General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 125 Fitzwilliam Street, HUDDERSFIELD, West Yorkshire, HD1 5PS

Pharmacy reference: 1039595

Type of pharmacy: Community

Date of inspection: 23/10/2019

Pharmacy context

The pharmacy is in a residential area in the suburbs of Huddersfield. Pharmacy team members mainly 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). Pharmacy team members supply medicines to people in multi-compartmental compliance packs. And, they provide seasonal flu vaccinations. The pharmacy delivers medicines 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 to its services. It 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. And, they sometimes use this information to learn and reduce the risk of further errors. But, they don't always discuss or record enough detail about why these mistakes happen. And, they don't always make changes to respond to the risks identified. So, they may miss opportunities to improve. The pharmacy has up-to-date written procedures. And, most pharmacy team members follow them to complete the required tasks. But, new pharmacy team members don't always read the procedures as soon as they start working in the pharmacy. So, they might not be clear about the safest and most effective ways to carry out their tasks.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. And the superintendent pharmacist's (SIs) office reviewed them regularly. The sample checked were last reviewed in 2017. And, the next review was scheduled for 2019. Some pharmacy team members had read and signed the SOPs since the last review. But, one pharmacy team member had not read all the procedures. She had been working at the pharmacy for approximately five weeks. And, she said she had only read the procedures relevant to preparation of multi-compartmental compliance packs. The pharmacy defined the roles of the pharmacy team members in each procedure. And, in a document defining which SOPs were relevant to various levels of qualification. The pharmacy kept the current SOPs in a file. But, it also kept the old, superseded SOPs in the same file. So, pharmacy team members may be unsure about which version they should follow.

The pharmacist highlighted and recorded near miss errors made by the pharmacy team when dispensing. The pharmacy team discussed the errors made. But, they did not know where the records were kept. After a search of the pharmacy, they found some records of near miss errors. In the examples seen, the last record made was in June 2019. And, they had made very few records prior to that, given the volume of dispensing. Pharmacy team members said all mistakes were recorded. But, they did not discuss or record much detail about why a mistake had happened. The data collected was analysed by the pharmacist each month. The analysis was based on quantitative information, such as the number of wrong strength or wrong form errors being made. They did not analyse the data for patterns of causes. And, the proposed changes documented were to asking pharmacy team members to be more careful next time. Pharmacy team members could not give any other examples of changes they had made in response to near miss errors to prevent them happening again. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It recorded incidents electronically. Some recent examples were seen. The team members recorded little detail of the causes of the errors or any action taken by the team to make their services safer. Pharmacy team members said they were not aware of the errors in the examples seen.

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. But, pharmacy team members did not know of any information received from the questionnaires. And, they could not provide any examples of any

changes they had made in response to people's feedback. They said the feedback would have been received by the pharmacist. But they did not know the details of the information.

The pharmacy had up-to-date professional indemnity insurance in place. They had a certificate of insurance displayed. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And they were audited against the physical stock quantity weekly. The pharmacy did not stock methadone. It 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. 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.

The pharmacy kept sensitive information and materials in restricted areas. It shredded confidential waste. Most pharmacy team members had been trained to protect privacy and confidentiality. They had read a file of policies about information governance and the General Data Protection Regulations (GDPR) in 2018 and 2019. The newest member of the team had not read the policies. The inspector questioned her about her knowledge. And, she could clearly explain how important it was to protect people's privacy and how she would protect confidentiality.

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 to the pharmacist. And, they showed procedures for children and vulnerable adults that were displayed on a noticeboard, including contact information for local safeguarding contacts. The pharmacist said they would assess the concern. And would refer to the company's head office for advice. Pharmacy team members completed mandatory training via e-learning every year.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. They feel comfortable discussing their ideas and concerns about the pharmacy's ways of working. Pharmacy team members undertake training. And, they reflect on their own performance, discussing any training needs with the pharmacist and other team members. They support each other to reach their goals. But not all team members complete their training in a timely way. Or have the opportunity to complete their training at work. This means they may miss opportunities to keep their knowledge and skills up to date.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were a locum pharmacist, a dispenser and a trainee dispenser. Pharmacy team members were required to complete mandatory e-learning modules periodically throughout the year. And, some pharmacy team members had completed training. But, the newest pharmacy team members said she had not had time to complete her required training. She showed her online training record. And, it showed several training tasks outstanding. For example, modules covering the General Data Protection Regulations (GDPR), information governance and the procedure for sending prescriptions to the company's off-site dispensing hub. She also explained that she had unresolved issues with the electronic system that were preventing her accessing her training when she did find time. She said she had raised this with her manager. But, she agreed she could do more to resolve the situation with the company's IT team. Pharmacy team members also had regular discussions with the pharmacists and colleagues about current topics. They had an appraisal each year with their manager. Pharmacy team members were given the opportunity to identify areas where they needed to develop their knowledge and skills further. And, they set objectives to try and address their needs. One example of an objective set was for a dispenser to stop rushing while dispensing and to reduce the amount she was influenced by distractions. She explained she was being supported by the manager to help her focus on one task at a time. This was discussed. She appreciated it might be helpful if she could be more specific about the distractions that affected her the most. And, understood this would help inform the changes she made to improve.

A dispenser explained she would raise professional concerns with the pharmacist or regional leader. She felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. But, pharmacy team members were unsure about how to access the procedure. Pharmacy team members communicated with an open working dialogue during the inspection. The explained that they felt comfortable making suggestions to improve the way they worked. But, during the inspection, they could not give any examples of changes they had discussed and implemented to improve the way they delivered their services.

The pharmacy asked the team to achieve targets in various areas, such as the number of prescriptions dispensed, the number of flu vaccinations delivered and the number of people nominating the pharmacy to receive their prescriptions. Pharmacy team members said the regional leader supported them to achieve their targets. But, they were unsure about how the regional leader provided support because targets were usually discussed between the manager and regional leader.

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. But, there is no hot running water in the toilet. So, it might be difficult for pharmacy team members to maintain proper hand hygiene.

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 throughout the premises. The pharmacy had a private consultation room available. The pharmacy team 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, which provided a sink with cold running water and other facilities for hand washing. But, there was no hot water available in the toilet. Pharmacy team members said they usually washed their hands with cold water. The pharmacy had hot water available at the sink in the dispensary. But, pharmacy team members said this sink was reserved for preparing medicines. 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 and its services are generally accessible to people. But, people who use wheelchairs may find it difficult to access the pharmacy premises. 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 some information to help them identify their medicines. But the information they provide is not always accurate. Pharmacy team members take steps to identify people taking high-risk medicines. And they give these people advice to help them take their medicines safely.

Inspector's evidence

The pharmacy was accessed via steps from the street. It did not have a ramp available. So, people using wheelchairs could not access the premises. But, there was a grab handle. And, it had a bell and a sign instructing people how to attract pharmacy team member's attention if they needed help. The pharmacy had a hearing induction loop to help communicate with people with a hearing impairment. And, pharmacy team members said they would also use written communication. They were unsure about how to help someone with a visual 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 all 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. Then the pharmacist sent the data to the hub electronically. Pharmacy team members then filed the printed prescription tokens 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. And, 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 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 pharmacy supplied medicines to people in multi-compartmental compliance packs when requested. It attached labels to the packs, so people had written instructions of how to take the medicines. And it added the descriptions of what the medicines looked like, so they could be identified in the pack. But, in some samples seen, the descriptions printed on the labels were not accurate. And, they did not match the medicine dispensed in the pack. This was discussed, and a pharmacy team member said this was because the brand of medicine had changed since the descriptions was printed on the label. This was

discussed, and she gave an assurance that the description would be checked carefully each time a pack was prepared. Pharmacy team members did not regularly supply information leaflets to people about their medicines provided in a pack. They explained they provided leaflets when a medicine was new to someone. But, not regularly after that. This was discussed. And, they gave an assurance that they would provide people with leaflets each month. Pharmacy team members documented any changes to medicines provided in packs on the patient's master record sheet. But they did not capture information about the prescriber who had initiated the changes, to help deal with future queries.

Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items with a sticker on the pack up to six months in advance of its expiry. And they removed items expiring before the next date check. 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. 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. It had adequate disposal facilities available for unwanted medicines, including controlled drugs (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. The pharmacy team kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits.

The pharmacist counselled people receiving prescriptions for valproate if appropriate. And, he checked 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. The pharmacy had a stock of printed information material to give to people to help them manage the risks. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). And, they had received training. The pharmacy had the necessary equipment and software available to scan complaint packs of medicines. But, pharmacy team members said they were not routinely scanning products. And, they were unsure about how to scan and decommission products from the supply chain.

The pharmacy delivered medicines to people. It recorded the deliveries made and asked people to sign for their deliveries. But, during the inspection, pharmacy team members could not find any completed records of the deliveries made. 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 CDs with a sticker on the bag and on the driver's delivery sheet.

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 had a set of clean, well maintained measures available for medicines preparation. It 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. And, it had a dispensary fridge, which was in good working order. Pharmacy team members used the fridge to store medicines only. They restricted access to all equipment. And, they stored all items 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.