal ramp and steps led to the public area. The pharmacy advertised its opening hours and its services to people. Its designated waiting area had seats available for people. There was a range of information leaflets available. These focussed on the pharmacy's services and common health conditions. Pharmacy team members signposted people to another pharmacy or healthcare provider if they required a service or medicine which the pharmacy could not provide. A team member was observed calling another pharmacy to check it had a medicine in stock, prior to signposting a person requiring their medicine urgently to the pharmacy.

The pharmacy protected its Pharmacy (P) medicines from self-selection. The team regularly referred to the RP when people required additional information or support when purchasing a medicine. Its team members were vigilant in monitoring requests for over-the-counter medicines subject to abuse, misuse and overuse. And provided examples of referring people to their GP when they recognised repeat requests for these medicines. The pharmacy team highlighted assembled bags of some higher-risk medicines with stickers to prompt referral to a pharmacist upon handout of the medicine. The team thought these checks were verbal and were not routinely recorded on the patient medication record (PMR) to support a person's continual care needs. The team also highlighted assembled bags to prompt additional checks when handing out cold-chain medicines and CDs. This prompted an additional check of the assembled medicine prior to it being handed out to a person. Pharmacy team members and the RP demonstrated their understanding of the dispensing requirements related to the valproate Pregnancy Prevention Programme (PPP). This included the updated safety information relating to supplying valproate in the manufacturer's original packaging and the need to determine if the person had engaged in an annual specialist review. The pharmacy had completed a recent audit that had identified it did not currently dispense to anybody within the at-risk group. It had resources to support it in supplying valproate safely should it dispense to a person within this group.

The pharmacy used coloured baskets throughout the dispensing process. This kept medicines with the correct prescription form and helped inform workload priority. It kept original prescriptions for medicines owing to people. Team members used the prescription throughout the dispensing process when the medicine was later supplied. The pharmacy maintained an audit trail of the medicines it delivered to people's homes. Each delivery was recorded on individual sheets within the delivery record. The delivery driver returned bags of medicines if a person was not available to receive the delivery, and a note informing them of the missed delivery was posted. This provided people with the opportunity to contact the pharmacy if required. The team routinely tried to contact people, or their carers if they missed two consecutive delivery attempts to ensure they were safe and well.

The pharmacy sent some dispensing workload offsite to the company's hub pharmacy. This workload was made up of original pack dispensing and the supply of medicines in a disposable pouch system. The team had up-to-date information about prescription items that could not be sent to the hub. This included medicines requiring specific storage requirements such as CDs and those with regular monitoring requirements such as warfarin. Team members followed the company's procedures when sending data to the hub. This included the need for the RP to complete a data accuracy check of the information being sent and confirmation that an up-to-date clinical check of the prescription was complete. The hub sent the dispensed medicines to the pharmacy for people to collect. The pharmacy team had a clear process for managing prescriptions when part was dispensed at the hub and part was dispensed in the pharmacy. This included ensuring all assembled medicines were ready for collection together, to avoid the risk of only supplying part of the prescription.

The pouch system was designed in a way that allowed people to detach the pouch containing their medicines for specific times of the day. Each pouch could hold up to seven medicines, this meant that some people had multiple pouches containing medicines to be taken together. The system contained 28 days' worth of medicine in date and time order. The system was designed to help people manage their medicines easier. Prior to people starting on the pouch service a team member met with them to provide specific details of how the system worked. And to establish whether the person understood how to safely use the system to help them take their medicines. The meeting included demonstrating sample packaging and going through a specific guide relating to how to use the pouch system. This included checking to ensure they understood to detach more than one pouch at a time if required. Following this patient profile sheets were created detailing the person's medication regimen. These sheets were regularly updated with supporting information when people had a change to their medicine regimen. Patient information leaflets (PILs) were only supplied with the first 28-day supply or when medicines changed. This meant people may not have the most up-to-date information available to them about the medicines they were taking. The pharmacy supplied medicines to two care homes. These were supplied in original packs with electronic medicine administration records (EMARs) provided to support carers in administering medicines to people. The pharmacy received copies of the prescriptions ordered by each home. This allowed team members to manage queries effectively with GP surgeries and care home teams through telephone calls. But the team did not routinely record the outcomes of this calls to support them in managing the service.

The pharmacy sourced medicines from licensed wholesalers and specials manufacturers. It stored medicines in an orderly manner, within their original packaging. The pharmacy stored medicines subject to safe custody arrangements securely. Medicines inside the current cabinet used for this purpose were stored in an orderly manner in containers that prevented them becoming mixed up with similar looking medicines. The pharmacy stored medicines requiring refrigeration neatly in two fridges. It monitored and recorded the operating temperature range of both fridges. These records confirmed they were operating within the correct temperature range of two and eight degrees Celsius.

The team regularly undertook stock management tasks such as date checking. The team explained that occasionally these checks may not have been recorded on its date checking matrix. The matrix provided evidence of recent checks. A random check of stock in the dispensary found an out-of-date medicine. This was segregated from stock and brought to the attention of the manager. Pharmacy team members routinely checked expiry dates during the dispensing process which reduced the risk of supplying an out-of-date medicine. Short-dated medicines were highlighted, and bottles of liquid medicines were annotated with details of their opening date. The pharmacy had appropriate medicine waste bins and CD denaturing kits available. It received details of drug alerts electronically. And it responded to these by providing a clear audit trail of the checks completed and the action taken in response to each alert.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has enough appropriately maintained equipment for providing its services. And its team members use the equipment in a way which protects people's privacy.

Inspector's evidence

Pharmacy team members had access to up-to-date reference resources. They had internet and intranet access to support them in resolving queries or obtaining up-to-date information. They used password protected computers and NHS smartcards when accessing people's medication records. The pharmacy suitably protected information on computer monitors from unauthorised view. It stored bags of assembled medicines in a corridor running alongside the dispensary. This arrangement prevented personal information on bag labels and prescription forms being visible from the public area.

Pharmacy team members used appropriate counting and measuring equipment when dispensing medicines. This included clean, crown stamped glass measures for measuring liquid medicines. The pharmacy stored equipment designated for use when measuring and counting higher-risk medicines separately to prevent any risk of cross-contamination. Its equipment was from recognised manufacturers. And it was subject to periodic safety checks to ensure it remained in safe working order. For example, electrical equipment was subject to annual portable appliance testing checks.

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.