General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, The Square, MINTLAW, Aberdeenshire, AB42 5EH

Pharmacy reference: 1041678

Type of pharmacy: Community

Date of inspection: 27/09/2022

Pharmacy context

This community pharmacy is amongst a small parade of shops in the village of Mintlaw. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy supplies some medicines in multi-compartment compliance packs to help people take their medicines. The pharmacy offers a range of services including the NHS Pharmacy First service and the seasonal flu vaccination service.

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 properly identifies and manages the risks to its services. It has the documented procedures it needs relevant to its services. And it keeps the records it must by law. Pharmacy team members understand their role to help protect vulnerable people. And they suitably protect people's confidential information. The pharmacy team members respond appropriately when errors happen. They identify and discuss what caused the error and they generally act to prevent future mistakes.

Inspector's evidence

The pharmacy had a range of up-to-date standard operating procedures (SOPs) that were kept electronically. 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.

The pharmacy had a procedure for managing errors identified during the dispensing process known as near misses. Each team member recorded their near miss, after it was highlighted to them, on a specific template. The records included details of the error but didn't always capture the action the team member had taken to prevent the same error from happening again. The pharmacy had a process for managing errors identified after a person had received their medication, 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 team also captured the incident on the pharmacy's patient medication record (PMR) so all team members were aware. The pharmacy manager regularly reviewed the near miss records and dispensing incidents to identify patterns. And shared the outcome of the review with the team members who discussed the actions they could take to prevent similar errors. A recent review was used to remind team members to ensure all prescribed medicines were labelled before moving to the next stage when dispensing a prescription. And to return any incomplete prescriptions to the labelling station before completing the next stages. The pharmacy had a procedure for handling complaints raised by people using the pharmacy services. A poster in the retail area and the company website 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 pharmacy completed regular balance checks of the CD registers to help identify errors such as missed entries. The pharmacy displayed a privacy notice in the retail area and on the company website advising people of the confidential information the pharmacy kept and how the information was protected. The team members had completed training about the General Data Protection Regulations (GDPR) and they separated confidential waste for shredding offsite.

The pharmacy had safeguarding procedures for the team members to follow and they had access to contact numbers for local safeguarding teams. The RP was registered with the protecting vulnerable group (PVG) scheme. The delivery driver reported concerns about people they delivered to back to the pharmacy team who took appropriate action.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has a team with the appropriate range of experience and skills to safely provide its services. Team members work well together and are good at supporting each other in their day-to-day work. They discuss ideas and implement new processes to enhance the delivery of the pharmacy's services. The team members take opportunities to complete training courses and they receive feedback on their performance. So, they can develop their skills and knowledge.

Inspector's evidence

A full-time pharmacist covered the opening hours with locum pharmacist cover when required. The pharmacy team consisted of two full-time accuracy checking technicians (ACTs), a full-time trainee pharmacy technician, three full-time dispensers, one part-time new member of the team and a part-time delivery driver. The pharmacy was recruiting for a part-time team member to work on a Saturday.

The pharmacy had faced some staffing vacancies in recent months after some experienced team members left the business. The team had at times struggled to manage the workload and had fallen behind with some tasks such as completing prescriptions as soon as the stock arrived so the person wasn't kept waiting. One of the ACTs was a manager based at another Rowlands Pharmacy in the area and had recently won the company's manager of the year award. The ACT was providing temporary managerial support for the team until a new manager was in post. The temporary manager had developed a team rota covering the main tasks to be completed and had trained all team members on how to undertake the tasks. This ensured the tasks were completed especially at times when team numbers were reduced such as unplanned absence. The rota was clearly displayed in the dispensary for the team to refer to. The temporary manager had developed 'how to' guides to remind the team members of the steps to take to complete certain tasks and displayed them at the dispensary workstations. The temporary manager regularly contacted the team members at the other pharmacy to ensure her absence was not having an impact.

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 regularly held team meetings and all team members were encouraged to participate and suggest ideas or new ways of working. The team identified two team members were needed to cover the pharmacy counter so moved the majority of the labelling and dispensing of prescriptions to the large dispensary upstairs. This enabled the team to focus on serving people presenting at the pharmacy and walk-in prescriptions. The pharmacy team used the group chat facility on a social media platform to share key pieces of information with all the team members so everyone was aware.

The temporary manager held one-to-one meetings with the team members to discuss the impact the last few months had on them. And had recently completed performance reviews for the team when each team member received individual feedback, discussed their development needs and set short and long-term objectives. The pharmacy had a whistleblowing policy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services provided. And the pharmacy has appropriate facilities to meet the needs of people requiring privacy when using the pharmacy services.

Inspector's evidence

The pharmacy was generally tidy and hygienic, it had separate sinks for the preparation of medicines and hand washing. The pharmacy had enough storage space for stock, assembled medicines and medical devices. The pharmacy team kept the floor spaces clear to reduce the risk of trip hazards. 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 small, soundproof consultation room which the team used for private conversations with people and when providing services such as the flu vaccination. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services which are easily accessible. It manages its services well to help people receive appropriate care and to make sure they receive their medicines when they need them. The pharmacy keeps detailed records to help monitor the services it provides. This enables the team to deal with queries effectively. The pharmacy gets its medicines from reputable sources and it stores them properly. The team regularly 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 kept a range of healthcare information leaflets for people to read and the team provided people with information on how to access other healthcare services when required. The team wore name badges detailing their role so people using the pharmacy knew who they were speaking to. The pharmacy provided the seasonal flu vaccination against up-to-date patient group directions (PGDs). The PGDs gave the pharmacist the authority to administer the vaccine. The pharmacist kept adrenaline in the consultation room where the vaccine was administered so they could respond promptly if someone had an anaphylactic reaction. The NHS Pharmacy First service was popular and the team was able to provide people with a range of medicines to treat minor ailments. The pharmacist had access to a range of PGDs to support the supply of medicines classed as prescription only medicines via this service.

The pharmacy sent some people's repeat prescriptions to Rowlands offsite dispensary hub. The team followed procedures and had received training on how to process prescriptions in this way. The team inputted the information from prescriptions before sending this prescription information to the offsite dispensary hub. This identified any prescriptions that could not be sent to the offsite dispensary and were marked as 'dispense locally.' These included prescriptions for quantities of medicines less than the original pack size and fridge lines. The team dispensed any prescriptions the person needed urgently such as antibiotics locally. The process included a clinical check by the pharmacist that was captured electronically before the prescription information was submitted to the hub for assembly. The offsite dispensary was based in England and was sometimes closed on an English Bank Holiday when the pharmacy was open. The team advised people of this and informed them there would be a slight delay to receipt of their medication. The team would dispense the prescription locally if the person needed their medication urgently.

The pharmacy provided multi-compartment compliance packs to help around 40 people take their medicines. To manage the workload the team usually started the process of preparing the packs a few weeks in advance of supply. This allowed time to deal with issues such as missing items and queries with prescriptions. Each person had a record listing their current medication and dose times. The team checked received prescriptions against the record and queried any changes with the GP team. The team kept a record of any changes made to people's medication to refer to if queries arose. The team stored the medicines picked for dispensing into the packs and the medication record in baskets labelled with the person's details. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging information leaflets. This meant people could identify the medicines in the packs and had information about their medicines. The pharmacist completed a clinical check on the prescriptions that enabled the ACT to complete an accuracy check of the packs. The team members

dispensed and checked the packs in an upstairs room away from the distractions of the main dispensary. They dated each completed pack and marked them one of four before storing them in box files labelled with the person's details.

The pharmacy supplied medicines to a few people daily as supervised and unsupervised doses. The doses were prepared in advance of supply to reduce the workload pressure of dispensing at the time of supply. The team provided people with clear advice on how to use their medicines and the pharmacist recorded key pieces of information from the person onto the PMR. The team members were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided. The pharmacy didn't have anyone prescribed valproate who met the criteria. The computer on the pharmacy counter had access to the PMR. So, when a person presented the team member could check what stage the dispensing of 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 and a sample found that the team completed the boxes. The pharmacy used 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 to the person. The pharmacy sent people a text message when their prescriptions were ready. This helped to reduce the number of people presenting at the pharmacy unnecessarily and helped the team manage its workload. The pharmacy kept a record of the delivery of medicines to people.

The pharmacy obtained medication from several reputable sources. The pharmacy team checked the expiry dates on stock and kept a record of this. 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 team members recorded the dates of opening for medicines with altered shelf-lives after opening. This was so they could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and a sample 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 controlled drugs (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 its services safely. It makes sure it uses its equipment appropriately to 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 suitable equipment available for the services provided including a range of CE equipment to accurately measure liquid medication.

The pharmacy computers were password protected and were positioned in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view and it held other private information in the dispensary and rear areas, which had restricted public access. The pharmacy provided the team members with cordless phones to enable them to have private conversations with people.

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.