General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 45-47 Bonnygate, CUPAR, Fife, KY15 4BY

Pharmacy reference: 1042061

Type of pharmacy: Community

Date of inspection: 09/09/2021

Pharmacy context

This is a high street community pharmacy close to two other pharmacies. It dispenses NHS prescriptions including supplying medicines in multi-compartment compliance packs. And it supplies medicines to care homes. The pharmacy offers a repeat prescription collection service and a medicines' delivery service. It also provides 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 other NHS services including smoking cessation and supply of palliative care medicines. The pharmacy was inspected 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	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 suitably identifies and manages the risks with its services including reducing the infection risk during the pandemic. The pharmacy team members follow written processes for the pharmacy's services to help ensure they provide them safely. They record and review their mistakes to learn from them and make changes to avoid the same mistakes happening again. The pharmacy keeps all the records it needs to by law and keeps people's private information safe. Team members know who to contact if they have concerns about vulnerable people.

Inspector's evidence

The pharmacy had put strategies in place to keep people safe from infection during the COVID-19 pandemic. It had screens up at the medicines' counter, hand sanitiser at the premises entrance and had marked the floor to encourage people to socially distance. Team members encouraged people to socially distance and when necessary limited the number of people on the premises. Most people coming to the pharmacy wore face coverings and team members all wore fluid resistant masks. They also washed and sanitised their hands regularly and frequently. They cleaned surfaces and touch points several times during the day. The pharmacy manager had carried out a personal risk assessment with each team member to identify any risk that may need to be mitigated in the pharmacy. No such risks had been identified. And team members carried out twice weekly lateral flow Covid tests.

The pharmacy had standard operating procedures (SOPs) which were followed. Pharmacy team members had read them, and the pharmacy kept records of this. The pharmacy superintendent reviewed them at least every two years and signed them off. Staff roles and responsibilities were recorded on individual SOPs. Team members could describe their roles and accurately explain which activities could not be undertaken in the absence of the pharmacist. 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 had useful phone numbers available in the dispensary e.g. other pharmacies, GP practices, other healthcare services and suppliers.

Team members used 'near miss logs' to record most dispensing errors that were identified in the pharmacy, known as near miss errors. And they recorded errors that had been identified after people received their medicines. They reviewed all near misses and errors each month to learn from them and they introduced strategies to minimise the chances of the same error happening again. A team member described double checking pack sizes following a few near misses with similar packs. Recently the team members had rearranged shelves and drawers, as they had reduced the amount of stock kept. And they described separating strengths of medicines involved in errors. The pharmacy had a complaints procedure and welcomed feedback. Team members described one written complaint about a year ago. The company had responded, but team members had felt that the issue was a positive one and were surprised by the complaint. A recent verbal complaint had been well dealt with and the pharmacy had acted appropriately in the person's best interest.

The pharmacy had an indemnity insurance certificate, expiring 31 March 2022. The pharmacy displayed the responsible pharmacist notice and had an accurate responsible pharmacist log. The pharmacy had private prescription records including records of emergency supplies and veterinary prescriptions. Some

of these records were incomplete and the inspector advised the team to revisit requirements. It kept unlicensed specials records and controlled drugs (CD) registers with running balances maintained and regularly audited. It had a CD destruction register for patient returned medicines. Team members signed any alterations to records, so they were attributable. All records were accurate and up to date. And they were tidily and logically filed. The pharmacy 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 company policies and kept records of this. They segregated confidential waste for secure destruction. No person identifiable information was visible to the public. Team members had also read a SOP on safeguarding. They knew how to raise a concern locally and had access to contact details and processes. The pharmacy had a chaperone policy in place and displayed a notice telling people this. The pharmacist was registered with the Disclosure Scotland 'Protecting Vulnerable Groups' (PVG) scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough qualified and experienced team members to safely provide its services. They are trained and competent for their roles and the services they provide. And they have time for training during the working day. Team members make decisions within their competency to provide safe services to people. And they use their professional judgement to help people. They know how to make suggestions and raise concerns if they have any to keep the pharmacy safe.

Inspector's evidence

At the start of the pandemic the manager had carried out a personal risk assessment for all team members to identify if any strategies were required to keep team members safe. And throughout the pandemic team members had been well and supported each other. The pharmacy had the following staff: one full-time pharmacist, one trainee pharmacy technician (PT)/manager, one full-time and three part-time dispensers, one Saturday only trainee healthcare assistant and two part-time delivery drivers. Typically, there were four team members and a pharmacist working at most times. At the time of inspection there were two dispensers, the trainee PT/manager and the regular pharmacist. Team members were able to manage the workload. They all had a few years' experience working together in this pharmacy. They worked well together as a team sharing information and supporting each other with healthy living initiatives. The pharmacy had recently recruited, and a new team member was expected to start in around two weeks. The pharmacy had been short-staffed sometimes recently, due to holidays and some absence. Part-time team members worked extra to fill some gaps. The team had a chart on the dispensary wall showing who was working when. This had identified the shortages to team members, enabling them to cover when necessary. This was not going to be continued as there were no known absences. The manager explained that there was scope and resource to coach, develop and train the new team member.

The pharmacy provided learning time during the working day for all team members to undertake regular training and development. Recently team members had re-visited some SOPs and completed some training on the company's training platform 'Moodles'. Team members recorded all training on the company intranet. The manager oversaw this and ensured they completed modules within the company timescale. Sometimes she had to do this at home as the internet speed in the pharmacy was slow. The pharmacy provided team members undertaking accredited courses with additional time to complete coursework. The manager was nearing completion of NVQ 3 training. And another team member was soon to start. She was aware of what was involved and believed she would have some time at work to undertake the course.

Team members 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 demonstrated an awareness of repeat requests for medicines intended for short term use. And they dealt appropriately with such requests. The pharmacy did not have dedicated medicines counter assistants, so team members took turns at working on the medicines' counter. They were aware of the need to keep their knowledge, skills and product knowledge current, so were planning a rota. Team members described working autonomously, for example phoning the GP practice if there were items missing on repeat prescriptions. They shared the

outcome with the pharmacist.

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. A locum pharmacist had suggested labelling palliative care 'just-in-case' boxes with the expiry date of the shortest dated item in the box, to facilitate people returning boxes to the pharmacy for items to be replaced. Team members had discussed this and devised a process that worked well, had been adopted and was now established. Some people had 'just-in-case' boxes in their homes for a long time e.g. over two years. The team had regular monthly meetings to discuss incidents, errors and anything else topical. Team members also shared information continually while working. They used whiteboards, diaries and notebooks to share important information. The company had a whistleblowing policy that team members were aware of. The company set targets for various parameters. Team members described only using these to benefit people accessing pharmacy services. A recent example was promoting lateral flow Covid test kits to people, following Scottish Government guidance on testing.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is safe and clean and suitable for the pharmacy services provided. It has suitable facilities for people to have conversations with team members in private. The pharmacy is secure when closed.

Inspector's evidence

These were reasonably-sized premises incorporating a retail area, dispensary and first floor providing an additional dispensing area, storage space and staff facilities. The premises were mostly clean, hygienic and well maintained. The carpet in the staff area was not very clean. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. And there was hand sanitiser available in the retail area and dispensary.

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. This room was just large enough for social distancing and this was carefully managed. Temperature and lighting were comfortable.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy helps people to access its services which it provides safely. Pharmacy team members follow written processes relevant to the services they provide. They support people by providing them with suitable information and advice to help them use their medicines. The pharmacy obtains medicines from reliable sources and stores them properly. Pharmacy team members know what to do if medicines are not fit for purpose.

Inspector's evidence

The pharmacy had good physical access by means of a level entrance and an automatic door. It listed its services and had leaflets available on a variety of topics. And it could provide large print labels for people with impaired vision. All team members wore badges showing their name and role. The pharmacy provided a delivery service which had increased during the pandemic.

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 was up to date with repeat dispensing. Team members labelled repeat prescriptions on receipt. The computer system separated these into items to be dispensed locally in the pharmacy, and items to be dispensed at the company's offsite hub. The pharmacy followed a thorough and robust process for the off-site dispensing. This included accuracy and clinical checks by the pharmacist, with records kept. Dispensed medicines were returned to the pharmacy two days later. The pharmacy had a system in place to match these dispensed medicines with prescriptions. And some prescriptions had medicines dispensed by the hub and the pharmacy. The pharmacy had a system to match these and ensure they were all supplied together. Team members explained that this process worked well. When they had started using it, they had explained it to people affected, so they all knew that their medicines were dispensed off-site. This did not increase the time between people ordering their prescriptions and receiving their medicines. The pharmacy also dispensed a reasonable number of 'walk-in' prescriptions, which were dispensed at the time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy usually assembled owings later the same day or the following day using a documented owings system.

The pharmacy managed the dispensing and the related record-keeping for multi-compartment compliance packs on a four-weekly cycle. Team members assembled four weeks' packs at a time, usually one week before the first pack was due to be supplied. They followed a robust process, using colour coding to identify the week each person's prescriptions were processed in. All team members were competent to carry out this process. They assembled the packs and completed the associated paperwork in a room on the first floor. The paperwork included a record of all changes, including the date and prescriber involved. The GP practice supplied the pharmacy with a notification of the change as well as a new prescription. The pharmacy team generated an additional backing sheet which it kept, providing a complete record of all medicines supplied. This was particularly helpful for locum pharmacists unfamiliar with these prescriptions. Team members filed all records chronologically and tidily making it easy to locate information. They included tablet descriptions on backing sheets and date of supply on the spine of the packs. The pharmacist sealed the packs when she checked them. The team stored completed packs in individual box files, alphabetically, by day of supply and whether collected or delivered. A few people received all four packs at the same time. Prescribers authorised this and the

pharmacy kept records. Team members used white boards, a diary and a notebook to communicate and ensure medicines supplied in compliance packs were correct. One whiteboard listed people in hospital and the other had general reminders on it. Team members used the diary to note tasks that had to be carried out on a certain day, and they used the notebook for other general information. They explained the value of these, and all team members felt informed. They could easily take over from each other. The pharmacy also provided pharmaceutical services to a care home. It supplied medicines in original packs. Team members dispensed these one week in four, when there were slightly fewer multi-compartment compliance packs, to try and balance the workload.

Some people received medicines in daily instalments. And each week a team member dispensed the instalments for the following week. A pharmacist checked these and stored them safely in separate bags per person. A pharmacist supervised consumption of some medicines in the consultation room.

The pharmacy was part of the local NHS palliative care network. It supplied palliative care medicines to people as prescribed in 'just-in-case' boxes. The process was methodical with thorough records kept. All team members were able to demonstrate how the process worked. At the suggestion of a locum pharmacist, all 'just-in-case' boxes were labelled with the expiry date of the shortest dated item. This enabled people to return the boxes for replenishment. The pharmacy requested prescriptions as required. At the time of inspection, the pharmacy had several boxes that could be supplied, and several were out in people's homes with records of this.

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. The pharmacist had counselled people and confirmed that they were on a pregnancy-prevention programme. And this was recorded on the patient medication record. Team members were aware of the programme and knew where the information to supply to people was kept. The pharmacy followed the service specifications for NHS services. It had patient group directions (PGDs) in place for unscheduled care and the Pharmacy First service. It also had private PGDs for services including period delay and facial hair removal. The pharmacist was trained in these services and had read and signed the PGDs but was not currently promoting these services. She explained that people could access these, particularly period delay easily from their NHS GP. The pharmacy team members were trained to deliver the Pharmacy First service 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. During the pandemic the pharmacist had delivered some services remotely by phone. This had ensured service delivery while minimising footfall on the premises. Services delivered in this way included smoking cessation, urinary tract infection (UTI) treatment and supply of emergency hormonal contraception (EHC). The pharmacist carried out the consultation remotely and if appropriate, the team prepared medication ready for collection when the person came to the pharmacy.

The pharmacy obtained medicines from licensed wholesalers. It stored medicines in original packaging on shelves, in drawers and in cupboards. And team members used space well to segregate stock, dispensed items and obsolete items. The pharmacy stored items requiring cold storage in two fridges and team members monitored and recorded minimum and maximum temperatures daily. They took appropriate action if there was any deviation from accepted limits. 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 actioned Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety 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 to deliver its services. Team members look after the equipment and raise concerns when equipment is faulty.

Inspector's evidence

The pharmacy had resources available including current editions of the British National Formulary (BNF) and BNF for Children. It had Internet access allowing online resources to be used. But the internet was observed to be very slow. Team members explained they had highlighted this on several occasions to head office. Various strategies had been attempted to improve it, but it remained very slow.

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 which was replaced/calibrated as per the manufacturer's guidance, and equipment required for the needles exchange service. The team was not using the carbon monoxide monitor during the pandemic to reduce the chance of spreading infection. Team members kept crown-stamped measures by the sink in the dispensary and used separate marked ones for methadone. And they kept clean tablet and capsule counters in the dispensary including a separate marked one for cytotoxic tablets.

The pharmacy stored paper records in well labelled folders in the dispensary and in the room upstairs where multi-compartment compliance packs were managed and assembled. These areas were inaccessible to the public. It stored prescription medication waiting to be collected in a way that prevented patient information being seen by any other people in the retail area. Team members used passwords to access computers and did not leave 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.