General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 42 High Street, AUCHTERMUCHTY, Fife, KY14 7AP

Pharmacy reference: 1042045

Type of pharmacy: Community

Date of inspection: 13/11/2019

Pharmacy context

This is a community pharmacy in a village. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides a smoking cessation service, substance misuse services and dispenses private prescriptions. The pharmacy team advises on minor ailments and medicines' use. And supplies a range of over-the-counter medicines. It offers seasonal flu vaccination, blood pressure measurement and a weight management 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	1.4	Good practice	The pharmacy has used feedback from people to completely review and improve information governance processes.
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 team members follow written processes for all services to ensure that they are safe. The pharmacist confirms that they are competent. Team members record mistakes to learn from them. They review these and make changes to avoid the same mistakes happening again. The pharmacy uses people's feedback to make its services better. The pharmacy keeps all the records that it needs to by law and keeps people's information safe. Team members help to protect vulnerable people.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were followed for all activities and tasks. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. The pharmacy had a table documenting which SOPs applied to which role. Each team member had their own record book confirming which procedures they were competent in. The pharmacy manager signed these off. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. A trainee team member who had worked in the pharmacy for around six months did not yet dispense multicompartment compliance packs and was in the process of learning how to handle controlled drugs. The pharmacy managed dispensing, a high-risk activity, well, with coloured baskets used to differentiate between different prescription types and separate people's medication. The pharmacy had a business continuity plan to address maintenance issues or disruption to services. It kept this on the wall for ease of access.

Team members used near miss logs to record dispensing errors that were identified in the pharmacy. They recorded their own incidents to reinforce the learning. They also recorded errors reaching patients to learn from them. They reviewed all near misses and errors each month. The team had not identified any trends recently, but previously 'form' had been a theme. Team members had separated some items e.g. co-codamol capsules. Errors mainly occurred in the morning when the pharmacy was busy. They had identified that distractions and lack of concentration at busy periods contributed. They re-checked their dispensing following interuptions. The pharmacy stored this information in a patient safety folder along with medicines recalls and notes of meetings. The pharmacist had reviewed systems and processes in the pharmacy when she started the previous year. She had made changes to the management of multicompartment compliance packs. Other team members were fully engaged and helped to implement changes.

The pharmacy had a formal complaints procedure and responded positively to feedback. It had received feedback regarding information governance. People in the village had discussed that sometimes team members talked about medicines by names in a way that other people could overhear. They had not provided specific examples that the team could reflect on, but team members had met and considered all aspects of information governance. They now avoided using medicines' names verbally, did not speak over the dispensary partition, ensured they didn't leave person sensitive information visible, spoke quietly in the dispensary and ensured computers were closed when not in use. All team members were using the consultation room more and had re-read the contents of the information governance folder.

The pharmacy had an indemnity insurance certificate, expiring 31 March 20. The pharmacy displayed the responsible pharmacist notice and kept the following records: responsible pharmacist log; private prescription records including records of emergency supplies and veterinary prescriptions; unlicensed specials records; controlled drugs (CD) registers with running balances maintained and regularly audited; and a CD destruction register for patient returned medicines. A few private prescription details were missing, such as vet's name, and both date of signing and date of supply were not always recorded. Team members signed any alterations to records, so they were attributable. The pharmacy filed records logically and in a well organised manner. And it displayed a notice on the dispensary wall reminding team members which activities could not be undertaken if there was no responsible pharmacist signed in, or if the responsible pharmacist was absent. It backed up electronic patient medication records (PMR) each night to avoid data being lost.

Pharmacy team members were aware of the need for confidentiality. They had all read and signed information governance (IG) policies. They segregated confidential waste for shredding. No person identifiable information was visible to the public. Team members had also read the company policy on safeguarding. They knew how to raise a concern locally. The pharmacy had a file of local guidelines, processes and contact details. And it had the Royal Pharmaceutical Society (RPS) guidance for child protection and protecting vulnerable adults on the dispensary wall. The pharmacist was PVG registered.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced staff to safely provide its services. The pharmacy compares staff numbers and qualifications to how busy the pharmacy is. And then it makes changes if possible when required. Team members have access to training material to ensure that they have the skills they need. The pharmacy gives them time to do this training at work. Team members can share information and raise concerns to keep the pharmacy safe. They can make suggestions to improve services. And they discuss incidents to learn from them and avoid the same thing happening again.

Inspector's evidence

The pharmacy had the following staff: one full-time pharmacist manager, one full-time pharmacy technician, two part-time dispensers, one trainee part-time dispenser, and a part-time delivery driver shared with another pharmacy. The pharmacy displayed their certificates of qualification. Typically, there were 3 team members working with a pharmacist at most times. The pharmacy technician was off for a few weeks at the time of inspection, so there were two team members working. Team members were usually able to manage the workload, but it was challenging during periods of absence. Part-time team members had some scope to work flexibly providing some contingency for absence. The pharmacy reviewed staffing levels when there was natural change such as a team member leaving. It had done this recently and replaced the gap with less hours.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development in terms of company modules (moodles) and SOPs as received. It provided team members undertaking accredited courses with additional time to complete coursework. The pharmacist had reminded team members to help and support the trainee which they described doing (she was not present). Some team members had annual development meetings with the pharmacy manager to identify their learning needs. They had development plans in place and objectives included learning to pour methadone under the pharmacist's supervision. All team members were working towards being able to undertake all activities. The various individuals were observed going about their tasks in a systematic and professional manner. They asked appropriate questions when supplying medicines over-the-counter and referred to the pharmacist when required. They shared information with the pharmacist about patients and medicines following phone calls, other discussions or ordering stock. They demonstrated awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests.

Pharmacy team members understood the importance of reporting mistakes and were comfortable owning up to their own mistakes. They had an open environment in the pharmacy where they could share and discuss these. They could make suggestions and raise concerns to the manager or area manager. All team members had been involved in re-arranging storage when the store room became unusable due to damp. The pharmacy manager welcomed and encouraged team members' opinions and suggestions. The superintendent pharmacist sent regular emails on a variety of topics e.g. services changing, drug recalls, storage of olanzapine following incidents elsewhere. The pharmacy team discussed incidents and how to reduce risks, mainly on-the-job, but sometimes had meetings. They had regular meetings prior to April 2019 and notes of meetings were retained. Topics recorded included developing services, supporting a trainee team member and changes to NHS services. The company had a whistleblowing policy that team members were aware of. The pharmacy displayed details and the

phone number on the staff room wall. Team members gave appropriate responses to scenarios posed. The company set targets for prescription numbers and services. The pharmacy team used these to improve services including customer service and stock availability.

Principle 3 - Premises ✔ Standards met

Summary findings

The premises are safe and clean and suitable for the pharmacy's services. The pharmacy addresses maintenance issues appropriately. The pharmacy team members use a private room for some conversations with people. People cannot overhear these conversations. The pharmacy is secure when closed.

Inspector's evidence

These were average sized premises incorporating a retail area, dispensary and back shop area including storage space and staff facilities. The premises were clean, hygienic and well maintained. The storage area had a damp wall. This had been caused partially by a leaking roof which had been repaired. Maintenance was underway, and the wall had been partially stripped. The pharmacy had a dehumidifier in the area. The pharmacy had not been able to use this storage room for several months and team members had removed all medicines and sundries. Previously they stored completed multi-compartment compliance packs in this area but had moved these to the dispensary. This had been challenging to devise a storage system that was safe and minimise disruption to the dispensary. The team had stored these packs in boxes according to day, on the dispensary floor. This caused some congestion and made it difficult to reach some storage shelves. Team members were aware of the increased risk this caused and were managing this carefully. The boxes and compliance packs were well labelled with patient details and date of supply. The dispensary became very congested when the stock delivery was received. The team had moved dispensing sundries from the damp storage area to the staff area. This caused congestion in that area as well, but ensured that these items were appropriately stored. Team members had raised concerns about the challenges with the pharmacy superintendent, maintenance department and health and safety department. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels.

People were not able to see activities being undertaken in the dispensary. The pharmacy had a consultation room with a desk, chairs, sink and computer which was clean and tidy, and the door closed providing privacy. The door was kept locked to prevent unauthorised access. The pharmacy also had a separate discreet area for handing out prescriptions and having quiet conversations with people. The pharmacist supervised consumption of methadone in the consultation room.

Temperature and lighting were comfortable. The pharmacy had removed a retail stand from the middle of the retail area, providing more space and making the pharmacy more accessible to wheelchair users and people with prams.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to ensure they can all use its services. The pharmacy team provides safe services. Team members give people information to help them use their medicines. They provide extra written information to people with some medicines. The pharmacy gets medicines from reliable sources and stores them properly. The pharmacy team know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a low step and door-bell. Team members assisted as required. They had good visibility of the door from the medicines counter so could see when people needed help. The pharmacy listed its services and had leaflets available on a variety of topics. The pharmacy could provide large print labels if required for people with impaired vision. All team members wore badges showing their name and role. The pharmacy provided a delivery service and people signed to acknowledge receipt of their medicines.

Pharmacy team members followed a logical and methodical workflow for dispensing. They used coloured baskets to differentiate between different prescription types and separate people's medicines and prescriptions. The pharmacy received prescriptions from the surgery at 9am and strived to dispense these during the morning. Team members arranged them into number of items, prioritising prescriptions with larger numbers of items. One team member labelled the three item and greater prescriptions, and another labelled the one and two item prescriptions. She also managed the 'walk-in' prescriptions. She worked at an area close to the medicines counter so served people as well. This process made it efficient when people were requesting their medication. It ensured that bigger prescriptions were processed first, with smaller ones sometimes being done while people waited. Team members dispensed on a dedicated bench with adequate space, then passed to the pharmacist's checking bench. The pharmacist handed dispensed medicines out from a discreet area close to the dispensing bench and retrieval area. This was a logical and linear workflow. The patient medication record (PMR) flagged new items, which dispensers marked on prescriptions using a stamp. The pharmacist accessed the PMR from the checking bench to carry out a clinical assessment. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy did not have any serial prescriptions. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

The pharmacist sometimes identified pharmaceutical care issues when discussing people's medicines with them. These included two paracetamol containing products on the same prescription, and incorrect doses for modified release preparations. The pharmacist queried and confirmed these issues with prescribers. She documented the interventions on the PMR to avoid asking the patient or prescriber the same questions with future prescriptions.

The pharmacy managed multi-compartment compliance packs on a four-weekly cycle with four assembled at a time, two weeks before the first supply was required. The pharmacist had reviewed the process and made changes to improve it. Previously two team members had their own cohort, so there was additional pressure prior to annual leave to ensure they were all done in advance. Now, the team members were all able to assemble any packs following the SOP, using a colour-coded system for different weeks. It was working well. They included tablet descriptions on packs and supplied patient

information leaflets (PILs) with the first pack of each prescription. The pharmacist sealed packs as she checked them, and team members gave her packaging to assist with the accuracy check. The pharmacy kept comprehensive records of changes and other detail. Team members updated and re-printed the record following each change. Before the storage area had suffered from damp, completed packs were stored in individual named boxes on designated shelves. They were now stored in large boxes depending on day of delivery and collection, with all trays for each person banded together. Team members explained that they needed to be very careful with names and dates when supplying packs. This was a slower process, but they recognised the risk and took their time. They had discussed the best way of managing packs and together decided on this process.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving high-risk medicines including valproate, methotrexate, lithium, and warfarin. She or a team member supplied written information and record books if required. The pharmacy had put the guidance from the valproate pregnancy prevention programme in place. It had undertaken a search for people in the 'at-risk' group and the pharmacist had counselled them appropriately and continued to supply information with each prescription. The pharmacy had also implemented the non-steroidal anti-inflammatory drug (NSAID) care bundle and written and verbal information was given to people supplied with these medicines over-the-counter, or on prescriptions. Team members also discussed 'sick day rules' with people on certain medicines, so that they could manage their medicines when they were unwell. The pharmacy team members had received training to enable them to provide this information. The pharmacy followed the service specifications for NHS services and patient group directions (PGDs) were in place for unscheduled care, pharmacy first, smoking cessation, emergency hormonal contraception, and supply of chloramphenicol ophthalmic products. It also followed private PGDs for flu. The pharmacy empowered team members to deliver the minor ailments service (eMAS) within their competence and under the pharmacist's supervision. They used the sale of medicines protocol and the formulary to respond to symptoms and make suggestions for treatment. They referred to the pharmacist as required.

The pharmacist delivered the flu vaccination service. She had undertaken appropriate training and had equipment including emergency adrenaline available. She also delivered the smoking cessation service, using nicotine replacement therapy and sometimes Champix®. She described a few successes. All team members were trained to measure blood pressure following guidelines. They referred to the pharmacist as required. This was not a busy service but during public health promotions the team tried to promote and increase the service. All team members were also able to deliver the weight management service. But no-one was accessing it currently. The GP practice had a 'self-service' weight facility which people used.

The pharmacy obtained medicines from licensed wholesalers such as Alliance, Phoenix and AAH. It did not yet comply with the requirements of the Falsified Medicines Directive (FMD). It had the equipment, but team members had not received training yet. They believed it was being trialled in other stores. The pharmacy stored medicines in original packaging on shelves, in drawers and in cupboards. It stored items requiring cold storage in two fridges with minimum and maximum temperatures monitored and action taken if there was any deviation from accepted limits. Team members used one for stock, and the other for dispensed items which were stored in clear bags to facilitate a visual check at the time of supply. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy protected pharmacy (P) medicines from self-selection. Team members followed the sale of medicines protocol when selling these. The pharmacy displayed the protocol, WWHAM questions and a list of red card substances on the wall near the medicines counter.

The pharmacy actioned MHRA recalls and alerts on receipt and kept records. Team members contacted

people who had received medicines subject to patient level recalls. They returned items received damaged or faulty to suppliers as soon as possible.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs for delivery of its services. The pharmacy looks after this equipment to ensure it works.

Inspector's evidence

The pharmacy had texts available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used.

The pharmacy kept equipment required to deliver pharmacy services in the consultation room where it was used with people accessing its services. This included a carbon monoxide monitor maintained by the health board, a blood pressure meter and scales which were calibrated as per the manufacturers' guidance. The pharmacy kept sundries and emergency adrenaline required for flu vaccination in the consultation room. Team members kept crown stamped and ISO marked measures by the sink in the dispensary. And they kept separate marked ones in a basket under the sink for methadone. The pharmacy team kept clean tablet and capsule counters in the dispensary and kept a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in the dispensary inaccessible to the public. Prescription medication waiting to be collected was stored in a way that prevented patient information being seen by any other patients or customers. Team members used passwords to access computers and never left them unattended unless they were locked.

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.