General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 381A North Deeside Road, Cults, ABERDEEN, Aberdeenshire, AB15 9SX

Pharmacy reference: 1041658

Type of pharmacy: Community

Date of inspection: 07/04/2022

Pharmacy context

The pharmacy is on a parade of shops on a main road in a largely residential area. The people who use the pharmacy are mainly older people. The pharmacy provides a range of services, including Pharmacy First and smoking cessation. And it supplies medicines against Patient Group Directions for urinary tract infections and emergency hormonal contraception. The pharmacy supplies medications in multi-compartment compliance packs to some people who live in their own homes to help them manage their medicines. And it provides substance misuse medications to a small number of people. The inspection was carried out during the Covid-19 pandemic.

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	2.2	Good practice	The pharmacy has a good culture of learning. It promotes learning, continuous improvement and the personal development of its team members. Team members are open about any mistakes that happen. And they regularly discuss them to help make the pharmacy's services safer.
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 to help provide them safely. It learns from mistakes that happen during the dispensing process to help make its services safer. The pharmacy protects people's personal information. And people can provide feedback about the pharmacy's services. It mostly keeps the records it needs to keep by law, to show that it supplied its medicines safely and legally. And team members understand their role in protecting vulnerable people.

Inspector's evidence

The pharmacy adopted adequate measures for identifying and managing risks associated with its activities. And it had carried out workplace risk assessments in relation to Covid-19. There were documented, up-to-date standard operating procedures (SOPs), and the pharmacy recorded and reviewed its dispensing mistakes. Team members had signed to show that they had read, understood, and agreed to follow the SOPs. Near misses, where a dispensing mistake was identified before the medicine had reached a person, were highlighted with the team member involved at the time of the incident. Team members identified and rectified their own mistakes. Near misses were recorded and reviewed regularly for any patterns as part of the monthly patient safety review. Items in similar packaging or with similar names were separated where possible to help minimise the chance of the wrong medicine being selected. And the outcomes from the reviews were discussed openly during the regular team meetings. Learning points were also shared with other pharmacies in the group. The last review highlighted that there had been several near misses where the wrong quantity of a medicine had been dispensed. Team members were reminded to self-check their counting before passing to the pharmacist to be checked. Dispensing errors, where a dispensing mistake had reached a person, were recorded electronically and a root cause analysis was undertaken. A recent error had occurred where an out-of-date medicine had been supplied to a person. A full date check had been carried out and the person was supplied with an in-date medicine.

Workspace in the dispensary was free from clutter. There was an organised workflow which helped staff to prioritise tasks and manage the workload. And baskets were used to minimise the risk of medicines being transferred to a different prescription. The team members signed the dispensing label when they dispensed and checked each item to show who had completed these tasks.

Team members' roles and responsibilities were specified in the SOPs. The pharmacy student said that the pharmacy would remain closed if the pharmacist did not arrive in the morning. She knew which tasks should not be carried out if there was no responsible pharmacist (RP). And she knew which tasks should not be carried out if the RP was absent from the premises.

The pharmacy had current professional indemnity and public liability insurance. The right RP notice was clearly displayed, and the RP record was completed correctly. All necessary information was recorded when a supply of an unlicensed medicine was made. There were signed in-date patient group directions available for the relevant services offered. Controlled drug (CD) registers examined were filled in correctly, and the CD running balances were checked at regular intervals. Liquid overage was recorded in the register. The private prescription records were mostly completed correctly, but the prescriber details were not always recorded. This could make it harder for the pharmacy to find these details if there was a future query. The nature of the emergency was not routinely recorded when a supply of a

prescription-only medicine was supplied in an emergency without a prescription. This could make it harder for the pharmacy to show why the medicine was supplied if there was a query. The pharmacist said that they would ensure that the nature of emergency was recorded in future.

Confidential waste was shredded, computers were password protected and the people using the pharmacy could not see information on the computer screens. People's personal information on bagged items waiting collection could not be viewed by people using the pharmacy. And team members had completed training about protecting information.

The complaints procedure was available for team members to follow if needed and details about it were displayed in the shop area and were also available online. The pharmacist was not aware of any recent complaints.

Team members had completed training about protecting vulnerable people. The pharmacy student could describe potential signs that might indicate a safeguarding concern and would refer any concerns to the pharmacist. The pharmacist explained how the pharmacy helped some people to manage their medicines. The pharmacy had contact details available for agencies who dealt with safeguarding vulnerable people. And details of the local safeguarding boards were displayed in the dispensary.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough trained team members to provide its services safely. They receive ongoing and structured training maintain their knowledge and skills. And they get time set aside in work to complete it. The pharmacy is good at promoting a culture of ongoing learning and continuous improvement. Team members can raise any concerns and make suggestions and they have regular meetings. This means that they can help improve the systems in the pharmacy. The team members take professional decisions to ensure people taking medicines are safe.

Inspector's evidence

There was one regular full-time pharmacist, one pharmacy student, one trained dispenser and one trainee dispenser working during the inspection. Most team members had completed an accredited course for their role and the other person was undertaking training. The team members wore smart uniforms with name badges displaying their role. They worked well together and communicated effectively to ensure that tasks were prioritised, and the workload was well managed. The inspector discussed with the pharmacist about the reporting process in the event that a team member tested positive for the coronavirus.

Team members appeared confident when speaking with people. The trainee dispenser was aware of the restrictions on sales of pseudoephedrine-containing products. And she said that she would refer to the pharmacist if a person regularly requested to purchase medicines which could be abused or may require additional care. She used effective questioning techniques to establish whether a medicine was suitable for a person. And she referred to the pharmacist before providing advice to a person. The team had recently started using an intervention book to record when people were repeatedly requesting OTC medicines.

The pharmacist was aware of the continuing professional development requirement for the professional revalidation process. And she had recently completed some training about emergency hormonal contraception and the weight loss service. She said that she regularly read pharmacy-related magazines and passed information on to other team members. The pharmacist felt able to take professional decisions. She had completed the necessary training for the services offered, as well as associated training. Team members were provided with ongoing training on a regular basis. The trainee dispenser explained that team members had weekly protected study time. She could also access the training modules at home. The pharmacy manager and the pharmacy's head office monitored staff training and ensured that the mandatory modules were completed in a timely manner.

Team members felt comfortable about discussing any issues with the pharmacist or pharmacy manager. There were regular informal meetings to discuss any issues and to allocate tasks. The dispenser said that the pharmacy manager carried out appraisals and performance reviews every six months for all team members. They also had regular reviews of any dispensing mistakes and discussed these openly in the team.

Targets were set for the Pharmacy First service. The pharmacist said that the pharmacy regularly met the target. And that the pharmacy provided the service for the benefit of the people using the pharmacy and she would not let any targets affect her professional judgement.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises provide a safe, secure, and clean environment for the pharmacy's services. People can have a conversation with a team member in a private area.

Inspector's evidence

The pharmacy was secured from unauthorised access. It was bright, clean, and tidy throughout which presented a professional image. Pharmacy-only medicines were kept behind clear plastic screens in the shop area. ‘Pharmacy strength please ask for assistance’ notices were displayed on the boxes. There was a clear view of the medicines counter from the dispensary and the pharmacist could hear conversations at the counter and could intervene when needed. Air conditioning was available, and the room temperature was suitable for storing medicines.

There were notices reminding people to wear a mask in the pharmacy and to maintain a suitable distance from each other. There were two chairs in the shop area, and both had arms to aid standing. The chairs were positioned away from the medicines counter to help minimise the risk of conversations at the counter being heard.

The consultation room was accessible to wheelchair users and was located in the shop area. It could also be accessed from behind the medicines counter. It was suitably equipped, well-screened, and kept secure when not in use. Conversations at a normal level of volume in the consultation room could not be heard from the shop area.

Toilet facilities were clean and not used for storing pharmacy items. There were separate hand washing facilities available.

Principle 4 - Services ✔ Standards met

Summary findings

Overall, the pharmacy provides its services safely and manages them well. The pharmacy gets its medicines from reputable suppliers and stores them properly. It responds appropriately to drug alerts and product recalls. This helps make sure that its medicines and devices are safe for people to use. People with a range of needs can access the pharmacy's services.

Inspector's evidence

There was step-free access to the pharmacy through a wide entrance. Team members had a clear view of the main entrance from the medicines counter and could help people into the premises where needed. Services and opening times were clearly advertised, and a variety of health information leaflets was available in the shop area. The dispenser said that the pharmacy could produce large-print labels and patient information leaflets for people who needed them. A lowered counter was available at the medicines counter for those people who needed it.

Prescriptions for Schedule 3 and 4 CDs were highlighted. This helped to minimise the chance of these medicines being supplied when the prescription is no longer valid. Dispensed fridge items were kept in clear plastic bags to aid identification. The pharmacist said they checked CDs and fridge items with people when handing them out. The pharmacist said that the pharmacy supplied valproate medicines to a few people. But there were currently no people in the at-risk group who needed to be on the Pregnancy Prevention Programme. The pharmacy had the relevant patient information leaflets and warning cards available. Prescriptions for higher-risk medicines were highlighted, so there was the opportunity to speak with these people when they collected their medicines. The pharmacist said that she checked monitoring record books for people taking higher-risk medicines such as methotrexate and warfarin. But a record of blood test results was not kept. This could make it harder for the pharmacy to check that the person was having the relevant tests done at appropriate intervals.

All team members were trained to deliver the Pharmacy First service. Universal claim forms were checked and signed by the pharmacist before medicines were supplied. And information about any advice, referral to another healthcare professional or medicine provided was passed on to a person's GP.

The pharmacy supplied medicines as part of the Medicines Care Review service. The prescriptions for this service were kept separate from other prescriptions. Each prescription had a tracker which showed when the medicines had been collected and when the next issue was due. The pharmacy contacted people if they had not collected their medicine. A treatment summary record was completed and sent to the person's surgery once all prescriptions issued had been dispensed and collected.

Stock was stored in an organised manner in the dispensary. Expiry dates were checked every three months and this activity was recorded. Stock due to expire within the next three months was marked. And lists were kept for short-dated items so that it was easier for these to be removed the month before they were due to expire. There were no date-expired items found in with dispensing stock.

Part-dispensed prescriptions were checked frequently. 'Owings' notes were provided when prescriptions could not be dispensed in full, and people were kept informed about supply issues.

Prescriptions for alternate medicines were requested from prescribers where needed. Prescriptions were kept at the pharmacy until the remainder was dispensed and collected. The pharmacy kept a record of any correspondence and the date action had been taken. Uncollected prescriptions were checked weekly. People were sent a text message reminder if they had not collected their items after four weeks. They were sent a further reminder a week later and if the items remained uncollected. Uncollected items were returned to dispensing stock where possible and the person's medication record was updated to show that they had not collected the medicine. The pharmacist said that CD prescriptions were returned to the prescriber.

People wanting their medicines in multi-compartment compliance packs had assessments carried out by a pharmacist to show that they needed them and would be able to manage their medicines in this way. And a record of the assessment was kept at the pharmacy. Prescriptions for people receiving their medicines in multi-compartment compliance packs were ordered in advance so that any issues could be addressed before people needed their medicines. Prescriptions for 'when required' medicines were not routinely requested. The dispenser said that the pharmacy contacted people to see if they needed them when their packs were due. The pharmacy kept a record for each person which included any changes to their medication and they also kept any hospital discharge letters for future reference. Medication descriptions were put on the packs to help people and their carers identify the medicines and patient information leaflets were routinely supplied. Cautionary and advisory warning labels were not recorded on the backing sheets. This could make it more difficult for people to know how to take their medicines safely. The pharmacist said that she would contact the computer provider to ask that these be added.

CDs were stored in accordance with legal requirements, and they were kept secure. Denaturing kits were available for the safe destruction of CDs. CDs that people had returned, and expired CDs were clearly marked and segregated. Returned CDs were recorded in a register and destroyed with a witness, and two signatures were recorded.

Deliveries were made by a delivery driver. The pharmacy did not currently obtain people's signatures to help minimise the spread of infection. The trainee dispenser said that the driver confirmed people's names before handing over medicines. When the person was not at home, the delivery was returned to the pharmacy before the end of the working day. A card was left at the address asking the person to contact the pharmacy to rearrange delivery.

The pharmacy used licensed wholesalers to obtain medicines and medical devices. Drug alerts and recalls were received from the NHS and MHRA. Any action taken was recorded and kept for future reference. This made it easier for the pharmacy to show what it had done in response.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide its services safely. It uses its equipment to help protect people’s personal information.

Inspector's evidence

Suitable equipment for measuring liquids was available. Separate liquid measures were marked for use with certain liquids. Triangle tablet counters were available and clean. A separate counter was marked for cytotoxic use only. This helped avoid any cross-contamination. Tweezers were available so that team members did not have to touch the medicines when handling loose tablets or capsules.

Up-to-date reference sources were available in the pharmacy and online. The shredder was in good working order. The phone in the dispensary was portable so it could be taken to a more private area where needed. The pharmacy had personal protective equipment available including, masks, gloves, and hand sanitiser.

Fridge temperatures were checked daily with maximum and minimum temperatures recorded. Records indicated that the temperatures were consistently within the recommended range. The fridge was suitable for storing medicines and was not overstocked.

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.