General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, Nuffield Health Centre, Welch Way, WITNEY, Oxfordshire, OX28 6JQ

Pharmacy reference: 1089109

Type of pharmacy: Community

Date of inspection: 12/11/2019

Pharmacy context

The pharmacy is located adjacent to a health centre. It dispenses NHS and private prescriptions, sells over-the-counter medicines and provides health advice. The pharmacy dispenses medicines in multi-compartment compliance aids for people who have difficulty managing their medicines. Services include prescription collection and delivery, substance misuse, needle exchange and seasonal flu vaccination. The pharmacy has healthy living status.

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's working practices are generally safe and effective. The pharmacy team makes sure that people have the information they need so that they can use their medicines safely. The pharmacy manages risk and keeps people's information safe. The pharmacy has written procedures which tell staff how to complete tasks effectively. The pharmacy mostly keeps the records it needs to so that medicines are supplied safely and legally. The pharmacy team members understand their role in protecting vulnerable people.

Inspector's evidence

Near misses were recorded and reviewed although records were not quite up to date, and staff explained that this was due to introducing the off-site dispensing service (ODS) including training. A monthly patient safety review (PSR) was compiled from analysis of near misses and one patient safety improvement point included general guidance on the dispensing process to reduce the number of near misses. There was a patient safety folder where drug alerts were filed along with near miss, PSRs and the safeguarding policy.

Workflow: baskets were used to separate medicines and prescriptions. Dispensing labels were generated from the prescription by scanning a barcode or manually entering the information into the pharmacy computer. Medicines were picked from reading the prescription. The pharmacist performed the clinical and final checks before initialling the dispensing audit trail showing which staff dispensed and checked the prescription. Interactions between medicines for the same patient were shown to the pharmacist. There was a procedure for dealing with outstanding medication. The original prescription was retained, and an owing slip was issued to the patient. For 'manufacturer cannot supply' items the patient was asked how urgently they required the medication and the doctor was contacted to arrange an alternative if necessary.

Electronically transmitted prescriptions which were suitable for ODS were downloaded and placed in a green basket for the pharmacist to clinically check. Repeat prescriptions with no changes were typically suitable to be dispensed off-site. The prescriptions were transmitted to the dispensing pharmacy and returned dispensed, checked and bagged to this pharmacy within a set number of days. Prescriptions to be dispensed locally at this pharmacy were placed in a brown basket.

Multi-compartment compliance aids were prepared for a number of patients on a rolling basis. The pharmacy managed prescription re-ordering for compliance aid items on behalf of patients. The pharmacy liaised with the prescriber when a new patient was identified who would manage taking their medicines more effectively via a compliance aid. Each patient had their own basket to contain their discharge summaries, notes and medicines during preparation of the compliance aid. There was a patient medication profile in a folder for staff to refer to. Labelling included a description to identify individual medicines and patient information leaflets (PILs) were generally supplied with each set of compliance aids. There was a discussion about ensuring PILs were always supplied so patients had the latest manufacturer's information about their medicines.

High-risk medicines such as alendronate were supplied separately from the compliance aid. Controlled drugs (CDs) were sometimes supplied in the compliance aid which was stored in the CD cabinet pending

supply. The dates of CD prescriptions were managed to ensure supply within the 28-day validity of the prescription. Levothyroxine and lansoprazole were in the process of being moved to compartments positioned to ensure being taken before other medication or food. Special instructions were highlighted on the backing sheet. Sodium valproate was usually supplied separate to the compliance aid but sometimes at the discretion of the pharmacist, sodium valproate was placed in the compliance aid.

There was a current set of standard operating procedures (SOPs) with a review date 2021 on the intranet. The locum dispenser who was also accredited to serve at the medicines counter said she would not give out a prescription or sell a P medicine if the pharmacist were not on the premises. Hydrocortisone cream would not be sold for use on the face and chloramphenicol eye drops would not be sold to treat an infant under two years old with conjunctivitis. The practice leaflet was on display and included details of how to comment or complain. The annual patient questionnaire was conducted.

To protect patients receiving services, there was professional indemnity insurance in place provided by Numark and expiring 31 Mar 2020. The responsible pharmacist notice was on display and the responsible pharmacist log was completed. Records for private prescriptions were missing some patient and prescriber details but were generally complete. Due to the proximity of the surgery emergency supplies were limited. The patient group direction (PGD) to administer flu vaccination was in date.

The CD registers were complete and the balance of CDs was audited regularly. A random check of the actual stock of two strengths of MST reconciled with the recorded balances in the CD registers. Footnotes correcting entries were signed and dated. Invoice number and name and sometimes the address of the supplier was recorded for receipt of CDs. All the headers in the methadone registers were not completed. FP10MDA prescriptions were endorsed at the time of supply. Patient returned CDs were recorded in the destruction register for patient returned CDs.

Staff had signed confidentiality agreements and the pharmacist had undertaken training in procedures regarding General Data Protection Regulation (GDPR). All staff did not yet have their own NHS cards. Ensuring staff were aware of GDPR procedures and obtaining their own NHS cards was discussed. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. The pharmacy computer was password protected and backed up regularly. Staff had undertaken safeguarding and dementia friends training and the pharmacist was accredited at level 2 in safeguarding training.

Principle 2 - Staffing ✔ Standards met

Summary findings

The pharmacy team manages the workload within the pharmacy and works well together. The team members are supported in keeping their knowledge up to date. They are comfortable about providing feedback to the pharmacist and are involved in improving the pharmacy's services.

Inspector's evidence

Staff comprised: one full-time regular pharmacist, three part-time trainee pharmacy assistants, one part-time NVQ2 dispenser and two locum dispensers. Pharmacy assistants were trained to dispense and as medicines counter assistants. There was a part-time delivery driver shared with another branch of the pharmacy. The pharmacist had been a relief pharmacist at the branch since May and had recently taken up the position of pharmacist manager.

Staff had their own profile on Moodle, the online training facility although some new staff did not yet have their own profile. The pharmacist did not yet have access to all staff profiles to monitor progress with completing regular training. Topics included eye health, GDPR and POM to P medicines. Staff had undertaken training in the new ODS. Two staff were enrolled on healthy living champion training. If other activities permitted, staff had one hour per week protected learning time.

The pharmacist had recently completed flu vaccination service training, so flu vaccination was to be offered as a service around the time of the visit. The pharmacist also explained that Community Pharmacist Consultation Service (CPCS) training was being undertaken. CPCS service replaced NUMSAS and patients were referred to a pharmacy for treatment for a minor illness or an emergency supply of medicine. Training had also been undertaken in safeguarding and sepsis for Pharmacy Quality Scheme (PQS) and 'Lookalike soundalike' (LASA) and risk management training were due to be undertaken.

There were planned annual appraisals to monitor staff performance. The pharmacist and staff had recently organised a meeting to plan dealing with pharmacy tasks including EPS, allocated time to change monthly promotion, shredding confidential waste paper straightaway, labelling and ordering medicines stock and a communications book to be used in the dispensary. There was a whistleblowing policy. Staff said targets and incentives were set but not in a way that affected patient safety.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy’s premises are clean and suitable for the provision of its services. The consultation room is used regularly so people can speak to the pharmacist in private. The pharmacy prevents people accessing the premises when it is closed.

Inspector's evidence

The premises were generally clean, tidy and presented a professional image. The dispensary benches and sink were clean. The consultation room was located to one side of the medicines counter and locked when not in use. There were health related leaflets on display and lockable cabinets to secure documents and equipment. There was a screened area where patients could have a quiet word with the pharmacist. The hatch to deposit used needle exchange packs in the sharps bin and collect new packs was within the screened area. Patient privacy was protected. There was sufficient lighting and air conditioning.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy provides its services safely and effectively. People with different needs can access the pharmacy services. It gets its medicines from reputable sources to protect people from harm. The pharmacy team know what to do if any medicines or devices need to be returned to the suppliers. The pharmacy team makes sure that medicines are stored securely at the correct temperature so that medicines supplied are safe to use. The pharmacy's team members are helpful and give advice to people about where they can get other support. They also make sure that people have all the information they need so that they can use their medicines safely.

Inspector's evidence

Staff went to the entrance to assist people with mobility issues and there was a hearing loop to assist hearing impaired people. Large font labels could be printed to assist visually impaired people. Staff could converse in Arabic and Polish to assist patients whose first language was not English. Patients were signposted to other local services including the drug and alcohol service and family planning.

The pharmacist explained the procedure for supply of sodium valproate to people in the at-risk group. Information on the pregnancy prevention programme (PPP) would be explained. The intervention was recorded on the PMR. The pharmacist explained the procedure for supply of isotretinoin to people in the at-risk group. Isotretinoin should be prescribed by a specialist and supplied within seven days following a negative pregnancy test. The prescriber would be contacted regarding prescriptions for more than 30 days' supply of a CD. CD prescriptions were highlighted to ensure supply within the 28-day validity period. Interventions were recorded on the PMR.

Prescriptions for high-risk medicines such as CDs and fridge items were highlighted with stickers. Staff checked ETP on the pharmacy computer for CD prescriptions due to expire. The pharmacist said when supplying warfarin, people were asked for their record of INR along with blood test due dates. INR was recorded on the PMR. Advice was given about side effects of bruising and bleeding. Advice was given about over-the-counter medicines and diet containing green vegetables and cranberries which could affect INR. People taking methotrexate were reminded to have regular blood tests and about the weekly dose, when to take folic acid. People were advised to seek medical advice if they developed an unexplained fever.

Audits had been conducted regarding use of inhalers in the treatment of asthma. The audit monitored children treated for asthma but who did not have a spacer or asthma treatment plan. The sodium valproate audit was due to be conducted again. There was an audit of dates of last foot checks and retinopathy screening for diabetic people.

There was a display of 'Rowlands recommends' advice leaflets on conditions including acne, dandruff, sexual health and pain. There was a poster telling people about the inhaler service and a larger poster on the consultation room door about other services such as blood pressure monitoring. Television screens displayed advice on asthma and Viagra Connect. 'Share good times not flu' leaflets were displayed raising public awareness of childhood flu immunisation.

Medicines and medical devices were delivered outside the pharmacy by a trained delivery person

shared with another branch of the pharmacy. Prescriptions requiring delivery were placed in a tote box. A drop sheet was prepared by attaching a bag label for each patient. A second bag label was attached to a separate, single page of a delivery record book and patient signatures were obtained indicating safe delivery. The number of deliveries per day was limited to manage workload.

Medicines and medical devices were obtained from Alliance, AAH and Phoenix. Floor areas were clear, and stock was neatly stored on the dispensary shelves. Stock was date checked and recorded. No date-expired medicines were found in a random check. Liquid medicines were marked with the date of opening and medicines were mostly stored in original manufacturer's packaging. There was a discussion about ensuring medicines were stored in appropriately labelled containers, so the pharmacy could identify stock affected by drug alerts or date checks. Cold chain items were stored in two medical fridges. Uncollected prescriptions from six weeks ago were cleared from retrieval every week. Waste medicines were stored separate from other stock. Falsified medicines directive (FMD) hardware and software was operational at the time of the visit. Drug alerts were received, printed, actioned and filed.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy's equipment keeps people's private information safe.

Inspector's evidence

There were current reference sources. The dispensary sink was clean and there were clean standard glass measures to measure liquids including separate marked measures for methadone. The medical fridges were in good working order. Minimum and maximum temperatures were monitored daily and found to be within range two to eight Celsius. The CD cabinets were fixed with bolts. The blood pressure monitor was marked with the date recalibration was due.

The sharps bin for needle exchange service was under the medicines counter in line with the hatch where used needle exchange packs were deposited. There was a sharps bin for disposal of flu vaccination sharps. An adrenalin injection device for use in the event of anaphylaxis was in-date and having a spare adrenaline injection devices in case the device failed during an emergency was discussed. There was a shredder to deal with confidential waste paper and a cordless phone to enable a private conversation. The pharmacy computer was password protected and backed up regularly.

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.