

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 130 Wrenthorpe Road,
Wrenthorpe, WAKEFIELD, West Yorkshire, WF2 0JG

Pharmacy reference: 1039964

Type of pharmacy: Community

Date of inspection: 30/06/2022

Pharmacy context

This pharmacy is in a small village near Wakefield. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy delivers medicines for some people to their home and it provides the Community Pharmacist Consultation Service.

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 identifies and manages the risks associated with its services well. The pharmacy has up-to-date written procedures for the team to follow to help ensure it provides pharmacy's services safely. And it keeps the records it needs to by law. The pharmacy team members respond appropriately when errors happen. They identify what caused the error and they act to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. The team members accessed the SOPs and confirmed they had read and understood them. And they had training certificates showing they had read the SOPs. The team received notification of new SOPs or when changes were made to existing SOPs. The team members demonstrated a clear understanding of their roles and worked within the scope of their role. The team referred queries from people to the pharmacist when necessary.

On most occasions the pharmacist when checking dispensed prescriptions and spotting an error asked the team member involved to find and correct the error. The pharmacy kept records of these errors known as near misses. The details recorded enabled the team to identify patterns, learn from the error and take action to prevent the error from happening again. The pharmacy had a process for managing errors that reached the person, known as dispensing incidents. The pharmacy completed electronic dispensing incidents reports to send to head office and the team discussed the error and any learning from it. The pharmacist manager regularly reviewed the near miss records and dispensing incidents to identify patterns. The pharmacist shared the outcome of the review with the team members and discussed actions they could take to prevent similar errors. This included recording hand-out errors involving people with similar names on the patient medication record (PMR). So, all the team members were aware. And advising the team to be alert to medicines that looked and sounded alike. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. And it provided people with information on how to raise a concern.

The pharmacy had up-to-date indemnity insurance. A sample of records required by law such as the Responsible Pharmacist (RP) records and controlled drug (CD) registers met legal requirements. The balance of CDs was regularly checked to spot errors such as missed entries. A random check of the balance of a CD register found it was correct. The team recorded CDs returned by people for destruction. The team members had completed training about the General Data Protection Regulations (GDPR) and the pharmacy had an up-to-date confidentiality policy. The pharmacy displayed details on the confidential data kept and how it complied with legal requirements. The team separated confidential waste for shredding onsite.

The pharmacy had safeguarding procedures and guidance for the team to follow. The team members had access to contact numbers for local safeguarding teams. And had received training on the Ask for ANI (action needed immediately) initiative. The pharmacist had recently completed training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The delivery driver reported any concerns they had about people they delivered to so the pharmacy team could take appropriate action such as contacting the person's GP.

Principle 2 - Staffing ✓ Standards met

Summary findings

The pharmacy has a small team with an appropriate range of experience and skills needed to support its services. Team members work well together and are good at supporting each other in their day-to-day work. They take opportunities to complete training courses and they regularly receive feedback on their performance. So, they can develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist manager and regular locum pharmacists covered the opening hours. The pharmacy team consisted of two full-time dispensers and a delivery driver. At the time of the inspection the pharmacist manager, the two dispensers and a company relief dispenser were on duty. The team worked well together and supported each other with the completion of tasks especially at times of increased workload.

The team members used company online training modules to keep their knowledge up to date. The team members were informed of new training modules and had protected time to complete the training. The pharmacy provided regular performance reviews for the team. This gave team members a chance to receive individual feedback and discuss their development needs. The team held regular meetings and team members could suggest changes to processes or new ideas of working. The team shared information such as medicines that were out of stock. And the team member responsible for the retail area asked the team for feedback on their ideas for displaying retail stock.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are clean and secure for the services provided. And there are good facilities to meet the needs of people requiring privacy when using the pharmacy services. However, the pharmacy stores several large boxes containing medicines on the floor in the small dispensary which creates a risk to the team's safety.

Inspector's evidence

The pharmacy premises were hygienic and generally tidy. The premises had separate sinks for the preparation of medicines and hand washing. And bottles of hand sanitiser were available for the team to use. Some sections of the pharmacy benches were cluttered with baskets which limited the amount of space available to undertake tasks such as dispensing. The dispensary was narrow with limited space to move around. The team stored several tote boxes containing completed prescriptions from the offsite dispensary and medicines delivered by the wholesaler on top of each other. The tote boxes covered a section of the floor space in the dispensary which further reduced the space available for the team to safely move around. And increased the risk of trip hazards.

The pharmacy was secure and it had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related. The pharmacy had a soundproof consultation room which the team used for private conversations with people. The pharmacy had restricted access to the dispensary during the opening hours.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy provides services which are easily accessible. And it manages its services well to help people receive appropriate care. The pharmacy keeps detailed records to help monitor the services it provides. This enables the team to deal with queries effectively. And it makes sure people receive their medicines when they need them. The pharmacy gets its medicines from reputable sources and it stores them properly. The team generally carries out checks to make sure medicines are in good condition and suitable to supply.

Inspector's evidence

People accessed the pharmacy via a step free entrance. The pharmacy had an information leaflet providing people with details of the services it offered and the contact details of the pharmacy. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy recently introduced a mobile phone application (App) that people used to order their repeat prescriptions and to track the processing of their prescriptions. The team provided people with information on how to access other healthcare services.

The pharmacy sent some people's repeat prescriptions to Rowlands offsite dispensary. The team followed procedures and had received training on how to process prescriptions in this way. The team labelled the prescriptions before sending the prescription to the offsite dispensary. This identified any prescriptions that could not be sent to the offsite dispensary and were marked as 'dispense locally.' The process included a clinical check by the pharmacist that was captured electronically before the prescription was submitted. The team stored the prescriptions in alphabetical order in a dedicated box so they could be easily located. The team scanned the sealed bags containing the dispensed items returned by the offsite dispensary to confirm receipt. The team members didn't open the sealed bags unless they'd supplied one of the items to a person who had needed it before the prescription was returned from the offsite dispensary. The team dispensed prescriptions onsite that included split packs, CDs and fridge lines. And any prescriptions the person needed urgently such as antibiotics. The team encouraged people to order their repeat prescription at least seven days before they needed the next supply. This gave time for the team to receive the prescription, process it and receive it back from the offsite dispensary. The team members reported the offsite dispensary helped to reduce their workload especially for prescriptions with many items.

The pharmacy provided some people with their medicines in multi-compartment compliance packs to help them take their medicines. The packs were dispensed at the offsite dispensary and each medication was supplied in individual pouches. The pouches were labelled and included the description of the product within. The manufacturer's packaging leaflets were not always supplied so people didn't always have up-to-date information about their medicines. The pharmacy received copies of hospital discharge summaries which the team checked for changes or new items. The team provided people with clear advice on how to use their medicines. The team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). But the pharmacy didn't have anyone currently prescribed valproate that met the criteria. The pharmacist sometimes spoke to people prescribed other high-risk medicines and captured the conversation on to the electronic patient record (PMR). The computer on the pharmacy counter had access to the PMR. So, when a person presented the team member could check what stage their prescription was at.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. Baskets were used during the dispensing process to isolate individual people's medicines and to help prevent them becoming mixed up. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample found that the team completed the boxes. The pharmacy used clear bags to hold dispensed CDs and fridge lines. This allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And kept the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy sent people a text message when their prescriptions were ready. This helped to reduce the number of people presenting at the pharmacy. The pharmacy kept a record of the delivery of medicines to people.

The pharmacy obtained medication from several reputable sources. The pharmacy team usually undertook monthly checks of the expiry dates on stock and kept a record of this. However, the last date check was in April 2022. The team members marked medicines with a short expiry date to prompt them to check the medicine was still in date. No out-of-date stock was found. The dates of opening were recorded for medicines with altered shelf-lives after opening. This meant the team could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day. A sample of these records found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned CDs separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs. The pharmacy received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) via email. The team usually printed off the alert, actioned it and kept a record.

Principle 5 - Equipment and facilities ✓ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services and it uses its facilities to suitably protect people's confidential information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided. The equipment included a range of CE equipment to accurately measure liquid medication. The pharmacy completed safety checks on the electrical equipment. The pharmacy computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view and it held private information in the dispensary and rear areas, which had restricted access. The pharmacy had cordless telephones to help the team ensure telephone conversations were not overheard by people in the retail area.

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.