

# Registered pharmacy inspection report

**Pharmacy Name:** Rowlands Pharmacy, 1A Richmond Terrace,  
CARMARTHEN, Dyfed, SA31 1HE

**Pharmacy reference:** 1087486

**Type of pharmacy:** Community

**Date of inspection:** 01/08/2022

## Pharmacy context

This is a pharmacy situated next door to a medical centre. It sells a range of over-the-counter medicines and dispenses NHS and private prescriptions. Some NHS prescriptions are assembled off-site at another pharmacy owned by the company. It offers a wide range of services including emergency hormonal contraception, smoking cessation, treatment for minor ailments and a seasonal 'flu vaccination service for NHS and private patients. Substance misuse services are also available.

## 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
<b>1. Governance</b>	Standards met	N/A	N/A	N/A
<b>2. Staff</b>	Standards met	2.2	Good practice	Staff have the appropriate skills, qualifications and competence for their roles and are supported to address their learning and development needs.
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	4.1	Good practice	The pharmacy works closely with local healthcare providers to ensure its services are accessible to patients and the public.
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy has written procedures to help make sure the team works safely. Its team members record and review their mistakes so they can learn from them. And they take action to help stop mistakes from happening again. The pharmacy keeps the records it needs to by law. And it keeps people's private information safe. The pharmacy's team members understand how to recognise and report concerns about vulnerable people to help keep them safe.

### Inspector's evidence

The pharmacy had systems in place to identify and manage risk, including the recording and analysis of dispensing errors and near misses. The accuracy checking technician conducted monthly patient safety reviews, although written reports of these were not very detailed and did not always identify patterns and trends. Action had been taken to reduce risks that had been identified: for example, different strengths of sertraline tablets had been separated on dispensary shelves following a near miss and chloramphenicol ear drops had been separated from eye drops in the drug fridge by storing them in a marked clear bag. The risks associated with the influenza vaccination service had been assessed and a poster describing the process to follow in the event of needlestick injury was displayed in the dispensary.

A range of electronic standard operating procedures (SOPs) underpinned the services provided. These were regularly reviewed. A grid showing the activities that could and could not take place in the absence of the responsible pharmacist was displayed on the dispensary wall for reference. The accuracy checking technician (ACT) said that she could check most prescription items that had been clinically checked by a pharmacist apart from controlled drugs requiring safe custody, insulin, cytotoxic medicines and unlicensed specials. She demonstrated that the pharmacist initialled each prescription to show that it had been clinically checked.

The pharmacy usually received regular customer feedback from annual patient satisfaction surveys, although these had been suspended during the pandemic. The pharmacist and ACT said that verbal feedback from customers was mostly positive. A formal complaints procedure was in place and information about how to make complaints was included in the practice leaflet displayed at the pharmacy entrance and in a poster displayed behind the medicines counter.

Evidence of current professional indemnity insurance was available. All necessary records were kept and properly maintained, including responsible pharmacist (RP), private prescription, emergency supply, unlicensed specials and controlled drug (CD) records. CD running balances were checked weekly.

Staff received annual training on the information governance policy and had signed confidentiality agreements. They were aware of the need to protect confidential information, for example by being able to identify confidential waste and dispose of it appropriately. A privacy notice displayed in the retail area gave information about the ways in which personal data was used and managed by the company.

The pharmacist and ACT had undertaken formal safeguarding training. Staff, including the delivery

driver, had received in-house training. The pharmacy team had access to local guidance and contact details that were available in the dispensary. Staff had been trained to provide customers with the 'Ask for Ani' domestic abuse support service and a poster detailing the process to follow was displayed in the dispensary. Another poster advertising the service was displayed in the pharmacy's front window. The pharmacy team said that they had not yet had any requests for the service.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy has enough staff to manage its workload. Pharmacy team members complete regular training and have a good understanding about their roles and responsibilities. And they feel comfortable speaking up about any concerns they have.

### Inspector's evidence

A regular pharmacist worked on most days and was assisted in the day-to-day operation of the pharmacy by the branch manager, who was a full-time accuracy checking technician (ACT). Their support team consisted of five part-time dispensing assistants (DAs), two of whom were trainees. One of the qualified DAs was enrolled on a pharmacy technician training course. There were enough suitably qualified and skilled staff present to comfortably manage the workload during the inspection and the staffing level appeared adequate for the services provided. The trainee DAs and trainee technician worked under the supervision of the pharmacist and other qualified staff members. The ACT said that one of the trainee DAs would shortly be leaving the company and her hours would initially be covered by the other trainee DA until a replacement member of staff could be recruited.

Some targets were set for the services provided but these were managed appropriately, and the pharmacist said that they did not affect his professional judgement or compromise patient care. Staff worked well together and said that they were happy to make suggestions within the team. They felt comfortable raising concerns with the pharmacist and area manager. Posters that included details of a confidential helpline that could be used to raise a concern outside the organisation were displayed in the staff area. Staff understood that they could also contact the GPhC to raise concerns.

Members of staff working on the medicines counter were observed to use appropriate questions when selling over-the-counter medicines to patients. They referred to the pharmacist on several occasions for further advice on how to deal with transactions. A computer terminal which allowed staff members to access patient medication records and help them make decisions about sales of medicines or provision of advice was situated at the medicines counter, but no confidential information was visible from the retail area. Staff undertook online training provided by the organisation on new products, clinical topics, operational procedures and services. They had recently completed an online GDPR training module. All staff were subject to twice-yearly performance and development reviews. The pharmacist and ACT understood the revalidation process. They said that they based their portfolio entries on external training and on situations they came across in their day-to-day working environment.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is clean, tidy and secure. It has enough space to allow safe working and its layout protects people's privacy.

### Inspector's evidence

The pharmacy was clean, tidy and well-organised, with enough space to allow safe working. Some stock and dispensed prescriptions awaiting collection were being temporarily stored on the floor, but these did not pose a trip hazard. The sink had hot and cold running water and soap and cleaning materials were available. Hand sanitiser was available for staff and customer use. A plastic screen had been installed at the medicines counter to reduce the risk of viral transmission between staff and customers. A consultation room was available for private consultations and counselling and was advertised appropriately. A semi-private screened area of the medicines counter was used for prescription handout and for quiet conversations and counselling. The lighting and temperature in the pharmacy were appropriate.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy promotes the services it provides so that people know about them and can access them easily. If it can't provide a service it directs people to somewhere that can help. The pharmacy's working practices are generally safe and effective. It stores medicines appropriately and carries out some checks to help make sure that they are in good condition and suitable to supply. But members of the pharmacy team do not always know when higher-risk medicines are being handed out. So they might not always check that medicines are still suitable, or give people advice about taking them.

### Inspector's evidence

The pharmacy offered a wide range of services that were appropriately advertised. There was wheelchair access into the pharmacy and consultation room. Staff said that they would signpost people requesting services they could not provide to nearby pharmacies or other healthcare providers such as the local surgery. A range of health promotional material was on display in the retail area. The ACT had recently visited local surgeries to discuss and promote services as part of a health board funded collaborative working initiative. These visits had involved discussions around the compliance aid service and a newly introduced UTI service. The pharmacy was located in a Welsh-speaking area and most written healthcare information was provided in Welsh as well as English, including the pharmacy's practice leaflet.

The pharmacist said that their pharmacy software system allowed about 70% of their prescription items to be assembled at the company's hub pharmacy. A notice at the medicines counter advised customers that their prescriptions might be dispensed offsite. Prescriptions were clinically checked by the pharmacist and then scanned or manually entered (if scanning was not possible) into the software system, which transmitted them electronically to the hub pharmacy. The paper copy of the prescription remained at the branch and was marked with a quad stamp or hand drawn four-way grid that was initialled by all members of staff who had been involved in the dispensing process. The hub pharmacy could not assemble split packs, fridge lines, glass bottles or most controlled drugs, and these continued to be dispensed in branch, as did items that were known to be out of stock at the hub. Prescription items scanned to the hub were returned to the branch within 48 hours and were marked to show that they had been dispensed by the hub pharmacy. Bags of dispensed medicines returned from the hub pharmacy had a clear panel through which the medicines could be viewed without opening the bag. A text messaging service was available to let patients know their medicines were ready for collection. However, some people attended the pharmacy to collect their prescription before it had been returned from the hub and in these cases, their prescriptions sometimes had to be re-dispensed in branch.

Dispensing staff used a colour-coded basket system in branch to help ensure that medicines did not get mixed up during dispensing and to differentiate between different prescriptions. Dispensing labels were initialled by the dispenser and checker to provide an audit trail. Stickers were attached to bags of dispensed medicines to alert staff to the fact that a CD requiring safe custody or fridge item was outstanding. There was no strategy in place to highlight prescriptions for Schedule 3 or 4 CDs to reduce the risk that they might be supplied to patients against an invalid prescription.

The ACT said that 'See Pharmacist' stickers were used to identify prescriptions for patients prescribed high-risk medicines such as warfarin, lithium and methotrexate. However, the pharmacy team did not

routinely obtain information about blood tests and dosage changes and this information was not recorded on the patient medication record (PMR). The pharmacist said that the local surgeries monitored people who were prescribed these high-risk medicines and attached blood test forms to prescriptions when tests were due. The pharmacy team were aware of the risks of valproate use during pregnancy. The ACT said that one patient prescribed valproate who met the risk criteria was counselled appropriately and provided with patient information, which was available in the dispensary. The pharmacy carried out regular high-risk medicines audits commissioned by the local health board. These audits were used to collect data about the prescribing, supply and record-keeping associated with high-risk medicines to flag up areas where risk reduction could be improved within primary care.

Disposable compliance aids were used to supply medicines to a number of people. Most of these were assembled offsite at the company's central 'PilPouch' pharmacy. Prescriptions for 'PilPouch' compliance aids were clinically checked by the pharmacist and then scanned or manually entered (if scanning was not possible) into the software system, which transmitted them electronically to the 'PilPouch' pharmacy. Dosage times were manually entered into the system by the pharmacy team. The paper copy of the prescription remained at the branch. Compliance aid medicines were dispensed into bags labelled with the name, form, quantity and strength of each medicine, as well as the correct day and time for each dose. Only seven tablets could be included in any one pouch, so if a person had more than this quantity prescribed for a particular time of day, the medicines were put into multiple pouches and marked e.g. 1 of 2. The pouches were rolled up and stored in a box that was labelled with patient and medication details. The pouches could then be pulled out of the box in the order that the medicines should be taken throughout the day. Any extra 'bulk' medicines that could not be dispensed into a compliance aid were dispensed by the pharmacy in branch. The 'PilPouch' pharmacy would not dispense warfarin, cytotoxic medicines, bulky tablets such as calcium supplements, hygroscopic medicines such as Epilim or any medicines that required variable dosages on different days. Three people had their medicines dispensed into disposable 'tray' style compliance aids at the branch. These compliance aids were labelled with descriptions to enable identification of individual medicines and patient information leaflets were routinely supplied. However, compliance aids supplied from the 'PilPouch' pharmacy did not always include enough detail to enable identification of individual medicines, with many described simply as: 'round white tablet'. Patient information leaflets were not routinely supplied with the 'PilPouch' compliance aids. There was a risk that people supplied 'PilPouch' compliance aids might not always have all the information they need for them to make informed decisions about their own treatment. A labelled basket for each patient contained a card listing their personal and medication details, collection or delivery arrangements, details of any messages or changes and relevant documents, such as current prescriptions and repeat prescription order forms.

The pharmacy provided a wide range of services. Uptake of the common ailments service was high, as the pharmacy received large numbers of referrals from local surgeries. The discharge medicines review service also had a high uptake as most patient discharge information was sent directly to the pharmacy electronically via the Choose Pharmacy software platform. The pharmacy had recently begun to provide a new UTI service to symptomatic females between the ages of 60 and 64 and had asked the local surgery to refer any eligible patients where appropriate. A supervised consumption service was available but the pharmacy did not currently have any clients. Uptake of the emergency supply of prescribed medicines service was quite low, as the pharmacy kept the same opening hours as the local surgery which was usually able to provide people with a prescription in an emergency. The pharmacy provided a prescription collection service from three local surgeries. It also offered a prescription delivery service. Signatures were obtained for deliveries of controlled drugs. In the event of a missed delivery, the driver put a notification card through the door and brought the prescription back to the pharmacy.



Medicines were obtained from licensed wholesalers and stored appropriately. Medicines requiring cold storage were stored in three well-organised drug fridges. Maximum and minimum temperatures were recorded daily and were consistently within the required range. CDs were stored appropriately in two well-organised CD cabinets and obsolete CDs were segregated from usable stock.

Stock was subject to regular expiry date checks. These were documented, and short-dated items were highlighted with stickers. Two packs of out-of-date insulin were found in one of the drug fridges: the ACT said that this was an oversight. Date-expired medicines were disposed of appropriately, as were patient returns and waste sharps. There was no separate bin for disposing of cytotoxic waste but the ACT said that she was in the process of ordering one from the pharmacy's waste contractor and would segregate any cytotoxic waste the pharmacy received in the meantime. The pharmacy received drug alerts and recalls via its NHS email account. The pharmacist was able to describe how he would deal with medicines or medical devices that had been recalled as unfit for purpose by contacting patients where necessary, quarantining affected stock and returning it to the supplier. Drug recalls were printed, filed and signed to show that they had been actioned.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs to provide services. It makes sure these are always safe and suitable for use. The pharmacy's team members use equipment and facilities in a way that protects people's privacy.

### Inspector's evidence

The pharmacy used a range of validated measures to measure liquids. Separate measures were used for methadone. Triangles were used to count loose tablets. A separate triangle was available for use with cytotoxics. The pharmacy had a range of up-to-date reference sources. All equipment was in good working order, clean and appropriately managed. Evidence showed that it had recently been tested. Equipment and facilities were used to protect the privacy and dignity of patients and the public. For example, the pharmacy software system was protected with a password and the consultation room was used for private consultations and counselling.

### 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.