General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, The City Hospital, Park Road, ABERDEEN, Aberdeenshire, AB24 5AU

Pharmacy reference: 1086151

Type of pharmacy: Community

Date of inspection: 27/09/2022

Pharmacy context

This pharmacy is in the grounds of the former City Hospital where other healthcare services including a community mental health team are based. The pharmacy's main activities are dispensing NHS prescriptions and selling over-the-counter medicines. The pharmacy provides the NHS Pharmacy First Service which supplies people with treatments for minor ailments and common clinical conditions.

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 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 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. The procedures included recording the near miss on a specific template. The details recorded enabled the team to identify patterns, learn from the error and take action to prevent the error from happening again. The pharmacy had a process for managing errors that were identified after a person received their medicine, 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 regularly reviewed the near miss records and dispensing incidents to identify patterns. The outcome from the latest review was clearly displayed in the staff room for everyone to read. A recent review was used to remind team members to ensure stock was put in the correct storage areas and to not get distracted when dispensing. The pharmacy provided people with information on how to raise a concern or provide feedback through leaflets and a poster displayed in the retail area along with information on the company website.

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 on and off site.

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 drivers were experienced in the role and 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 generally 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 identify ways to support the effective delivery of the pharmacy's services. The team members have some opportunities to complete training to develop their knowledge and skills.

Inspector's evidence

A part-time employee pharmacist and locum pharmacists covered the pharmacy's opening hours. The pharmacy team consisted of four part-time dispensers and two part-time delivery drivers. Occasionally the pharmacy employed students from the nearby School of Pharmacy to provide support to the team. A new pharmacy manager was in post and the pharmacy had recently recruited a team member to work Saturday mornings.

The pharmacy had faced some staffing challenges in recent months after some experienced team members left the business. The team reported to have 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. The team members with the support of each other and additional staff had worked to get back on track with tasks. And they had developed a rota covering the main tasks to be completed to ensure they were completed especially at times when team numbers were reduced such as unplanned absence.

The team members used company online training modules to keep their knowledge up to date. The team members were informed of new training modules but didn't have protected time at work to complete the training. One of the experienced dispensers provided the new team member with initial training and clearly explained the key procedures and processes. The pharmacy occasionally held team meetings and team members received informal feedback on their performance.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy was tidy and hygienic, it had separate sinks for the preparation of medicines and hand washing. The consultation room contained a sink and alcohol gel for hand cleansing. The pharmacy had enough storage space for stock, assembled medicines and medical devices and the team kept floor spaces clear to reduce the risk of trip hazards. 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 pharmacy services. The pharmacy also had a separate entrance and a cordoned off area that provided privacy to people receiving their medication as a supervised dose and when accessing the needle exchange service. The pharmacy had restricted public access to the dispensary during the opening hours.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides a range of services which support people's health needs and it manages its services well. It keeps detailed records to help monitor the services it provides and to enable the team to deal with queries effectively. The pharmacy gets its medicines from reputable sources and it stores them properly. The team members carry out checks to make sure medicines are in good condition and appropriate to supply.

Inspector's evidence

People accessed the pharmacy via an automatic door. The pharmacy had an information leaflet that provided people with details of the services it offered and the contact details of the pharmacy. The team members provided people with information on how to access other healthcare services when required. And they kept a range of healthcare information leaflets for people to read or take away. The team worked well with the pharmacist when people presented for treatment for minor ailments to ensure their request fitted the NHS Pharmacy First service. The team asked appropriate questions to discuss with the pharmacist. The pharmacy had up-to-date patient group directions (PGDs) which gave the pharmacist the legal authority to supply certain prescription only medicines (POMs) within the criteria of the Pharmacy First service. Team members asked an appropriate range of questions and provided clear advice when selling over-the-counter products. The team provided people with clear advice on how to use their medicines. The team was aware of the criteria of the valproate Pregnancy Prevention Programme (PPP) and the information to be provided. The computer on the pharmacy counter had access to the pharmacy's electronic patient medication records (PMR). So, when a person presented the team member could check what stage the dispensing of their prescription was at.

The pharmacy provided multi-compartment compliance packs to help a few people take their medicines. To manage the workload the team divided the preparation of the packs across the month. And usually ordered the prescriptions in advance of supply to allow time to deal with issues such as missing items. Each person had a record listing their current medication and dose times which the team checked the received prescriptions against to identify any changes. These were checked with the prescriber. The team recorded the descriptions of the products within the packs and supplied the manufacturer's packaging leaflets. This meant people could identify the medicines in the packs and had information about their medicines.

The pharmacy supplied medicines to several people daily as supervised and unsupervised doses. The pharmacy prepared the doses using a pump that was linked to a laptop. The team inputted prescription information into system on the laptop to ensure the pump measured the required doses and printed labels. The team regularly checked and cleaned the pump to ensure the correct doses were measured on each occasion. The team asked the person to confirm their date of birth as part of the process of ensuring the person received the correct dose. The team stored prescriptions for the doses waiting to be supplied each day separately from prescriptions once the dose had been supplied. This enabled the team to monitor people presenting for their dose and to ensure the correct records were made. The team prepared the unsupervised doses that were taken away by the person in advance to reduce the workload pressure of dispensing at the time of supply. Many people received other medicines as instalments so the team members prepared these doses at the same time to ensure the person received all their medication. The pharmacy provided a needle exchange service, the sections holding

the items to be supplied were organised to enable the team to easily access the items requested by the person. The pharmacy clearly displayed healthcare guidance and advice in the area where people presented for the needle exchange service.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The team used baskets 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. A sample found that the team completed the boxes. The pharmacy used clear bags to hold dispensed fridge lines, this allowed the team, and the person collecting the medication, to check the supply. The pharmacy used CD and 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. The pharmacy kept a record of the delivery of medicines to people that included a signature from the person receiving the medication. The pharmacy used a text messaging service to inform people when their prescription was ready to collect.

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 dates of opening were recorded for medicines with altered shelf-lives after opening. This meant the team could assess if the medicines were still safe to use. The team checked and recorded fridge temperatures each day and a sample of these records 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 its equipment is used appropriately to protect people's confidential information.

Inspector's evidence

The pharmacy had reference resources and access to the internet to provide the team with up-to-date clinical information. The pharmacy had equipment available for the services provided that included a range of CE equipment to accurately measure liquid medication. The pharmacy completed safety checks on its electrical equipment. The pharmacy computers were password protected and the computer on the pharmacy counter was positioned in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view and it held private information in the dispensary and rear areas, which had restricted public access.

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.