General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, Farnham Centre for Health, Hale Road, FARNHAM, Surrey, GU9 9QL

Pharmacy reference: 1088791

Type of pharmacy: Community

Date of inspection: 12/08/2020

Pharmacy context

A busy community pharmacy based within a large health centre in a residential area of Farnham. The health centre consists of a small hospital, some clinics and a few GP surgeries. The pharmacy opens five days a week. And most people who use it are patients of the health centre. The pharmacy sells a range of over-the-counter (OTC) medicines. And it dispenses people's prescriptions too. The pharmacy offers substance misuse treatments. It supplies medicines to a few care homes and provides multi-compartment compliance packs (compliance packs) to help people take their medicines. And it delivers medicines to people who can't attend its premises in person. The pharmacy offers Medicines Use Reviews (MURs) and the NHS New Medicine Service (NMS). And it also offers winter influenza (flu) vaccinations. This inspection took place during the coronavirus (COVID-19) pandemic.

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 has written procedures to help make sure its team works safely. It adequately monitors the safety of its services. It has appropriate insurance to protect people if things do go wrong. It mostly keeps all the records it needs to by law. And it asks people using its services for their views. People who work in the pharmacy can explain what they do, what they're responsible for and when they might seek help. They identify and manage risks appropriately. They review the mistakes they make and learn from them to try and stop them happening again. They understand their role in protecting vulnerable people. And they keep people's private information safe.

Inspector's evidence

A member of the pharmacy's management team had completed a risk assessment of the impact of COVID-19 on the pharmacy and its services. And, as a result, the pharmacy suspended some of its face-to-face services during the peak of the pandemic. So, its consultation room could be cordoned off and used to store some people's prescriptions in. The pharmacy offered to undertake an occupational risk assessment for each team member to help identify and protect those at increased risk in relation to COVID-19. The pharmacy had up-to-date standard operating procedures (SOPs) for the services it provided. The SOPs were held in an electronic format. Members of the pharmacy team were required to read, sign and follow the SOPs relevant to their roles. The pharmacy's head office team regularly reviewed the SOPs. The pharmacy team had received some supplemental guidance from head office to help it manage its services safely during the pandemic.

The team members responsible for making up people's prescriptions used containers to separate people's prescriptions and to help them prioritise the dispensing workload. They referred to prescriptions when labelling and picking products. They initialled each dispensing label. And assembled prescriptions were not handed out until they were checked by one of the pharmacists who also initialled the dispensing label. The pharmacy had systems to record and review dispensing errors and near misses. Members of the pharmacy team discussed and documented individual learning points when they identified a mistake. They reviewed their mistakes periodically to help spot the cause of them. And they shared any learning from these reviews with each other. So, they could try to stop the same types of mistakes happening again. The pharmacy team recently highlighted and separated the different strengths of mirtazapine after the wrong one was selected during the dispensing process.

The pharmacy displayed a notice that identified the responsible pharmacist (RP) on duty. The roles and responsibilities of the pharmacy team were described within the SOPs. Members of the pharmacy team knew what they could and couldn't do, what they were responsible for and when they might seek help. They explained that they wouldn't hand out prescriptions or sell medicines if a pharmacist wasn't present. And they would refer repeated requests for the same or similar products to one of the pharmacists. The pharmacy had a complaints procedure. It undertook a patient satisfaction survey once a year. And the results of last year's survey were available online. The pharmacy team asked people for their views. The pharmacy's practice leaflet told people how they could provide feedback about the pharmacy. The pharmacy team tried to keep people's preferred makes of prescription-medicines in stock when asked to do so.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for

the services it provided. The pharmacy's controlled drug (CD) register, its emergency supply records, its private prescription records and its RP records were appropriately maintained. And the CD register's running balance was checked regularly. The pharmacy's records for the supply of unlicensed medicinal products ('specials') didn't always include the date the product was obtained.

The pharmacy had an information governance (IG) policy. And its team members were required to complete IG training. The pharmacy had arrangements to make sure confidential waste was collected and then destroyed securely onsite. And its team tried to store prescriptions in such a way so people's names and addresses couldn't be seen by someone who shouldn't see them. The pharmacy had safeguarding procedures and contacts should its team need to tell someone about a safeguarding concern. Members of the pharmacy team were required to complete safeguarding training relevant to their roles. And they could explain what to do or who they would make aware if they had concerns about the safety of a child or a vulnerable person.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy has enough people in its team. Members of the pharmacy team keep their skills and knowledge up to date. So, they can deliver safe and effective care. They use their judgement to make decisions about what is right for the people they care for. They're comfortable about giving feedback on how to improve the pharmacy's services. They know how to raise a concern if they have one. And their professional judgement and patient safety are not affected by targets.

Inspector's evidence

The pharmacy's leadership had changed since the last inspection. The pharmacy team consisted of a full-time pharmacy manager, two full-time pharmacists, a full-time accuracy checking pharmacy technician (ACPT), two part-time pharmacy technicians, a full-time dispensing assistant, a part-time dispensing assistant and a part-time medicines counter assistant. The pharmacy relied upon its team, team members from other branches and locums to cover some absences.

The RP, a second pharmacist, the ACPT and a dispensing assistant worked during the inspection. The pharmacy was without three of its regular team members when the inspection took place. But the team members on duty worked well together and supported each other. So, prescriptions were processed efficiently, but safely, and people were served promptly. The pharmacists supervised and oversaw the supply of medicines and advice given by the pharmacy team. The pharmacy had a sales of medicines protocol which its team needed to follow. A team member described the questions they would ask when making OTC recommendations. They explained that they would refer requests for treatments for animals, babies or young children, people who were pregnant or breastfeeding, people who were old and people with long-term health conditions to a pharmacist. Team members needed to complete mandatory training during their employment. And they, including the pharmacy manager, were required to undertake accredited training relevant to their roles. They discussed their performance and development needs with their line manager when they could. They were encouraged to ask questions and familiarise themselves with new products. They were also asked to complete online training to make sure their knowledge was up to date. And they could train while they were at work when the pharmacy wasn't busy. But they could choose to train in their own time. The pharmacy held meetings and one-to-one discussions to update its team and share learning from mistakes or concerns.

The pharmacy's team members weren't under pressure to complete tasks. And they were adequately managing the pharmacy's workload at the time of the inspection. They didn't feel their professional judgement or patient safety were affected by targets. The pharmacy only provided MURs and NMS consultations when a suitably qualified pharmacist decided it was clinically appropriate to do so and when the workload allowed. Members of the pharmacy team felt comfortable about making suggestions on how to improve the pharmacy and its services. The pharmacy had a whistleblowing policy in place. And its team members knew who they should raise a concern with if they had one. The team's feedback led to a review of the staffing profile and the number of team members at the pharmacy.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy provides a suitable and secure environment for people to receive healthcare. And its premises are clean and tidy. The pharmacy has a room where people can have private conversations with members of the pharmacy team.

Inspector's evidence

The pharmacy was located within a good-sized unit within the health centre. The pharmacy's premises were air-conditioned, bright, clean, secure and adequately presented. The pharmacy had a spacious dispensary. This meant that team members could easily socially distance themselves from each other. The pharmacy had enough workbench and storage space for its current workload. It had a separate area to assemble people's multi-compartment compliance packs in. But this area was also used as the pharmacy's staffroom and stockroom.

The pharmacy had a small consultation room for the services it offered and if people needed to speak to a team member in private. People's conversations in the consultation room couldn't be overheard in the areas next to it. And it was locked when it wasn't being used. So, its contents were kept securely.

The pharmacy had a sink in its dispensary. This had a supply of hot and cold water. The pharmacy was thoroughly and regularly cleaned. Its team members were responsible for keeping its premises clean and tidy. They frequently wiped and disinfected the surfaces they and other people touched. The pharmacy had plenty of handwash and alcoholic hand sanitiser for people to use. So, its team members could wash or sanitise their hands regularly.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides services that people can access. Its working practices are generally safe and effective. It delivers prescription medicines to people's homes and keeps records to show that it has delivered the right medicine to the right person. It gets its medicines from reputable sources and it mostly stores them appropriately and securely. Members of the pharmacy team generally carry out the checks they need to. So, they can make sure the pharmacy's medicines are safe and fit for purpose. And they mostly dispose of waste medicines properly too.

Inspector's evidence

The entrance to the health centre and the pharmacy was level with the outside pavement. So, people with mobility difficulties, such as wheelchair users, could access the building and the registered pharmacy premises. The pharmacy's services were advertised in-store and were included in the pharmacy's practice leaflet. The pharmacy team knew where to signpost people to if a service wasn't provided. The pharmacy offered a 'contactless' delivery service to people who couldn't attend its premises in person. It kept an audit trail for each delivery to show that the right medicine was delivered to the right person. The pharmacy team was getting ready to deliver a winter flu vaccination service. And it had thought about how it could reduce the time people spent in the consultation room.

The pharmacy carefully managed its dispensing workflow to reduce the chances of its team making mistakes. The pharmacy team explained that most repeat prescriptions were assembled off-site at a centralised dispensary. But only when people agreed to this happening first. This had led to a reduction in the pharmacy's dispensing error rate and freed up members of the pharmacy team. So, they could spend more time talking to people about their medicines and prioritising the assembly of urgent prescriptions during peak times.

The pharmacy team made up people's compliance packs in as separate area to the main dispensary. The pharmacy largely used a disposable and tamper-evident compliance pack system. But it sometimes used another type. And this wasn't tamper-evident and wasn't always appropriately labelled. The pharmacy team checked whether a medicine was suitable to be re-packaged into a compliance pack. It generally provided a brief description of the medicines contained within each compliance pack. But it didn't always keep an audit trail of the person who had assembled the prescription. And patient information leaflets weren't always supplied. So, sometimes people didn't have all the information they needed to make sure they took their medicines safely.

The pharmacy used clear bags for dispensed CDs and refrigerated lines to allow the pharmacy team member handing over the medication and the person collecting the prescription to see what was being supplied and query any items. Prescriptions were highlighted to alert the team member when these items needed to be added or if extra counselling was required. Members of the pharmacy team were aware of the valproate pregnancy prevention programme. And they knew that people in the at-risk group who were prescribed valproate needed to be counselled on its contraindications. The pharmacy had some valproate educational materials available.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. It kept most of its medicines and medical devices in an organised fashion within their original manufacturer's packaging.

But a few loose blisters strips of prescription-medicines were found. And some medicines were found on the floor underneath the dispensary drawer system. The pharmacy team regularly checked the expiry dates of medicines. It documented when it had done these checks. And it marked products which were soon to expire. This helped the team reduce the chances of it giving people out-of-date medicines by mistake.

The pharmacy stored its stock, which needed to be refrigerated, appropriately between two and eight degrees Celsius. And it also stored its CDs, which weren't exempt from safe custody requirements, securely. The pharmacy kept a record of the destruction of patient-returned CDs. The pharmacy team was required to keep patient-returned and out-of-date CDs separate from in-date stock. But some intact patient-returned pregabalin capsules were found in one of the pharmaceutical waste bins.

Members of the pharmacy team were aware of the Falsified Medicines Directive (FMD). They could check the anti-tampering device on each medicine was intact during the dispensing process. But they weren't decommissioning stock. And they didn't know when the pharmacy would become FMD compliant. The pharmacy had procedures for handling unwanted medicines people returned to it. And its team checked if these included any CDs or prohibited items. People attempting to return prohibited items, such as spent sharps, were appropriately signposted. The pharmacy had suitable pharmaceutical waste bins for the disposal of hazardous and non-hazardous waste. But these bins, which were being used to store people's unwanted medicines in, were found in an unsecured corridor that people could access. The pharmacists gave an assurance that these bins would be promptly moved into a more secure area of the pharmacy.

The pharmacy had a process for dealing with alerts and recalls about medicines and medical devices. And its team members described the actions they would take and demonstrated what records they kept when the pharmacy received a concern about a product.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and the facilities it needs to provide its services safely. It uses its equipment to make sure people's data is kept secure. And its team makes sure the equipment it uses is kept clean.

Inspector's evidence

The pharmacy had reviewed the equipment its team needed as a result of the pandemic. It had put up two plastic screens above its counter. And markings on its floor were there to help people keep two metres apart. The pharmacy had a hand-sanitising station for people to use if they wanted to. Members of the pharmacy team wore appropriate face masks when they couldn't socially distance from people or each other. And they could also wear a face visor if they wanted to.

The pharmacy had a range of clean glass measures. It had equipment for counting loose tablets and capsules too. And its team members made sure the equipment they used to measure, or count, medicines was clean before they used it. The pharmacy team had access to up-to-date reference sources. And it could contact the superintendent pharmacist's office to ask for information and guidance. The pharmacy had two medical refrigerators to store pharmaceutical stock requiring refrigeration. And its team regularly checked and recorded the refrigerators' maximum and minimum temperatures.

The pharmacy restricted access to its computers and patient medication record system. And only authorised team members could use them when they put in their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. The pharmacy had a cordless telephone system. So, its team could have confidential conversations with people when necessary. The team members responsible for the dispensing process each had their own NHS smartcard. And they made sure it was stored securely when they weren't working.

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.