General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 30 The Town, Thornhill, DEWSBURY, West Yorkshire, WF12 0RB

Pharmacy reference: 1039529

Type of pharmacy: Community

Date of inspection: 17/01/2020

Pharmacy context

This is a community pharmacy in the village of Thornhill, Dewsbury. The pharmacy team offers advice to people about minor illnesses and long-term conditions. It provides NHS services, such as medicine use reviews and the New Medicines Service (NMS). The pharmacy provides a substance misuse service to a small number of people. And it supplies medicines in multi-compartment compliance packs to some people living in their own 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 mostly identifies and manages the risks associated with the services it provides to people. And it has a set of written procedures for the team members to follow. The pharmacy keeps the records it must have by law. And it keeps people's private information secure. The team members know when and how to raise a concern to safeguard the welfare of vulnerable adults and children. The team members openly discuss some mistakes that they make when dispensing. But they do not keep up-to-date records of these mistakes. And so, they may miss out on the opportunity to learn from them and reduce the risk of similar mistakes happening again.

Inspector's evidence

The pharmacy was busy at the time of the inspection with many people either waiting for their prescriptions to be dispensed or asking the pharmacy's team members for advice about their medicines and their health. There was a relatively large retail area which led to the dispensary at the rear. The dispensary was raised and overlooked the pharmacy counter. The dispensary was set back far enough from the pharmacy counter to allow the team members discuss confidential matters without being overheard by people in the retail area. And the pharmacist used the bench closest to the pharmacy counter to complete final checks on prescriptions. And this allowed her to easily oversee any sales of medicines and listen to any advice the team members were giving to people. A small fire had broken out in the pharmacy's consultation room a few days before the inspection. And so, the pharmacy had been closed to the public for one day. The team members informed the local GP surgeries of the situation and asked them to change any electronic prescriptions for people who used the pharmacy to physical prescriptions. This allowed them to take their prescriptions to another nearby pharmacy.

The pharmacy had a set of standard operating instructions (SOPs) in place. The pharmacy's superintendent pharmacist's team reviewed the SOPs every two years. The pharmacy defined the roles of the pharmacy team members in each procedure. Which made clear the roles and responsibilities within the team. All the team members who had been working in the pharmacy for over three months had read and signed each SOP that was relevant to their role. A new dispenser had started work at the pharmacy a few weeks ago. She was in the process of reading and understanding the SOPs.

The pharmacist highlighted near miss errors made by the team when dispensing. And the details of each near miss error were recorded onto a paper near miss log. The dispensers made the entries in the log. Which helped them analyse their own mistakes. And records were seen dating back to September 2019. The team members did not record the details of each error they made, and they had only made four entries between September and December 2019. They explained this was because during this time, they did not have a regular pharmacist. And, many of the locum pharmacists that worked were unfamiliar with the near miss error reporting process. The entries seen included the time, date and type of error. But the team members did not always record the reason why an error might have happened. And so, they may have missed out on the opportunity to make specific changes to their processes to reduce the risk of a similar error happening again. The team members collectively discussed why an error may have happened at the time of the incident. And they demonstrated some examples of improvement measures they had made. For example, they had noticed they were receiving the same brand of esomeprazole 20mg and 40mg capsules. And the two strengths had very similar packaging. As a result, they were sometimes mixing the two up when they were dispensing. To reduce the risk of this

happening again, the team members decided to separate the two strengths on the dispensary shelves. The pharmacy had a process to record and report dispensing incidents that had reached the patient. It recorded the details of such incidents using an electronic reporting system. And a copy of the report was kept in the pharmacy for future reference. The pharmacy had most recently supplied a person with the incorrect strength of a medicine. A team member explained the error had happened because the dispenser had dispensed the medicines against the dispensing labels instead of the prescription. The team members had a short discussion about the error, and they reminded each other of the importance of dispensing from the prescription and following the SOP on dispensing.

The pharmacy displayed the correct responsible pharmacist notice. So, people in the retail area could see the identity and registration number of the responsible pharmacist on duty. The team members explained their roles and responsibilities. And they were seen working within the scope of their role throughout the inspection. The team members accurately described the tasks they could and couldn't do in the absence of a responsible pharmacist. For example, they explained how they could only hand out dispensed medicines or sell any pharmacy medicines under the supervision of a responsible pharmacist.

The pharmacy had a formal complaints procedure in place. And it was available for people to see via a poster in the retail area. The pharmacy collected feedback from people by using questionnaires. Pharmacy team members could not give any examples of any changes they had made in response to feedback to improve their services.

The pharmacy had up-to-date professional indemnity insurance. Entries in the responsible pharmacist record complied with legal requirements. The pharmacy kept complete records of private prescription and emergency supplies. The pharmacy kept controlled drugs (CDs) registers. And they were completed correctly. The pharmacy's SOPs on CDs stated running balances against physical stock should be checked every week. But a full balance check had not been completed since September 2019. A physical balance check of two randomly selected CD matched the balance in the register. The pharmacy kept complete records of CDs returned by people to the pharmacy. The pharmacy held certificates of conformity for unlicensed medicines and they were completed in line with the requirements of the Medicines & Healthcare products Regulatory Agency (MHRA).

The team members were aware of the need to keep people's personal information confidential. They explained the importance of offering the use of the consultation room to people as people often congregated close to the pharmacy counter and so any conversations that took place near the pharmacy counter could be overheard. They were seen moving to the back of the dispensary to take any telephone calls. The pharmacy had an information governance policy which the team members could refer to. Records containing personal identifiable information were held in areas of the pharmacy that only the team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was periodically destroyed via a shredder.

The pharmacist had completed training on safeguarding vulnerable adults and children via the Centre for Pharmacy Postgraduate Education. And the other team members had completed some training organised by Rowlands. The team members gave several examples of symptoms that would raise their concerns in both children and vulnerable adults. A team member explained how she would discuss her concerns with the pharmacist on duty, at the earliest opportunity. The pharmacy had some basic written guidance on how to manage and report a concern. And the contact details of the local support teams.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services safely and effectively. They work well together to manage their workload. And they feel comfortable to raise professional concerns when necessary. The pharmacy provides its team members with a structured training programme to help them keep their knowledge and skills refreshed and up to date. But they are not always able to take time in the working day to complete this training.

Inspector's evidence

The pharmacist on duty was the pharmacy manager and worked four days a week. She was supported by a full-time NVQ 2 qualified pharmacy assistant and a part-time trainee pharmacy assistant. The pharmacy also employed another pharmacist, who worked when the resident pharmacist was absent, and two other dispensers. The pharmacist had recently joined the pharmacy. Prior to her employment the pharmacy did not have a regular pharmacist and the team members said this was a challenging time. But they felt they maintained a good quality of service. Since the pharmacist had joined the pharmacy the team members explained they were managing the workload better and waiting times for prescriptions to be dispensed had reduced. Two team members had recently left the pharmacy. A new dispenser had started working at the pharmacy but not all of the vacancy hours had been replaced. The pharmacist felt she had enough staff to manage the workload when everyone was working. As the pharmacy had been closed for a day due to the fire, the team members were a day behind with the dispensing workload. But they were seen managing the workload well and had a manageable workflow. And throughout the duration of the inspection, the waiting times for prescriptions to be dispensed was no more than ten minutes. They felt they could speak to senior management if they needed extra support but had not needed to do so. The team members were seen asking the pharmacist for support, especially when presented with a query for the purchase of an over-the-counter medicine. They mostly acknowledged people as soon as they arrived at the pharmacy counter. They were informing people of the waiting time for prescriptions to be dispensed and taking time to speak with them if they had any queries. The team members often worked additional hours to cover absences and holidays. They did not take holidays in the run up to Christmas to make sure the pharmacy had enough team members working, as this was the busiest time of the year for the pharmacy.

The pharmacy provided the team members with a structured training programme. The programme involved team members completing various modules. The modules covered various topics, including mandatory compliance training such as information governance. Other modules were based on various healthcare related topics and could be chosen voluntarily in response to an identified training need. The team members completed about one module every one or two months. They were allocated protected training time during the working day to complete the modules. So, they could train without any distractions. But they were not always able to take the time because of the dispensing workload. And so, they often completed training during their lunch hours or in their own personal time.

The pharmacy had an appraisal process in place for its team members. And they were scheduled to take place every year. The appraisals were an opportunity for the team member to discuss which aspects of their roles they enjoyed and where they wanted to improve. They could also take the opportunity to give feedback to improve the services the pharmacy offered. None of the team members working on the day of the inspection had been employed for a minimum of twelve months. And so, had not yet had

their first appraisal.

The team members felt comfortable to raise professional concerns with the pharmacist or senior management. The pharmacy had a whistleblowing policy. And so, the team members could raise concerns anonymously. The team was set various targets to achieve. These included the number of prescription items dispensed and the number of services provided. The targets did not impact on the ability of the team to make professional judgements. The team members explained the pharmacy's senior management had told the team their targets would be adjusted during this period of change in the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is kept secure and is well maintained. The premises are suitable for the services the pharmacy provides. It has a sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy premises were spacious and suitable for the services provided. They were clean and professional in appearance. There was an open plan dispensing area which had plenty of bench space and storage for medicines. Floor spaces were kept clear to minimise the risk of trips and falls. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a toilet with hot and cold running water and other facilities for hand washing.

The pharmacy had a sound-proofed consultation room with seats where people could sit down with the team member. The room was smart and professional in appearance and was signposted by a sign on the door. And it was generally kept locked when it wasn't in use. But the door was left open during the inspection. This was because the fire had originated in the consultation room and the pharmacy smelt of the fire. External contractors had visited the pharmacy to deal with the issue. The temperature was comfortable throughout the inspection. Lighting was bright throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people. It engages with people using the pharmacy to help them improve their health. The pharmacy manages its services appropriately and delivers them safely. It provides medicines to some people in multi-compartment compliance packs to help them take them correctly. The pharmacy sources its medicines from licenced suppliers. And it stores and manages its medicines appropriately.

Inspector's evidence

The pharmacy had level access from the street. So, people with wheelchairs and prams could easily access the premises. There were several car parking spaces on the street outside the pharmacy. The pharmacy advertised its opening hours in the main window and its services on the consultation room door. It stocked a large range of healthcare related leaflets in the retail area, which people could select and take away with them. For example, leaflets on travel sickness and stopping smoking. There was a television monitor in the retail area. It displayed promotions for service such as flu and over-the-counter medicines. The pharmacy could supply people with large print dispensing labels if needed.

The team members regularly used various stickers during dispensing, and they used these as an alert before they handed out medicines to people. For example, to highlight interactions between medicines or the presence of a fridge line or a controlled drug that needed handing out at the same time. The team members signed the dispensing labels when the dispensing and checking processes were complete. And so, a robust audit trail of the process was in place. They used baskets to hold prescriptions and medicines. This helped the team members stop people's prescriptions from getting mixed up. The baskets were of different colours to help the team organise their workload. For example, grey for home delivery and red for waiting prescriptions. They used 'CD' stickers to help the team members remember to check the date of issue of the prescription. This helped prevent them from handing out any CDs to people after their prescription had expired. Owing slips were given to people on occasions when the pharmacy could not supply the full quantity prescribed. One slip was given to the person. And one kept with the original prescription for reference when dispensing and checking the remaining quantity. The pharmacy kept records of the delivery of medicines it made to people. The records included a signature of receipt. So, there was an audit trail that could be used to solve any queries. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

The pharmacy sent a small number of its prescriptions to an off-site dispensing hub. And the team members demonstrated the process of entering the prescription data that was sent to the hub. They first assessed if the prescription was eligible to be sent to the hub. For example, prescriptions for acute antibiotic courses or CDs were not sent to the hub. All the information entered onto the system was accuracy and clinically checked before being sent to the hub. The medicines dispensed at the hub were delivered to the pharmacy after two working days. And the medicines were packed in plastic bags which were clear on one side. So, the team members and the person collecting could carry out a final visual check of the medicines.

The pharmacy supplied medicines in multi-compartment compliance packs for people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The

team was responsible for ordering people's prescriptions. And this was done around a week in advance to give the team members the time to resolve any queries, such as missing items or changes in doses, and to dispense the medication. They dispensed the packs on a bench at rear of the dispensary. This was to minimise distractions. The pharmacy managed the workload across four weeks. And it kept all documents together that related to each person on the service. This included any hospital discharge summaries and master sheets, that detailed a record of the person's current regime. The team members used these to check off prescriptions and confirm they were accurate. The pharmacy kept records of details of conversations they had with people's GPs. For example, if they were notified of a change in directions, or if a treatment was to be stopped. The packs detailed what medicines were in the pack and when to take them. The team provided information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. But the pharmacy did not supply the packs with patient information leaflets. Which was not in line with requirements.

The pharmacy dispensed high-risk medicines for people such as warfarin, lithium and methotrexate. The pharmacist explained she asked people prescribed high-risk medicines various questions to make sure they were taking their medicines safely. For example, for warfarin, the pharmacist asked for the person's current and target INR, their daily dosage and the date of their next blood test. If a person was delivered warfarin, lithium or methotrexate to their home, the pharmacy gave the delivery a small reminder slip to give to the person. The slip reminded the person to call the pharmacy in various scenarios. For example, if the person had not been to the warfarin clinic within the last twelve weeks or if they did not know their warfarin dose or INR. The team members were aware of the pregnancy prevention programme for people who were prescribed valproate and of the risks. They demonstrated the advice they would give people in a hypothetical situation. The team members had access to literature about the programme that they could provide to people to help them take their medicines safely. They had completed a check to see if any of its regular patients were prescribed valproate. Those people who were, were given advice by the team.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy had removed all the medicines that were stored next to the consultation room from sale. The pharmacist explained this was because the pharmacy could not guarantee that the medicines had not been damaged by the fire. The pharmacy had also removed any medicines stored in the pharmacy fridges. This was because on the day of the fire the pharmacy had a power cut. And so, fridges were not functioning. The pharmacy stored its medicines in the dispensary tidily. The pharmacy had a process to check the expiry dates of its medicines to make sure none had expired. And records were seen which showed that the process was completed regularly. No out of date medicines were found following a check of approximately ten randomly selected medicines. The team members used alert stickers to highlight medicines that were expiring in the next twelve months. They recorded the date liquid medicines were opened on the pack. So, they could check they were in date and safe to supply. The pharmacy had a robust procedure in place to appropriately store and then destroy medicines that had been returned by people. And the team had access to CD destruction kits.

The team was not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). Drug alerts were received via email to the pharmacy and actioned. The alerts were printed and stored in a folder. And the team kept a record of the action it had taken. The pharmacy checked and recorded the fridge temperature ranges every day. And a sample checked were within the correct ranges. The CD cabinets were secured. One of the CD cabinets was at full capacity and the CDs inside were not stored tidily. And so, there was an added risk of the team members selecting the wrong medicine during the dispensing process.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy's equipment is well maintained and appropriate for the services it provides. The pharmacy uses its equipment to protect people's confidentiality.

Inspector's evidence

The pharmacy had copies of the BNF and the BNF for children for the team to use. And the team had access to the internet as an additional resource. The pharmacy used a range of CE quality marked measuring cylinders. And there were some clearly marked cylinders which were only used for dispensing methadone. The team members used tweezers and rollers to help dispense multi-compartment compliance packs. The fridges used to store medicines were of an appropriate size. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't seen by unauthorised people. The computers were password protected to prevent any unauthorised access. The pharmacy had cordless phones, so the team members could have conversations with people in private.

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.