General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, 189A West Main Street, BROXBURN, West Lothian, EH52 5LH

Pharmacy reference: 1087380

Type of pharmacy: Community

Date of inspection: 11/09/2024

Pharmacy context

This is a community pharmacy located inside a health centre in the town of Broxburn in West Lothian. Its main services include dispensing NHS prescriptions, including serial prescriptions and selling over-the-counter medicines. It supplies medicines in single dose compliance pouches and multi-compartment compliance packs to people who need help to take their medicines at the right times. And it provides a private influenza vaccination service and delivery service.

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 appropriately identifies and manages the risks with the services it provides. Pharmacy team members record and discuss mistakes identified during the dispensing process and make changes to mitigate the risk of the same mistake happening again. The pharmacy keeps the records it needs to by law, and team members understand their role in helping to protect vulnerable people.

Inspector's evidence

Team members had access to a set of standard operating procedures (SOPs) designed to help them work safely and effectively. They included SOPs about the management of controlled drugs (CDs) and transferring prescriptions to be assembled at the company's offsite pharmacy hub. SOPs were reviewed by the Superintendent Pharmacist (SI) team every two years and team members accessed them online. Paper-based records were maintained for each team member to show they had read and understood them. Notification of new or updated SOPs were communicated via email. Team members described their roles and responsibilities within the pharmacy and accurately described what activities they could and couldn't undertake in the absence of the responsible pharmacist (RP). There was a process in place to address any disruption to services or unexpected closure. And team members had the appropriate information printed to attach to the outside of the building, to alert people as to why the pharmacy was closed and provide information for other services available in the local community.

A signature audit trail on medicines labels showed who had dispensed and checked each medicine. This meant the RP could help team members learn from dispensing mistakes identified within the pharmacy, known as near misses. The pharmacy kept paper-based records of near misses and included details such as the date and time the near miss happened, and any contributing factors. Team members were encouraged to record the near miss when it happened as a method of reflection following a mistake. Mistakes identified after a person received their prescription, known as dispensing incidents, were recorded on an online system, and reviewed by the SI team at head office. A monthly safety audit was carried out on near misses and dispensing incidents by the RP. And team members discussed the findings from the safety audit and agreed actions which were then put in place to manage the risk of a similar mistake happening again. This included separating strengths of higher-risk medicines such as trazodone to prevent selection errors and implementing a second check on all controlled drugs (CDs) dispensed before a final accuracy check, due to a trend identified in the safety audit. Team members kept paper-based records of discussions following the safety audit, which included details such as learning points and any actions taken. The pharmacy had a complaints procedure and welcomed feedback. There was a feedback notice on display in the retail area to let people know how they could submit feedback about the service they had received. Team members were trained to manage complaints and aimed to do so informally. However, if they could not resolve the complaint, they would provide contact details for the SI team.

The pharmacy had current professional indemnity insurance. And it displayed an RP notice that reflected the correct details of the RP on duty. The RP notice was not clearly visible from the retail area, this was discussed at the time of inspection and the RP provided assurances it would be moved to a more visible area. The RP log held electronically was mostly complete with minor omissions of when the RP ceased duties at the end of the working day. Team members maintained complete CD registers and they checked the physical quantity in stock matched the balance recorded in the registers weekly.

Mostly CD registers were paper-based and stored in folders but the register for substance misuse liquid medicines was held electronically. A random balance check on the physical quantity of three CDs against the balances recorded in the registers showed one discrepancy, which was investigated and rectified at the time of inspection. The pharmacy had records of CDs people had returned for safe disposal and it had contact details for the Controlled Drug Accountable Officer (CDAO). The pharmacy held certificates of conformity for unlicensed medicines and details of supply were included to provide an audit trail. Private prescription records held electronically were mostly complete, but some records were missing the prescriber details or showed the incorrect prescriber details.

There was a privacy notice on display in the retail area. Team members had completed online training relating to information governance (IG) and the safeguarding of vulnerable people. Confidential waste was segregated and shredded onsite. There was a safeguarding policy in place and team members provided examples of signs that would raise concerns, and of interventions they had made to help protect vulnerable people. And they had contact details for local safeguarding agencies.

Principle 2 - Staffing ✔ Standards met

Summary findings

Team members have the necessary skills and knowledge for their role. They work well together and provide support to each other as they work. And they feel comfortable raising professional concerns, should they need to.

Inspector's evidence

The pharmacy employed one part-time regular pharmacist who was independent prescriber, one-full time dispenser who also had the position of pharmacy manager, one full-time pharmacy technician, one part-time dispenser, three part-time trainee dispensers, one full-time trainee dispenser and a part-time delivery driver. Regular locum pharmacists provided cover throughout the week. The deliver driver planned their route in advance and kept paper-based records to record the delivery of each prescription. The RP was unable to confirm if the delivery driver had been enrolled on the appropriate accredited qualification training for their role. The inspector provided advice on the accredited qualification training, and both the RP and pharmacy manager provided assurances this would be addressed. Team members were observed managing the workload well. The pharmacy manager managed annual leave requests to ensure staffing levels remained sufficient to manage the workload safely. And they had access to the company's relief team members, should they require contingency cover during periods of absence. The pharmacy did not have an official appraisal procedure, but the pharmacy manager had regular informal professional discussions throughout the year to review progress and identify any individual learning needs. For example, following professional discussions about how to support new team members, a daily task rota checklist was implemented for the front shop and dispensary. The rotas listed daily tasks that should be completed such as, cleaning, organising retail stock on display and processing dispensing labels. This ensured continuity of work and managed skill mix arrangements within the pharmacy.

Team members undertaking accredited qualification spoken to at the time of inspection felt well supported in their roles. They received protected learning time and provided support to each other throughout their induction and further training. Protected learning time was also provided for specific learning and development. The RP attended specialist training to provide a private influenza vaccination service, and team members completed online training to provide the service. Team members asked appropriate questions when selling over-the-counter medicines. And they described how they would handle repeated requests for medicines liable to misuse, such as codeine-containing medicines, by referring to the RP or persons GP for supportive discussions.

There was a supportive culture within the pharmacy team. Team members were aware of a whistle blowing policy and explained they would feel comfortable raising concerns with the pharmacy manager or RP, should they need to. The pharmacy manager was in regular contact with the area manager and felt well supported in their role. The pharmacy was set targets by the company, team members felt these were relevant to their role and did not feel under pressure to achieve them.

Principle 3 - Premises ✔ Standards met

Summary findings

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

Inspector's evidence

The pharmacy premises were clean and provided a professional appearance. There was a well-presented retail area with chairs for people waiting that led to a healthcare counter and dispensary. The healthcare counter acted as a barrier to prevent unauthorised access to the restricted areas of the pharmacy. The dispensary was laid out in a way which allowed the pharmacist to supervise the sale of medicines and intervene in a sale where necessary. But also provided privacy to prevent distractions during the dispensing process. Medicines were stored neatly on shelves and in drawers around the perimeter of the dispensary. The dispensary was good-sized with plenty of work bench space. And it had a sink with access to hot and cold water for professional use and hand washing. There was a second area that provided a storage area for prescriptions awaiting deliveries and retail stock. And there was a separate office space. Staff facilities were hygienic with access to hot and cold water.

There was a consultation room that was clearly advertised. It was of appropriate size, clean and fit for use. Lighting and temperature were kept to an appropriate level throughout the premises.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy manages its services safely and effectively. And it makes them easily accessible to people. It sources its medicines from recognised suppliers and team members carry out the appropriate checks to ensure they keep medicines in good condition.

Inspector's evidence

The pharmacy had good physical access by means of an open entrance from the health centre. It advertised its opening hours in the main window and services available in the local community such as help to stop smoking. Team members provided large print labels to help people with visual impairments take their medicines safely. And they explained how they would communicate with people who did not use English as their first language, by accessing a translator service online. The pharmacy purchased medicines and medical devices from recognised suppliers, and they stored them appropriately. For example, liquid medicines that had been opened were clearly labelled with the date of opening and the date they should be safely destroyed. Purified water used for preparing liquid medicines was not labelled with an opened or use by date. This was discussed at the time of inspection and the RP provided assurances they would add the appropriate disposal date going forward. Team members checked the expiry dates of medicines regularly and recorded these checks on a date checking matrix. And they placed stickers on the boxes of medicines due to expire to indicate it should be used first. Records showed date checking was up to date and a sample of 20 medicines showed none out of date. The pharmacy used two well-organised fridges to store its medicines and prescriptions awaiting collection that required cold storage. And team members recorded the temperatures daily with records showing the fridges were operating within the recommended limits of between 2 and 8 degrees Celsius.

The pharmacy had safeguards in place during the dispensing process. Team members used baskets to separate people's prescriptions and prevent medicines from becoming mixed-up. And they attached coloured stickers to the outside of the bags of dispensed medicines to indicate it contained a fridge line, CD or higher-risk medicines that required further counselling. Team members were aware of the Pregnancy Prevention Programme and the risks associated with valproate-containing medicines. They supplied patient information leaflets (PILs) and patient alert cards with each supply. The pharmacy supplied valproate-containing medicines outside of its original packaging to one person. A risk assessment had been completed, but there were no records of this. The RP agreed that this should be recorded on the patient medication record (PMR). The pharmacy received Medicines Healthcare and Regulatory Agency (MHRA) patient safety alerts and product recalls via email and actioned these on receipt. Recalls were printed, and team members recorded their actions and then signed the paper copy to indicate the recall had been actioned. And they kept these for future reference.

Team members used the company's off-site pharmacy hub to assemble some people's prescriptions, which helped manage workload within the pharmacy. They entered prescription details electronically on the PMR then these were clinically checked, and data accuracy checked by the RP before the data was sent to the hub pharmacy for assembly. Completed prescriptions were returned to the pharmacy within two working days. There was a poster visible in the retail area to make people aware their prescription could be dispensed off-site. Some people received serial prescriptions under the Medicines: Care and Review service. Team members prepared prescriptions in advance of people's

expected collection dates. And they kept paper-based records of each supply and expected collection dates. This allowed them to plan their workload in advance and allowed the pharmacist to identify any issues with people not taking their medicines as they should.

The pharmacy supplied medicines in multi-dose compliance pouches to people who needed help to take their medicines. These individually labelled and sealed pouches contained people's medicines required for each dose. The roll of individual pouches were contained in a cardboard box. The pharmacy maintained a record of each person's current medicines on a master sheet. The master sheet was used to check against the prescription when entering the details on the PMR. The details were entered at the pharmacy and then the medicines were assembled in the pouches at the off-site pharmacy hub. If changes had to be made to any medicine supplied within a compliance pouch for example, if a medicine strength had to be increased or decreased, a new pack had to be assembled. And the turnaround time for this was two weeks. A team member explained how they managed changes to people's medicines that are urgent, by supplying any new medicines or changes to medicines in a multi-compartment compliance pack until changes could be made to the compliance pouches. This was communicated with people to ensure they understood the changes and they continued to take their medicines safely. Backing sheets were provided with each pack of pouches which included directions for use, warning labels for each medicine and a description of what each medicine looked like. PILs were supplied monthly so people had up-to-date information relating to their medicines. Some medicines weren't suitable to be supplied in compliance pouches, this included CDs and higher-risk medicines. The RP carried out a risk assessment on people's understanding of how to use the pouch system before they were dispensed this way. This included the risks associated with supplying some medicines outside of the pouches in boxes. Following the risk assessment, some people received medicines in multi-compartment compliance packs dispensed at the pharmacy.

The pharmacy provided private influenza vaccinations to people in the local community. The pharmacist received relevant resources and refresher training to continue to provide the service safely. And they kept records of administration on an online platform. The NHS Pharmacy first service was popular. Team members were trained to deliver the service within their competence and under the supervision of a pharmacist. The pharmacist provided medicines for common conditions such as skin infections and urinary tract infections under a Patient Group Direction (PGD). The pharmacy kept well-organised paper-based records of treatment provided or referral decisions. And they communicated these to people's GPs to ensure their medical records were kept up to date.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the appropriately maintained equipment that it needs to provide its services. And team members use the equipment properly to help protect people's confidentiality.

Inspector's evidence

The pharmacy had access to internet services to obtain up-to-date information and guidelines to support them in their roles, such as the British National Formulary (BNF), National Institute for Health and Care Excellence (NICE) guidelines and the local health board formulary.

There was a range of equipment available in the consultation room to aid the pharmacist in delivering the NHS Pharmacy First Plus service in the future. This included a blood pressure monitor, otoscope and in-ear thermometer. Electrical equipment was visibly free from wear and tear. The pharmacy had a set of clean CE-stamped measuring cylinders and tablet counters that were fit for use. Team members used an automated dispensing pump for measuring its substance misuse liquid medicines. The RP calibrated the pump each morning to ensure it measured accurate doses and it was cleaned after each use.

Prescriptions awaiting collection were stored in a retrieval area behind the healthcare counter and confidential information was not visible to people in the retail area. Computers were password protected and positioned in a way that prevented unauthorised view. There was a telephone in use that wasn't cordless, but it was stored in a private area of the pharmacy. And team members were aware of the importance of protecting people's confidentiality during telephone conversations.

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.