General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Rowlands Pharmacy, 63-65 Highgate Lane, Lepton, HUDDERSFIELD, West Yorkshire, HD8 0DS

**Pharmacy reference:** 1039602

**Type of pharmacy:** Community

**Date of inspection:** 17/10/2019

## Pharmacy context

This is a community pharmacy in the village of Lepton, Huddersfield. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including a home delivery service, medicines use reviews (MURs), a substance misuse service and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

Follow this link to find out what the inspections possible outcomes mean

## 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 written procedures to help the team protect the safety and wellbeing of people who access its services. It keeps the records it must have by law. And it keeps people's private information secure. The pharmacy team members have tools available to them to help safeguard the welfare of vulnerable adults and children. They use surveys to receive feedback from people who use the pharmacy. The team members discuss and learn from the mistakes that happen whilst dispensing. And they take some steps to make sure they don't repeat these errors. But they do not always keep records of the errors. And so, they may miss out on opportunities to learn from them.

### Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs). There was an index. And so, it was easy to find a specific SOP. The superintendent pharmacist's team reviewed each SOP every two years. This ensured that they were up to date. But the team were using an older set of SOPs which were several months overdue from the recorded review date. There was a matrix which listed the SOPs that each team member needed to follow, depending on their role, for example delivery driver. The team members explained how they would ask the pharmacist if there was a task they were unsure about. Or felt unable to deal with.

The pharmacy had a process to record near miss errors that were spotted during dispensing. The pharmacist typically spotted the error and then informed the dispenser that they had made an error. The dispenser made a record of the error onto a paper near miss error log. But the team members did not record all the errors they made, and they had only recorded nine errors since August 2019. The details recorded included the time, date and description of the error. The team members did not record the reasons why they had made errors. And so, they may have missed out on some learning opportunities. They sometimes recorded the action they had taken following the errors, but the details were often non-specific, for example, 'double check prescription'. The pharmacy asked the team members to complete a formal analysis of the near miss errors each month to help them identify any trends or patterns in the errors. But the team had not completed the process for several months due to a lack of time. They instead tried to discuss any significant patterns whenever they could make time to do so, and they talked about ways they could prevent the errors from happening again. For example, the team had attached alert stickers on the shelves to highlight medicines that were more likely to be involved in a selection error. The pharmacy had a process to record dispensing errors that had been given out to people. And it recorded these incidents electronically. The team members completed a root cause analysis and discussed how they could learn from the error and prevent it happening again. A copy of the report was sent to the superintendent pharmacist's office for analysis and kept in the pharmacy for future reference. The pharmacy had recently supplied a medicine in error. The longer release form of the medicine was supplied instead of the standard release form. The team members discussed ways they could stop a similar error happening in the future. And they decided to separate the two forms on the shelves.

The pharmacy had a poster on display in the retail area which advertised how people could make comments, suggestions and complaints. It detailed the company head office contact details. A team member described how she would escalate any concerns or complaints from people who used the pharmacy. The pharmacy collected feedback from people through an annual survey. And the results of

the 2017 survey were displayed and were positive overall. The results of the survey from 2018 were published on the pharmacy's NHS webpage. The team was unable to provide any examples of any improvements they had made to the pharmacy following feedback from people.

The pharmacy had up-to-date professional indemnity insurance. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record were completed correctly. The pharmacy kept complete records of private prescriptions and emergency supplies. The pharmacy kept the certificates of conformity of special supplies. And they were completed correctly as required by the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy kept controlled drugs (CDs) registers. These were in order including completed headers, and entries made in chronological order. The team members were required to check running balances against physical stock each week. But they had not completed a full check of the stock since August 2019. And so, the pharmacy may find it difficult to resolve any discrepancies. The running balance of three random CD items were checked, and they matched the physical stock. The pharmacy kept complete records of CDs returned by people to the pharmacy.

The team held records containing personal identifiable information in areas of the pharmacy that only team members could access. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The team used a shredder to destroy the confidential waste. The pharmacy displayed a poster explaining how people's information was used and stored. The team members understood the importance of keeping people’s information secure. And they had all completed training on information governance. An information governance policy was available. And each team member had read the policy in August 2019.

The pharmacist on duty had completed training on the safeguarding of vulnerable adults and children via the Centre for Pharmacy Postgraduate Education to level 2. The other team members had completed a company module via the Moodle training programme. They gave several examples of symptoms that would raise their concerns. And how they would discuss their concerns with the pharmacist on duty, at the earliest opportunity. The team members had an up-to-date safeguarding guidance policy and procedure readily available to them to help them manage and report a potential concern. And they knew to contact the local safeguarding teams or the superintendent pharmacist’s office for further advice if they had any concerns.

## Principle 2 - Staffing ✔ Standards met

### Summary findings

The pharmacy team members have the appropriate qualifications and skills to provide the pharmacy's services. They work well together to manage their workload and to ensure people receive a high quality of service. The pharmacy supports its team members to ensure their knowledge and skills are up to date. It achieves this by providing its team members with an online training programme. They can make suggestions to improve the pharmacy's services. And they feel comfortable to raise professional concerns when necessary.

### Inspector's evidence

At the time of the inspection, the team members present were a locum pharmacist, a part-time pharmacy technician and a trainee pharmacy assistant. A full-time pharmacy assistant was not working on the day of the inspection. The team members did not take time off in the few weeks before Christmas. As this was the pharmacy's busiest period. The pharmacy could call on the help of team members from other local Rowlands branches to cover planned and unplanned absences. The pharmacy had been without a regular pharmacist since March 2019 and had locum pharmacists working each day. The team members explained they had found the first few months of being without a regular pharmacist challenging but they had recently had block bookings of two regular locums which had helped give them some direction and continuity. The vacant pharmacist position had been filled and the team members were looking forward to welcoming the new pharmacist in December 2019.

The team members had access to the Moodle training programme which they used to make sure their knowledge and skills were up to date and regularly refreshed. They explained that this helped them provide a high standard of care and advice to people who had questions about their health or were interested in purchasing a healthcare related product. The pharmacist provided the team members with set time to complete training. And so, they were able to complete their learning without any distractions. But they were not always able to take this protected time, due to the dispensing workload. The team members were required to keep records of any completed training modules. Many modules that were completed were sent from the company's head office and were mandatory for the team members to work through. The team members could tailor their training to their own personal needs if they wished. For example, a team member explained that she had recently asked for time to learn about how to complete the end of month prescription submission process. The pharmacy had an annual performance appraisal process in place. Before each appraisal, they team members were required to assess their own performance over the last year. They discussed their assessment with the pharmacy's manager in a one-to-one meeting. They also discussed what parts of their roles they felt they enjoyed and which parts they felt they wanted to improve. They could give feedback on how to improve the pharmacy's services.

The team held ad-hoc informal meetings and discussed topics such as company news, targets and patient safety. If a team member was not present during the discussions, they were updated the next time they attended for work. The team members openly and honestly discussed any mistakes they had made while dispensing and discussed how they could prevent the mistakes from happening again. The team members said they were able to discuss any professional concerns with the pharmacy's regional leader or with the company head office. The pharmacy had a whistleblowing policy. So, the team could raise a concern anonymously. The pharmacy set several targets for its team to achieve. These included

services and prescription volume. The team members were well supported to help them achieve the targets.

## 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 had a small retail space and an open plan dispensary. A metal gate separated the retail area from the dispensary. This prevented any unauthorised access. The pharmacy was clean and was professional in its appearance. The building was easily identifiable as a pharmacy from the outside. The dispensary was tidy and well organised during the inspection and the team had ample bench space to organise the workflow. Floor spaces were clear kept clear so there were no trip hazards. There was a clean, well-maintained sink in the dispensary for medicines preparation and staff use. There was a WC which had a sink with hot and cold running water and other facilities for hand washing. There was a sink in the staff area used for drink and food preparation. The pharmacy had a sound-proofed consultation room which contained adequate seating facilities, a sink and a computer terminal. The room was smart and professional in appearance and was signposted by a sign on the door. 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. The team members take steps to identify people taking high-risk medicines. And, they provide these people with appropriate advice to help them take these medicines safely. The pharmacy provides medicines to some people in multi-compartment compliance packs to help them take them correctly. And it appropriately manages the risks associated with the service. The pharmacy sources its medicines from licenced suppliers. And it generally stores and manages its medicines appropriately.

### Inspector's evidence

The pharmacy had level access from the pavement outside. There were several parking spaces available outside. Seating was provided for people waiting for prescriptions. Large print labels were provided on request. A hearing loop was available for people with a hearing impairment. The pharmacy advertised its services on the consultation room door, and opening hours in the front window. The pharmacy displayed several posters and leaflets that people could select and take away with them, including leaflets on help with stopping smoking and various common conditions, such as eye infections and period pain. The team members had access to the internet allowing them to signpost those patients requiring a service the pharmacy did not offer.

The team members regularly used various stickers that they could use 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 to indicate who had dispensed and checked the medication. And so, a robust audit trail was in place. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were available to hold prescriptions and medicines. This helped the team stop people’s prescriptions from getting mixed up. And they used different colour baskets to distinguish between the different types of service. For example, a prescription for a person waiting in the pharmacy, or a prescription that was for home delivery. The team annotated alert stickers to highlight the expiry date of CD prescriptions awaiting collection. And this helped them prevent handing out CDs after the 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 team attempted to complete the owing the next day. The pharmacy kept records of the delivery of medicines from the pharmacy 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 often dispensed high-risk medicines for people such as warfarin, lithium and methotrexate. The team members demonstrated how the computer system displayed a pop-up alert when they generated dispensing labels for prescriptions for such medicines. The alert reminded the team to ask people various questions and provide appropriate advice on how they should be taking their medicines. The team occasionally recorded details of the conversations if they were significant, for example a discussion about a change in dose or directions. But the frequency of this had reduced since the pharmacy had been without a regular pharmacist. The team members were aware of the pregnancy

prevention programme for people who were prescribed valproate and of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team had access to literature about the programme to provide to people to help them take their medicines safely. The team had completed a check to see if any of its regular patients were prescribed valproate. And met the requirements of the programme. None were identified. The pharmacy used clear bags to store dispensed insulin. This allowed the team member and the person collecting it to undertake a final visual check of the medicine before handing it out.

The pharmacy supplied medicines in multi-compartmental compliance packs people living in their own homes. And the pharmacy supplied the packs to people on either a weekly or monthly basis. The team members were responsible for ordering the prescriptions. And they did this around a week in advance. And then they cross-referenced the prescription with a master sheet to ensure it was accurate. The team members queried any discrepancies with the person's prescriber. The packs had backing sheets which listed the medicines in the packs and the directions. The pharmacy supplied information to help people visually identify the medicines. For example, the colour or shape of the tablet or capsule. But it did not routinely provide patient information leaflets with the packs. This is not in line with requirements. The team members recorded the details of any changes such as dosage increases or decreases. They kept the details of when the change was authorised and who had authorised it.

Pharmacy medicines (P) were stored behind the pharmacy counter. So, the pharmacist could supervise sales appropriately. The pharmacy stored its medicines in the dispensary tidily. Every three months, the team members were required to check the expiry dates of its medicines to make sure none had expired. They were up-to-date with the process. No out-of-date medicines were found after a random check. The team members 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. The team members used alert stickers to highlight medicines that were expiring within the next six months.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). The team had received training on how to follow the directive. The team was unsure of when they were to start following the directive. 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 and of an appropriate size. The medicines inside were well organised.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy's equipment is clean and suitable for the services it provides. The pharmacy uses its equipment appropriately 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. Including separate cylinders used to dispense methadone only. 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 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. The electrical equipment had recently been subjected to portable appliance testing.

## 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. |