

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 32 Castle Street, TAYPORT,
Fife, DD6 9AF

Pharmacy reference: 1042133

Type of pharmacy: Community

Date of inspection: 04/01/2024

Pharmacy context

This is a community pharmacy in the village of Tayport in Fife. Its main activity is dispensing NHS prescriptions. And it supplies medicines in multi-compartment compliance packs to some people who need help remembering to take their medicines at the right times. The pharmacy offers a medicines delivery service. And it supplies a range of over-the-counter medicines. The pharmacy team advises on minor ailments and medicines' use.

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 has suitable systems in place to identify and manage the risks associated with its services. Team members record any mistakes they make and review them to identify the cause. The pharmacy team then makes the necessary changes to stop mistakes from happening again. The pharmacy suitably protect people's private information and keeps the records it needs to by law.

Inspector's evidence

The pharmacy had a set of written standard operating procedures (SOPs). These were reviewed regularly by the superintendent pharmacist (SI) and the pharmacy kept records to show that team members had read and agreed to follow them. SOPs had been reviewed by all team members within the last year. Team members described their roles within the pharmacy and the processes they were involved in. And accurately explained which activities could not be undertaken in the absence of the responsible pharmacist (RP). The pharmacy employed an Accuracy Checking Pharmacy Technician (ACPT). Team members described the process for prescriptions being clinically checked by the pharmacist prior to dispensing and how this was clearly marked on the prescriptions. This enabled the ACPT to complete the accuracy check. The pharmacy had a business continuity plan to address disruption to services or unexpected closure.

Team members kept records about dispensing mistakes that were identified in the pharmacy, known as 'near misses.' 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. For example, they had stored different strengths of codeine tablets in separate drawers to prevent selection errors caused by similar packaging. And at the last review, the team had identified an increase in near misses caused by workload pressures due to sickness. As a result, team members had created a rota for answering the phone in the dispensary to minimise distraction when dispensing medication. The pharmacy had a complaints procedure. Its team members understood how to respond to feedback and concerns from people. And they knew how to escalate a concern to either the RP or area manager if it could not be resolved locally. The pharmacy had recently received communication from the company's managing director acknowledging recent positive feedback.

The pharmacy had current indemnity insurance. The RP notice displayed had the correct details of the RP on duty. And the RP record was generally completed in full though several records did not have the sign-out times of the RP. From the records seen, it had accurate private prescription records including records about veterinary prescriptions. It kept records for unlicensed medicines and controlled drug (CD) records with running balances. A random balance check of three CDs matched the balance recorded in the register. Stock balances were observed to be checked on a weekly basis. The pharmacy had a CD destruction register to record CDs that people had returned to the pharmacy. But there were some recently returned medicines stored securely that had not yet been entered onto the register. The pharmacist gave assurances this would be updated following the inspection. The pharmacy backed up electronic patient medication records (PMR) to avoid data being lost.

Pharmacy team members were aware of the need to protect people's private information. They separated confidential waste for shredding. No person-identifiable information was visible to the

public. The pharmacy had a safeguarding procedure and information for local safeguarding teams was accessible to its team members. The pharmacist was registered with the protecting vulnerable group (PVG) scheme. A team member explained how they would act to keep a person safe from harm in the event they required access to a safe space.

Principle 2 - Staffing ✓ Standards met

Summary findings

There are enough team members to manage the pharmacy's workload and they are appropriately trained for the jobs they do. And members of the pharmacy team complete ongoing training to help them keep their knowledge up to date.

Inspector's evidence

The pharmacy employed one full-time pharmacist, a full-time ACPT, who also held the role of pharmacy manager, one full-time and three part-time pharmacy assistants, and a part-time delivery driver. On the day of inspection there were three dispensing assistants working with the regular pharmacist. Team members were seen to be managing the workload. Part-time team members had some scope to work flexibly providing contingency for absence.

Team members had regular appraisals with the pharmacy manager to identify their learning needs. And those spoken to felt confident in seeking support from the manager. In addition to mandatory learning, all team members undertook periodic e-learning relevant to their roles. A trainee dispenser was observed being supervised in their role and described the training plan that they were working through.

Team members asked appropriate questions when supplying over-the-counter medicines 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. They understood the importance of reporting mistakes and were comfortable openly discussing their own mistakes with the rest of the team to improve learning. The pharmacy superintendent shared information and incidents from elsewhere in the organisation for all team members to learn from incidents. The pharmacy team discussed incidents and how to reduce risks. The pharmacy had a whistleblowing policy that team members were aware of.

Principle 3 - Premises ✓ Standards met

Summary findings

The pharmacy premises are suitable for the services it provides. They are clean, secure, and well maintained. And the pharmacy has a suitable, sound-proofed room where people can have private conversations with the pharmacy's team members.

Inspector's evidence

The pharmacy was secure and generally well maintained. It incorporated a small retail area, dispensary and small back shop area providing storage and staff facilities. Team members knew how to report maintenance concerns and had recently reported an issue with the water ingress near the rear entrance of the pharmacy. The pharmacy was clean and relatively tidy throughout. There were sinks in the dispensary, staff room and toilet. These had hot and cold running water, soap, and clean hand towels. Its overall appearance was professional. The pharmacy had clearly defined areas for dispensing and the RP used a separate bench to complete their final checks of prescriptions. Lighting was bright and heating arrangements were appropriate.

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 which provided privacy. And it provided a suitable environment for services.

Principle 4 - Services ✓ Standards met

Summary findings

The pharmacy manages its services well to help people look after their health. And the pharmacy team provides appropriate advice to people about their medicines. The pharmacy receives its medicines from reputable sources and stores them appropriately. And it completes regular checks of them to make sure they are in date and suitable to supply.

Inspector's evidence

The pharmacy was accessed via a step at the front door. Team members had sight of the door and assisted anyone requiring help if they had difficulty entering the pharmacy. The pharmacy advertised its services and its opening hours in the main window and front door.

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. And they attached coloured labels to bags containing people's dispensed medicines to act as an alert before they handed out medicines to people. For example, to highlight the presence of a fridge line or a CD that needed handing out at the same time. Team members initialled dispensing labels to provide an audit trail of who had dispensed and checked all medicines. The pharmacy maintained an audit trail of the medicines it delivered to people's homes.

A large proportion of people received medicines from 'Medicines Care Review' (MCR) serial prescriptions. The pharmacy dispensed these on an eight-week cycle a week in advance of when people would collect them. Team members maintained records of when people collected their medication. This meant the pharmacist could then identify any potential issues with people not taking their medication as they should. The pharmacy notified the GP practice for a further prescription when all episodes of the prescription were collected. And they added notes of any care issues identified. This helped make sure people's medicines were reviewed by their GP appropriately.

The pharmacy supplied medicines in multi-compartment compliance packs to people who needed extra support with their medicines. The pharmacy had a schedule to support it in managing the workload for these packs. It used individual records to record people's medication regimens. And it updated these records with care following confirmation of changes to a person's medication regimen. The pharmacy had recently started supplying people's medicines in compliance pack pouches to help people better manage their medicines. The pharmacist and ACPT had assessed people to ensure they were suitable for these pouches before they started. Each pouch contained all the person's medicines to be taken at a particular time. These were dispensed at an offsite dispensing hub pharmacy. This process involved the team securely transferring data from people's prescriptions to the dispensing hub. The hub then dispensed the prescription and sent the medicine back to the pharmacy to be collected by or delivered to people. The pharmacy also supplied a variety of other medicines by instalment. A team member dispensed these prescriptions in their entirety when the pharmacy received them. The pharmacist checked the instalments and placed the medicines in bags labelled with the person's details and date of supply.

A pharmacist undertook clinical checks and provided appropriate advice and counselling to people receiving higher-risk medicines. People were supplied with written information and record books if

required. The pharmacy team was aware of the risks associated with people becoming pregnant whilst taking sodium valproate as part of the Pregnancy Prevention Programme (PPP). Team members took care not to apply labels over the warning cards on the boxes of valproate products when dispensing. They were not all aware of the new requirement to only dispense valproate in original packs to ensure people receiving it could see the warning about the risks of becoming pregnant whilst taking it. The pharmacist assured the inspector that all team members would receive training on this following the inspection.

The pharmacy had patient group directions (PGDs) for unscheduled care, the Pharmacy First service, smoking cessation and emergency hormonal contraception (EHC). The pharmacy team members were trained to deliver the Pharmacy First service within their competence and under the pharmacist's supervision. They referred to the pharmacist as required. Pharmacists providing consultation services had access to current PGDs and supportive information to help them in delivering these services safely. And the team benefitted from a positive relationship with local surgeries who regularly referred people to the pharmacy for support when appropriate.

The pharmacy obtained medicines from recognised suppliers. It stored medicines in their original packaging on shelves and in drawers. The pharmacy protected pharmacy (P) medicines from self-selection to ensure sales were supervised. And team members followed the sale of medicines protocol when selling these. 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 these went above or below accepted limits. Team members regularly checked expiry dates of medicines and those inspected were found to be in date. The pharmacy had medicine waste receptacles and CD denaturing kits available. It received Medicines and Healthcare products Regulatory Agency (MHRA) recalls and safety alerts by email. But it could do more to maintain records about what action was taken on each alert.

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 private information.

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 access to a range of further support tools. This meant the pharmacy team could refer to the most recent guidance and information on medicines.

The pharmacy stored prescription medication waiting to be collected in a way that prevented patient information being seen by people in the retail area. Team members used passwords to access computers and did not leave them unattended unless they were locked. They used a cordless telephone handset to allow them to move out of earshot of the public area when discussing confidential information over the telephone.

Pharmacy team members used a range of clean counting and measuring equipment for liquids, tablets, and capsules. Equipment to support the pharmacy's consultation services was readily available. This included a blood pressure machine from a recognised manufacturer which was replaced as per the manufacturer's guidance.

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.