General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 1 The Cobbles, Meltham, HUDDERSFIELD, West Yorkshire, HD9 5QQ

Pharmacy reference: 1086846

Type of pharmacy: Community

Date of inspection: 11/03/2024

Pharmacy context

The pharmacy is next to a health centre in the village of Meltham, West Yorkshire. It mainly dispenses NHS prescriptions and sells over-the-counter medicines. It supplies medicines for some people in compliance packs, known as pouches, to help people take their medicines properly. It provides a range of services, including the NHS Pharmacy First service and blood pressure monitoring 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	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 appropriately identifies and manages risks associated with delivering its services. And team members follow written procedures relevant to their roles to help them provide services safely. They keep people's confidential information secure, and they mostly keep the records they need to by law complete. Team members record and learn from the mistakes they make to reduce the risk of the same mistake happening again. And they understand their role in helping to protect vulnerable people's welfare.

Inspector's evidence

The pharmacy had electronic standard operating procedures (SOPs) for its processes and the services provided. This included for Responsible Pharmacist (RP) regulations and controlled drug (CD) management. From the sample of SOPs seen they had been written in 2023 and due for review in 2025. Team members had read the SOPs and they kept a printed record for audit and training purposes. Team members were seen following procedures, such as asking people to confirm their address before handing out medicines.

Pharmacy team members recorded near miss errors on a paper record, with a page of entries for February 2024. These were errors identified before people received their medicines. When the pharmacist or accuracy checking pharmacy technician (ACPT) identified the error they informed the dispenser so they could rectify the mistake themselves and reflect on why it happened. Although the paper record lacked details of the learning and what actions had been taken, a dispenser described actions taken to minimise the risk of repeat errors. This included their individual learning following the incorrect selection of tamsulosin tablets and capsules. Their action was to highlight tablets and capsules on prescriptions to reduce the risk of a selection error. The team had separated gabapentin and pregabalin on to shelves in different parts of the dispensary due to repeated selection errors. The pharmacist manager completed a monthly analysis of near miss errors and shared any learning with the team. One action had been to encourage more recording of near miss errors. The pharmacy reported dispensing incidents online to the pharmacy superintendent's team, with enough detail to enable resolution with the person. These were errors that were identified after the person had received their medicine. The team was open and honest in discussing their errors and there was a culture of learning.

The correct RP notice was displayed, and this was visible at the pharmacy counter. Team members were aware of their roles and responsibilities and were observed working within the scope of their role. The ACPT checked prescriptions that had been clinically checked by the pharmacist. These were identified by the pharmacist's signature on the prescription. The ACPT did not check any prescriptions when they had been involved in the dispensing process. A dispenser correctly described what could and couldn't be done in the absence of the RP. The pharmacy had a complaints procedure, including an escalation process to the pharmacy superintendent's team. Since the pharmacist joined the team a month ago there had been no complaints, just positive feedback from people. There was a QR code to scan so people could provide feedback and two posters in the retail area advertising how to provide feedback.

The pharmacy had current professional indemnity insurance. It had electronic private prescription records, which were completed correctly except that on several of the entries the prescriber recorded was different from the prescription and the prescribers' addresses were missing. The pharmacist

explained how they would use this as learning for the team. The pharmacy held up-to-date electronic CD registers, with checks of the physical stock against the register balance recorded weekly. The two stock checks completed against the register balance during the inspection were correct. And the pharmacist demonstrated how annotations of amendments to the running balance was done, including adding in the reason for the alteration. The pharmacy kept an electronic record for CDs returned by people for destruction as no longer needed. One of these entries was incorrect, but the team resolved this during the inspection. The electronic RP record was mostly completed correctly. From the sample checked there were a handful of entries missing the time the RP had ceased their duties.

Team members understood what to do to keep people's personal information safe and they separated confidential waste from general waste whilst dispensing. They periodically shredded the waste and disposed of it appropriately. There were two copies of the privacy policy displayed in the retail area for people to view. And the team completed annual General Data Protection Regulation (GDPR) training. The pharmacist and ACPT had completed level 2 safeguarding training and the dispensers had certificates to confirm training relating to vulnerable adults and children. This training was completed every two years. A team member explained how if they were concerned about a vulnerable person, they would discuss this with the pharmacist. And they were aware of the local safeguarding contact details displayed on the wall if needed.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team has the appropriate qualifications and skills to provide services safely and effectively. Team members work well together to manage the workload. And they complete regular ongoing training to help keep their knowledge up to date. They share ideas to improve the way they work, and they feel comfortable in raising any concerns should they need to.

Inspector's evidence

The RP was the pharmacist manager and they had been appointed into the position the previous month after spending some time working as a relief pharmacist in the pharmacy. They had taken over from a long-standing pharmacist manager. They were supported by an ACPT who worked at the pharmacy three days a week and two dispensers. Another dispenser was on annual leave and a part-time delivery driver worked two days a week. The pharmacist manager authorised holidays and team members covered each other by working additional hours. The team appeared to be managing the workload well and the atmosphere was calm.

Team members displayed their qualification training certificates and regularly completed online training modules. The pharmacist had completed the required training for the NHSE Pharmacy First service and team members had been briefed so they understood when to refer people to the pharmacist. A dispenser knew the risks of people taking medicines such as codeine-containing painkillers. They explained the advice they gave people and how the pharmacist had previously supported people who had requested to purchase painkillers regularly. Team members were enthusiastic and knowledgeable about the operation of the pharmacy, and openly discussed errors to learn from them. A team member described their knowledge of the whistleblowing policy and how they felt comfortable raising any matters confidentially with the pharmacist manager. The team had recently discussed how to improve communication around learning from incidents and sharing knowledge of patient safety alerts by using a whiteboard. This had been put up in the dispensary ready for use. The team had targets to meet for example for blood pressure checks and the APCT welcomed them as an opportunity to help people who may have raised blood pressure.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and provides a professional environment suitable for the services it delivers. It has a private consultation room where people can have confidential conversations with a member of the pharmacy team if needed.

Inspector's evidence

The pharmacy premises were clean, secure, and portrayed a professional image. There was a small, well-presented retail area, a tidy pharmacy counter, and the main dispensary downstairs. And there was a barrier at the pharmacy counter to prevent unauthorised access. The dispensary was well organised with plenty of work bench space. It was screened in a way which allowed the pharmacist to supervise the sale of medicines and intervene in a sale where necessary. And it also allowed for privacy to prevent distractions during the dispensing and checking of prescriptions. Stock was stored neatly on shelves around the perimeter of the dispensary and in drawers. A pharmacy team member had reported ongoing health and safety concerns over the drawers to head office and was awaiting resolution. They managed the safe use of the drawers and informed locum pharmacists of the issue.

The dispensary had a sink with hot and cold water for professional use and hand washing. There were staff and toilet facilities that were hygienic. Lighting and temperature were kept to an appropriate level to provide healthcare services and for storage of medicines. The pharmacy had a consultation room that was clearly advertised. It was of adequate size, clean and appropriate for use. No confidential information was stored in the room and the computer was password protected.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy team manages and delivers its services safely and effectively. Team members plan well for new services, and they make services easily accessible. The pharmacy obtains its medicines from recognised suppliers. And it stores and manages its medicines appropriately to make sure people receive their medicines when they need them. It makes the necessary checks to ensure its medicines are in date and suitable to use.

Inspector's evidence

The pharmacy was accessed from a car park with level access into a small retail area of the pharmacy. There was a seat for people to use whilst waiting for prescriptions. The outside of the building portrayed a professional image and people knew the opening times from signs in the window and on the door. The team displayed healthcare related posters and leaflets for people to read. The pharmacy provided a medicines delivery service and medicines awaiting delivery were stored in a separate box, away from other prescriptions. The team attached labels with people's names and addresses on to separate pages of a delivery book to keep people's confidential information safe when people signed for the receipt of their medicines. From a sample seen the delivery driver had signed the book to confirm delivery. They had annotated the time of the delivery, which may help in case of queries.

The pharmacy was organised to provide the NHSE Pharmacy First service. It had separate folders for the care pathways for each condition with the associated Patient Group Directions (PGDs). It kept a separate training record to show which pharmacists, including locum pharmacists had signed all PGDs. The team kept medicines used for the service on separate shelves to ensure it had stock available, and there was a process to rotate with dispensary stock to prevent them from becoming short dated.

The team had an organised workflow for dispensing. There were separate areas for labelling, dispensing, and checking of prescriptions and the benches were kept clear throughout the inspection. The pharmacy used dispensing aids to manage risk in the dispensing process. This included baskets to keep people's prescriptions and medicines together to reduce the risk of errors. And the use of stickers to highlight when people may benefit from services such as a blood pressure check. Team members initialled dispensed by and checked by boxes on the dispensing labels to provide an audit trail. Instalment prescriptions for the substance misuse service were dispensed and checked each morning and stored securely awaiting collection. The team used baskets to store them neatly in the cabinet and kept individual people's doses separate to minimise the risk of error. An additional check was made by the pharmacist before handing out to the person. Members of the team showed a good understanding of the requirements of dispensing valproate for people who may become pregnant and of the recent safety alert updates. They kept valproate containing medicines separate and explained how they dispensed prescriptions in original manufacturer's packs.

The pharmacy dispensed some medicines in compliance packs. Some that were dispensed in the pharmacy were in multi-compartment packs but most people requiring support in this way received their medicines dispensed into pouches. These pouches were a roll of individually labelled and sealed packs containing all of people's medicines required for one dose. They were dispensed at another of the company's pharmacies, known as an offsite hub pharmacy. The roll of individual pouches was contained in an outer cardboard box, which was labelled with all the medicines in the pouches and included

mandatory warning labels and descriptions of what the medicines looked like. The pharmacy supplied patient information leaflets (PILs) for all new medicines, and this was reportedly repeated at intervals of about six months rather than at each dispensing. The pharmacy had a completed record card for each person which detailed their current medicine regime and included a signed and dated record of the pharmacist's clinical check. Some higher-risk medicines such as warfarin were dispensed in the pharmacy, rather than using the pouch system. Once data from prescriptions had been entered into the patient medication record (PMR) on the computer the pharmacist or ACPT checked it for accuracy. There was an additional check completed against the prescription when the pouches were received back in the pharmacy. And the pouches were laid out in an orderly manner in the upstairs dispensing area awaiting this check.

The pharmacy obtained medicines from recognised wholesalers. Pharmacy-only (P) medicines were displayed behind the pharmacy counter and in plastic boxes in the retail area. The boxes were labelled to ask for assistance, which a team member confirmed happened. The layout of the pharmacy allowed the pharmacist to supervise sales of over-the-counter medicines. Medicines on the dispensary shelves were kept in a tidy and orderly manner. The pharmacy had a date checking matrix, which was up to date. There were no out-of-date medicines found from a sample checked. A team member was observed completing the date checking process and removing short-dated medicines from the shelves. The pharmacy had bins for pharmaceutical waste, and these were stored neatly upstairs away from usable stock. It stored medicines requiring cold storage in a medical fridge, and it kept daily records which showed the temperatures were within the required range. The pharmacy stored its CDs neatly with different strengths separated. The team received notification of medicine recalls and safety alerts by email and held printed and signed records of actions they had taken. These records were up to date.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

Pharmacy team members have access to suitable equipment for the services they provide. And it is fit for purpose and safe to use. Team members use equipment and facilities appropriately to protect people’s confidentiality.

Inspector's evidence

The pharmacy had up-to-date written reference resources available including the British National Formulary (BNF). Team members had access to the internet and the company's intranet to support them in obtaining current information to help them in their role. A range of equipment was available for use in the consultation room. The pharmacist confirmed new equipment, such as a blood pressure monitor, and otoscope had been recently purchased to provide the NHSE Pharmacy First Service. Electrical equipment was visibly free from wear and tear and appeared in good working order. It had been safety tested and date stickers indicated the next tests were not yet due. The pharmacy had CE stamped measuring cylinders that were clean and appropriate for measuring liquids.

Prescriptions awaiting collection were stored on shelves in a retrieval area in the dispensary, so confidential information was not visible to people waiting in the retail area. Computers were password protected and team members were seen using individual NHS smart cards to access computers. Computer screens were protected from unauthorised view and there was a cordless telephone to enable team members to have private conversations in a quieter area.

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.