General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 26 Station Road, Clayton, BRADFORD, West Yorkshire, BD14 6AN

Pharmacy reference: 1039485

Type of pharmacy: Community

Date of inspection: 24/01/2020

Pharmacy context

The pharmacy is in a residential area in Clayton. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). And, they provide medicines to people in multi-compartment compliance packs. The pharmacy provides a substance misuse service, including supervised consumption.

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 has procedures to identify and manage risks to its services. And pharmacy team members follow them to complete the required tasks. The pharmacy protects people's confidential information. And it keeps the records it must by law. Pharmacy team members know how to safeguard the welfare of children and vulnerable adults. They record and discuss mistakes that happen when dispensing. But they don't always discuss or record much detail about the causes of mistakes. Or use the information collected about mistakes to inform the changes they make. So, they may miss opportunities to improve and reduce the risk of further errors.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. And these were available electronically. The superintendent pharmacist reviewed the SOPs every two years. And reviewed SOPs were sent to pharmacy team members to read periodically. Pharmacy team members had last read and understood the procedures in 2019. The pharmacy defined the roles of the pharmacy team members in each procedure. The pharmacy had a daily and weekly checklist of tasks that needed to be completed. These included making sure the responsible pharmacist (RP) log had been completed, near-miss errors were being recorded and medicines expiry dates were being checked. Pharmacy team members recorded they had completed these checks in some examples of records available. But some records had not been completed. Pharmacy team members explained that the checks were usually carried out by the same people. If those people were not available, the checks were not usually carried out.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. They discussed the errors made. But they did not discuss or record much detail about why a mistake had happened. Pharmacy team members analysed the data collected about mistakes together every month. They identified patterns of errors. Their patterns were based on quantitative information, such as the number of quantity errors being made. They did not analyse the data for patterns of causes. They had identified that quantity errors were the most common over the past five months. And their proposed changes to help prevent these errors was to be more careful when dispensing. They had not made any other changes. Pharmacy team members explained that in response to isolated errors, they had separated look-alike and sound-alike (LASA) medicines, such as amlodipine and amitriptyline. And they highlighted the edge of the shelves or drawers where the medicines were kept highlighting the risks when dispensing. But they only did this when the medicines had been involved in an error. And not proactively to help prevent errors from happening in the first place. The pharmacy had a process for dealing with dispensing errors that had been given out to people. It recorded incidents electronically. In the samples of reports available, pharmacy team members had recorded what had happened. But they had recorded very little information about why the errors had happened. Or what they had changed to help reduce the risks of them happening again. They could not give any examples of any changes they had made after they had made a dispensing error. And one of the most recent errors had involved someone being supplied with the wrong quantity of their medicines.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a practice leaflet available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. And verbal feedback from people. A

dispenser explained the pharmacy had received feedback from people after the company had changed their delivery policy. The change meant that some people who had previously received deliveries could no longer have their medicines delivered. The dispenser explained the team had worked hard to communicate the change to people. And to make sure the most in need of the service continued to receive deliveries.

The pharmacy had up-to-date professional indemnity insurance in place. It kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity monthly. They audited methadone registers weekly. The pharmacy kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record electronically. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. Pharmacy team members monitored and recorded fridge temperatures daily in two fridges. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. And, it shredded confidential waste. Pharmacy team members had been trained to protect privacy and confidentiality. They completed mandatory training online each year. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR). When asked about safeguarding, a dispenser gave some examples of symptoms that would raise their concerns in both children and adults. They explained how they would refer their concerns to the pharmacist or regional support pharmacist. The pharmacist said they would assess the concern. And would refer to head office and local safeguarding teams for advice. The pharmacist had completed training in 2019. Other pharmacy team members said they had not completed any formal training about safeguarding. But they had a sound knowledge of their responsibilities to safeguard vulnerable people.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. The team members feel comfortable discussing their ideas and concerns about the pharmacy's ways of working. And they work well together to improve ways of working. They undertake ongoing training regularly. But they do not always have the opportunity to receive formal feedback on their own performance.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist, two dispensers and a medicines counter assistant. The pharmacy had not had a regular pharmacist or a manager since September 2019. Pharmacy team members explained the pharmacist was usually someone different every day. And in the absence of a manager, they were dealing with the management responsibilities between them. Pharmacy team members trained by completing mandatory online training modules each month. They explained they tried to keep up with their training requirements. And usually found time at work to complete their training. But sometimes they found this difficult.

The pharmacy had a yearly appraisal process for pharmacy team members. But team members could not remember their last appraisals And they explained they had not had an appraisal since their manager left. They could not give any examples of any objectives set at their last appraisals. And there was no one appointed to monitor their training or progress with any learning objectives.

The dispenser explained that he would raise professional concerns with the regional support pharmacist or head office. He said he felt comfortable raising a concern. And confident that his concerns would be considered. The pharmacy had a whistleblowing policy. But pharmacy team members did not know how to access the procedure. Pharmacy team members communicated with an open working dialogue during the inspection. After discussing areas of improvement, pharmacy team members had changed the way prescriptions were stored while they were waiting to be collected. They explained that previously, bags of dispensed prescriptions were left in the retrieval area for an undefined period. And the area was often very full and cluttered. This made it difficult to find the right prescription. And increased the risks of handing out the wrong prescription. So, pharmacy team members changed their process. They now checked the retrieval area each week. And prescriptions that had not been collected after four weeks were removed. The removed bags were segregated, and pharmacy team members contacted people to ask if they still required the prescription. If the prescriptions remained uncollected for another four weeks, the medicines were returned to stock and the patients GP was informed of the uncollected prescription. Pharmacy team members explained this had helped to greatly reduce clutter in the retrieval area. And it had made prescriptions easier to find when people came to the pharmacy. They also said it had worked well to reduce wastage. The company asked the team to achieve targets in several areas of the business. These included the number of medicines use review and new medicines service consultations being completed. And the number of prescriptions being dispensed.

A dispenser explained they discussed targets with the regional support pharmacist as a team. The regional team was supportive. And understanding that it could be a challenge with no manager. The pharmacists used their professional judgement when providing services.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. And it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. It kept equipment and stock on shelves and in drawers throughout the premises. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, with a sink which provided hot and cold water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy is easily accessible to people, including people using wheelchairs. And it clearly advertises its services to people. The pharmacy has systems in place to help provide its services safely and effectively. It stores, sources and manages its medicines safely. Pharmacy team members dispense medicines into devices to help people remember to take them correctly. And they provide these people with the information they need to identify their medicines. They take steps to identify people taking high-risk medicines. And they give these people advice and support to help them take their medicines safely.

Inspector's evidence

The pharmacy had level access from the street. It advertised services in various areas throughout the retail area. And in the pharmacy's window. Pharmacy team members explained they could provide large-print labels to help people with a visual impairment. And, they would use written communication to help someone with a hearing impairment.

The pharmacy had recently started sending a proportion of its prescriptions to the company's off-site dispensing hub, where most medicines were picked and assembled by a dispensing robot. Pharmacy team members explained that prescriptions sent to the hub were usually for regular repeat medication. The pharmacy computer system determined which prescriptions could be sent to the hub. And, whether the whole prescription or only part could be dispensed at the hub. Prescriptions were then placed in a queue and a dispenser inputted the information from the prescription for each one. The pharmacist clinically checked prescriptions that were to be sent to the hub. And they signed each prescription token to confirm they had performed the clinical check. The data from the prescription added by the dispenser was checked for accuracy by the pharmacist and sent to the hub. The prescriptions were picked and labelled at the hub pharmacy using automation. Pharmacy team members filed the prescriptions to wait for the medicines to be returned from the hub two days later. Prescriptions dispensed at the hub were returned to the pharmacy in dedicated totes. Pharmacy team members scanned all returned bags. The computer system recorded how many items had been dispensed at the hub. Pharmacy team members checked each sealed bag, using a transparent window in the bag, to confirm it contained the correct number of items. They dispensed any outstanding items not dispensed at the hub and attached the bags together. They then placed the bags in the retrieval area ready for collection or delivery. Pharmacy team members explained that the implementation of the hub system had coincided with their manager leaving in September 2019. And they had found it difficult to manage the volume of changes required at once. They felt they were now managing the system well. And they were continuing to communicate with people about the timescales involved from ordering their prescriptions with their GP to them being ready to collect at the pharmacy.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. The pharmacist counselled people receiving prescriptions for valproate if appropriate. He described how he would check if the person was aware of the risks if they became pregnant while taking the medicine. He also checked if they were on a pregnancy prevention programme. And would refer people back to their GP if he had any issues or concerns. The pharmacy had a stock of printed information material to give to

people to help them manage the risks. The pharmacy supplied medicines in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the packs. And provided people with patient information leaflets about their medicines each month. They documented any changes to medicines provided in packs on the patient's electronic medication record. And in a communications diary. The pharmacy delivered medicines to people's homes. It recorded the deliveries made and asked people to sign for their deliveries. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. The team highlighted bags containing controlled drugs (CDs) with a sticker on the bag and on the driver's delivery sheet.

The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They had received training and procedures were in place to incorporate the necessary checks in to the dispensing process. Each compliant medicine pack was scanned during dispensing to check for falsified medicines. And pharmacy team members scanned an aggregated barcode on each bag as they were collected by people or sent out for delivery to decommission the medicines from the supply chain. The pharmacy had adequate disposal facilities available for unwanted medicines, including CDs. Pharmacy team members kept the CD cabinets tidy and well organised. And out-of-date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct. Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items on the pack up to six months in advance of its expiry. If a medicine expired before the next scheduled date check, the system relied on team members noticing a highlighted pack and removing it from stock. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. Pharmacy team members kept the contents of the pharmacy fridges tidy and well organised. They monitored minimum and maximum temperatures in each fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy obtained equipment from reputable suppliers. It had a set of clean, well maintained measures available for medicines preparation. Pharmacy team members used a separate, marked set of measures to dispense methadone. The pharmacy positioned computer terminals away from public view. And, it protected the computers with passwords. It stored medicines waiting to be collected in the dispensary, also away from public view. It had two dispensary fridges, which were in good working order. And pharmacy team members used them to store medicines only. They restricted access to all equipment and all items were stored securely.

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.