General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 33 Burnbank Road, HAMILTON, Lanarkshire, ML3 9AA

Pharmacy reference: 1042542

Type of pharmacy: Community

Date of inspection: 26/06/2024

Pharmacy context

This is a pharmacy in the town of Hamilton in Lanarkshire. Its main activity is dispensing NHS prescriptions. It provides some people with their medication as individual doses in compliance packs to help them take their medicine correctly. It provides NHS services such as NHS Pharmacy First. And it delivers medicines to people in their homes.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

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 not all met	4.4	Standard not met	The pharmacy does not action alerts about the safety of medicines in a timely and appropriate way to ensure medicines in the pharmacy are fit for supply.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy's written procedures help team members manage risk and deliver services safely and effectively. Team members mostly keep the records required by law and they keep people's private information secure. They have the necessary training to respond appropriately to concerns for the welfare of vulnerable people accessing the pharmacy's services. Team members take some steps to learn from mistakes they make when dispensing to help prevent them happening again. But they do not routinely record the details of these mistakes so they may miss opportunities to learn from them and make services safer.

Inspector's evidence

The pharmacy had standard operating procedures (SOPs) which were designed to manage risks and guide team members to work safely and effectively. These included SOPs about the responsible pharmacist (RP), controlled drug (CD) management and dispensing processes. Team members accessed the SOPs on an online platform and a sample of SOPs seen had been reviewed in the last two years. Team members received completion certificates once the SOPs had been read and they electronically signed to say they understood them. A sample of these seen showed team members had read the SOPs in the past year.

The pharmacy had a process for recording mistakes identified and corrected during the dispensing process known as near misses. But team members were unclear who was responsible for recording the details of the error and few records had been recorded. Team members completed a monthly patient safety review and the review in March highlighted a lack of near misses recorded, with an improvement in records to be made highlighted for the next month. But the following months review showed no near misses recorded. And there were none recorded for May. And not all team members had signed to say they had read the monthly patient safety review. Team members had previously separated medicines that looked-alike and sounded-alike but hadn't made any recent changes. Team members explained that medicine selection errors had reduced overall due to the volume of prescriptions which were now dispensed at a central hub pharmacy using automation. The pharmacy completed reports for mistakes that were identified after a person had received their medicine, known as dispensing incidents. These were completed electronically and shared with the company's head office. An action from the last reported error was for the team to re-read the SOP. The pharmacy had a complaints procedure displayed in the retail area. Team members aimed to resolve complaints or concerns informally. If they were unable to resolve the complaint, they signposted people to the company's head office.

The pharmacy had current professional indemnity insurance. Team members knew which tasks could and could not take place in the absence of the RP. The RP notice was prominently displayed in the retail area and reflected the correct details of the RP on duty. The RP record was mostly completed correctly, with the occasional minor omission of the time the RP ceased duty. The pharmacy recorded the receipt and supply of its CDs. The entries checked were in order, with minor omissions of the wholesaler address for the receipt of its CDs. Team members checked the physical stock levels of medicines matched those in the CD register weekly. Records of patient-returned CDs were captured upon receipt and their destruction was witnessed. The pharmacy kept complete records for supplies of medicines made against private prescriptions and retained the corresponding prescriptions.

Team members were aware of their responsibility to protect people's private information. They received annual training about information governance and General Data Protection Regulation. They separated and shredded confidential information on site. The pharmacy displayed an NHS Scotland privacy notice in the retail area informing people of how their private data was used. Team members received annual training about safeguarding. Team members provided examples of signs that would cause them concern about potentially vulnerable people. And they referred any concerns to the pharmacist. Both the pharmacist and pharmacy technician were members of the protecting vulnerable groups scheme.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough suitably qualified and team members in training to deliver its services safely. It supports its team members in training. And team members complete ongoing training to help develop their skills and knowledge. They give appropriate advice when assisting people with their healthcare needs.

Inspector's evidence

The pharmacy team at the time of the inspection included a regular locum pharmacist who was the RP. They were supported by a pharmacy technician and a dispenser. A team member who had been in position two months began their shift during the inspection. An additional three dispensers, one of whom was a trainee, and a pharmacy student also worked at the pharmacy but were not present during the inspection. Relief pharmacists employed by the company and locums covered the pharmacy's opening hours. And there was a delivery driver. Team members had either completed, or were in the process of completing, accredited qualification training. The pharmacist confirmed the newly employed team member would be enrolled on accredited qualification training within three months of commencing employment as per requirements. The team member made sales of medicines and referred requests for pharmacy only (P) medicines to the pharmacist. And they completed some dispensing activities under supervision. Team members in training were supported by one of the relief pharmacists. And other team members ensured their skills and knowledge were kept up to date by completing regular training provided by the company. The pharmacist had completed training to provide the NHS Pharmacy First service and had signed declarations of competency for each patient group direction (PGD).

The team shared issues with each other to support safe working and they were observed supporting each other to complete the workload. Team members felt comfortable to raise professional concerns with the pharmacy's management team, area manager or through a company confidential telephone line. Annual leave was planned in advance so that contingency arrangements could be made, with part-time team members increasing their hours to support periods of absence. The company had a performance review process for its team members, but they had not yet received this as the pharmacy had been acquired less than a year previously by the company. Team members received daily communications from the company's head office with information for both pharmacy and retail operations. They were not set any targets by the company.

Team members asked appropriate questions when selling medicines over the counter. They knew to be vigilant about repeated requests for medicines liable to misuse, for example medicines containing codeine. Team members referred any such requests to the pharmacist who would have supportive conversations and refer to the person's GP where necessary.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy premises are clean, secure and suitable for the services it provides. It has appropriate facilities where people can have private conversations with team members.

Inspector's evidence

The pharmacy had two floors. The ground floor comprised of the retail area and a small dispensary. There were two storage rooms upstairs, one of which was used to store medicines awaiting collection. The second room was used for storage of retail stock and other items. The pharmacy portrayed a professional appearance. There was limited space in the main dispensary and in the rear corridor leading to the stairs. Team members managed the limited space well in the dispensary but there was some clutter in the rear corridor which made it more difficult to move freely. There was a good workflow in the dispensary and there were different benches used for dispensing and checking medicines. The pharmacist's checking bench was situated within the dispensary in a way that allowed for effective supervision of the dispensary and medicines counter. The dispensary had a sink with hot and cold water. And toilet facilities provided separate hand washing facilities. Team members ensured the pharmacy was cleaned daily and the toilet facilities were cleaned once or twice weekly. Lighting provided good visibility throughout and the temperature was comfortable.

The pharmacy had a soundproofed consultation room which allowed people to have private conversations with team members and access services. It had a desk, two chairs and a computer.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy team does not always respond to alerts about the safety of medicines appropriately. So, there is a risk people may receive medicines that are not safe to supply. The pharmacy suitably manages the delivery of its services. And team members give people relevant information to help them take their medicines safely. They obtain medicines from recognised sources and they complete checks on the storage and expiry dates of medicines to ensure they remain fit for supply.

Inspector's evidence

The pharmacy advertised its opening hours in the front window. It had level access from the street which provided ease of access to those using wheelchairs or with prams. Team members provided written information to people with hearing difficulties. And they used translation applications for people who did not speak English as their first language.

Team members used baskets when dispensing to keep people's prescriptions and medicines together and prevent them becoming mixed-up. And they signed dispensing labels to confirm who had dispensed and who had checked the medicines so there was an audit trail of those involved in each stage of the process. Team members highlighted the inclusion of a CD, fridge line or if the pharmacist wanted to speak to a person when they were given their medicines using stickers. Team members were aware of the Pregnancy Prevention Programme (PPP) for people who were prescribed valproate and the additional information to be supplied to help them take their medicines safely. They highlighted other higher-risk medicines such as methotrexate to the pharmacist including other information such as dose changes to inform the pharmacist's clinical check. Team members told people if they had medication owed to them. And they reviewed prescriptions with owed medication daily to ensure these were provided to people in a timely manner. For medicines that were out of stock, people were given the option to try an alternative pharmacy, or an alternative was arranged. Team members were observed making suitable checks when handing out medicines to people to ensure they were given to the correct person.

The pharmacy provided the NHS Pharmacy First service for people. The pharmacist accessed up-to-date versions of PGDs online. The pharmacy had recently introduced a service where people were issued with a weekly supply of their medicines as individual doses in a compliance pouch to help them take their medicines correctly. Team members ordered the prescriptions in advance which allowed time for any queries regarding the medicines to be resolved. The pharmacist completed a clinical check of the prescription and data accuracy check of the information on the person's patient medication record (PMR). The information was transferred electronically to an offsite pharmacy hub to be assembled. The packs included descriptions of the medicines in the pack so they could be easily identified. And patient information leaflets were provided so people could read about their medicines. The pharmacy provided a delivery service, taking medicines to people in their homes. The delivery driver knew the local area well and planned the route using the address on people's prescriptions. Any medicines that could not be delivered were returned to the pharmacy. The delivery driver left a card through the letterbox if someone was not at home when the delivery was attempted.

The pharmacy sourced its medicines from licensed wholesalers. Pharmacy only (P) medicines were stored within clear plastic boxes on shelves in the retail area. And they had a direction on them that informed people to ask for assistance if they required the medication. Team members had a process for

checking the expiry date of medicines and records showed this was up to date. Medicines that were going out of date in the next three months were highlighted for use first. A random selection of medicines checked were within their expiry date. The pharmacy had a fridge for medicines that required cold storage and team members recorded the temperatures daily. Records showed that the fridge was operating between the required two and eight degrees Celsius. Team members reported receiving notifications about drug safety alerts and medicine recalls via supplier invoices and on the company's intranet. The pharmacy had a process for actioning drug alerts and recalls. The team stated they actioned the alerts as they were received, however the last record available during the inspection was from December 2023. This meant the safeguards in place were not sufficient to ensure that medicines subject to alerts were not supplied to people. Team members were aware of the process to follow if a person reported an adverse reaction to a medicine. The pharmacy had destruction kits available for patient returned or out of date CDs.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has suitable equipment to provide its services. Team members use the equipment and facilities in a way that mostly protects people’s private information.

Inspector's evidence

The pharmacy had access to paper and electronic reference resources including the British National Formulary (BNF) and British National Formulary for children (BNFc). It had ISO marked measuring cylinders which were marked to identify which were for water and which were for liquid medicines. And they were cleaned after each use. The pharmacy provided medicines as part of a substance misuse service using an automated machine. Team members calibrated and cleaned the medicine daily.

The pharmacy stored medicines awaiting collection to the side of the medicines counter. Most prescriptions and people's private information faced away from people at the medicines counter. There was little risk of people's private information being seen although the risk was discussed with the pharmacist. Confidential information was secured on computers using passwords. And computer screens were positioned within the dispensary and the consultation room in a way that prevented unauthorised access to confidential information.

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.