

# Registered pharmacy inspection report

**Pharmacy Name:** Rowlands Pharmacy, 5 George Street, Wombwell, BARNSELY, South Yorkshire, S73 0DD

**Pharmacy reference:** 1089949

**Type of pharmacy:** Community

**Date of inspection:** 17/04/2019

## Pharmacy context

This is a community pharmacy adjacent to a GP health centre in the Wombell area of Barnsley, South Yorkshire. The pharmacy sells over-the-counter medicines and dispenses NHS prescriptions. It also dispenses private prescriptions. The pharmacy team offers advice to people about minor illnesses and long-term conditions. And it offers services including medicines use reviews (MURs), flu vaccinations and the NHS New Medicines Service (NMS). It also supplies medicines in multi-compartmental compliance packs to people living in their own homes.

## 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	N/A	N/A	N/A
<b>3. Premises</b>	Standards met	N/A	N/A	N/A
<b>4. Services, including medicines management</b>	Standards met	N/A	N/A	N/A
<b>5. Equipment and facilities</b>	Standards met	N/A	N/A	N/A

## Principle 1 - Governance ✓ Standards met

### Summary findings

The pharmacy has suitable processes and written procedures for the team to protect the welfare of people who access its services. And it keeps the records it must by law. The pharmacy advertises how people can provide feedback and raise concerns about its services. But the pharmacy team members cannot demonstrate how they use the feedback to improve the pharmacy's services. The pharmacy team members keep people's private information safe. And they know what to do to protect the welfare of children and vulnerable people. The pharmacy's team members record and discuss errors that happen with dispensing. They sometimes use this information to learn and make changes to help prevent similar mistakes happening again. But, they don't always record all the details of why errors happen. So, they may miss out on learning opportunities.

### Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) available for reference in the pharmacy. But these had been due for review in Jan 2019. It held the recently reviewed SOPs electronically. And the pharmacy team members had read them. They each had a work booklet which provided evidence of the SOPs they had read. It may be confusing to the team having two sets of SOPs available to refer to. The SOPs included details of which team member role could complete which tasks.

The pharmacy had a process in place to report near misses. The pharmacist typically spotted the error and then let the team member know that they had made an error. The team member identified what had happened to help them reflect on why it occurred and to help with their learning. The team members were encouraged to record details of their near misses on to a log. But the pharmacist usually made the record. The records included the time and date of the near miss. But the team didn't regularly record the causes of the errors. The team was required to analyse the near misses each month. This was to help them spot any trends or patterns. But the team had not done this for several months. The team said that they discussed near misses openly if they were seen to be common. For example, they noticed that they sometimes mixed up sildenafil and sertraline. To stop this happening, they segregated them on the dispensary shelves. The pharmacy recorded details of dispensing incidents electronically. The team printed off the record for future reference. And the mistakes were reported to the superintendent pharmacist. The team had not had any incidents over the last few months.

The pharmacy had leaflets in the retail area which contained information on how to make a complaint. The pharmacy organised an annual survey to establish what people thought about the service they received. The results of a survey from 2017 was displayed on a wall in the retail area. The team did not know the results of the latest survey. And they could not give an example of how they had improved the service they offered following public feedback.

Appropriate professional indemnity insurance facilities were in place. The responsible pharmacist notice displayed the correct details of the responsible pharmacist on duty. Entries in the responsible pharmacist record complied with legal requirements.

A sample of controlled drug (CD) registers were looked at and were found to be in order including completed headers, and entries were in chronological order. Running balances were maintained. And

they were checked every week. A random CD item was balance checked and verified with the running balance in the register (MST Continus 30mg tablets X 150). A CD destruction register for patient returned medicines was correctly completed. The pharmacy corrected retained records of private prescription and emergency supplies. The pharmacy retained completed certificate of conformities following the supply of an unlicensed medicine.

The team held records containing personal identifiable information in staff only areas of the pharmacy. Confidential waste was placed into a separate bin to avoid a mix up with general waste. The confidential waste was destroyed periodically. Prescription medication waiting to be collected was stored in a way that prevented people's confidential information being seen by members of the public. And computer screens were positioned to ensure confidential information wasn't on view to the public. The computers were password protected.

The responsible pharmacist, a pharmacy technician and an accuracy checking technician (ACT) had completed training via the Centre for Pharmacy Postgraduate Education on safeguarding the welfare of vulnerable people. The other team members completed training each year via an internal online training module. The team had policy available to them which guided them on how to manage and report a concern. The team had access to a document which outlined the signs of child exploitation. All team members had read and signed both documents. The team members gave several examples of symptoms that would raise their concerns. And they said they would discuss their concerns with the pharmacist on duty, at the earliest opportunity.

## Principle 2 - Staffing ✓ Standards met

### Summary findings

The pharmacy team members have the right qualifications and skills for their roles and the services they provide. The pharmacy provides access to ongoing learning. And the team members complete regular training, mainly in their own time to keep their knowledge up-to-date. But they don't have the opportunity to discuss or reflect on their performance or individual training needs. So, they may miss out on opportunities to develop their skills.

### Inspector's evidence

A locum pharmacist was on duty at the time of the inspection. And supported by a part-time ACT, two full-time and one part-time qualified dispensers and a full-time dispenser who was currently in training. A part-time ACT and a part time dispenser were not present at the time of the inspection. The pharmacy had recently employed a trainee dispenser who was due to begin work in May 2019. The team members said they were looking forward to the new team members starting as they felt they had recently struggled with the dispensing workload. The pharmacy had not had a manager or a regular pharmacist since November 2018. The pharmacy had been using a pool of locum pharmacists. And it was often a different locum each day. The team said that they felt some pressure to manage their work without a manager or a regular pharmacist. But they had always looked to support each other. This included working overtime during busy periods.

The pharmacist on duty supervised the team members. And they involved the pharmacist in offering advice to people who were purchasing over-the-counter products for various minor ailments. They carried out tasks and managed their workload in a competent manner. And they asked appropriate questions when selling medicines that could only be sold under the supervision of a pharmacist. The team members accurately described the tasks that they could and could not perform in the pharmacist's absence.

The pharmacy provided access to training for the team, through an online training portal. The portal consisted of a library of compulsory modules and assessments. These covered topics from all aspects of the pharmacy. This included medical conditions, health and safety, law and ethics and over-the-counter products. The team members could voluntarily choose a module to work through if they felt their knowledge in an area of their work needed improvement. The team members had recently completed a mandatory module based on skin care. A team member showed a sample of their training record. It confirmed that they were completing training on a regular basis. The team members said that they almost never had the time to complete training during their working day. And so, they completed most of their training at home. The team said that this helped them learn without any distractions.

The pharmacy was scheduled to organise monthly team meetings. The team members were required to talk about specific topics such as dispensing accuracy, any concerns they may have, give feedback and discuss how they could improve their services. But the team said that the meetings rarely took place since the previous manager had left the business as they couldn't plan the time in due to workload. The team members said that instead, they discussed common dispensing mistakes amongst each other, immediately after they occurred. They said that this helped them ensure that they all learnt from each other's mistakes. But there was no system in place to share the learning with team members who were

not present at the time.

The team members were also scheduled to receive an annual performance review. The reviews were designed to allow the team members to give feedback on how to improve the pharmacy's service, discuss various aspects of their performance, including what they had done well, what could be improved. They also discussed any learning needs they had identified. But most of the team members were overdue their appraisal because of the lack of a manager or regular pharmacist. The team said that they were somewhat frustrated by the lack of managerial structure. And this meant that they found it more difficult to raise any concerns they had. The team described how they would raise professional concerns. And they explained that any significant concerns would be discussed with the area manager or the superintendent pharmacist. A whistleblowing policy was in place. So, the team members could raise a concern anonymously.

The pharmacy asked the team to meet targets in areas such as prescription volume, over-the-counter sales and the number of medicine use review (MUR) and New Medicines Service (NMS) consultations completed. The pharmacy team said they did not feel under pressure to deliver targets.

## Principle 3 - Premises ✓ Standards met

### Summary findings

The pharmacy is secure and is well maintained. The pharmacy has the facility to allow people to have private conversations.

### Inspector's evidence

The dispensary area was large and open plan. The pharmacy was professional in its appearance. And was clean, hygienic and well maintained. Floor spaces were clear with no trip hazards evident. There was a clean, well maintained sink in the dispensary used for medicines preparation and staff use. There was a WC which provided a sink with hot and cold running water and other facilities for hand washing. The area was free of clutter.

The pharmacy had a sound proofed consultation room which contained adequate seating facilities. The room was smart and professional in appearance. But it was not signposted. Temperature was comfortable throughout inspection. Lighting was bright throughout the premises.

## Principle 4 - Services ✓ Standards met

### Summary findings

The pharmacy provides a range of services to help people meet their health needs. It stores, sources and manages medicines safely. The pharmacy generally identifies and manages risks associated with its services such as dispensing. And the team members generally give advice to people taking high-risk medicines. But they don't always supply written information to these people to take away. So, they may not receive all the information they need to help them take their medicines safely.

### Inspector's evidence

The pharmacy could be accessed from a public car park through an automatic door. The services on offer, and opening times were advertised in the front window. Seating was provided for people waiting for prescriptions. Large print labels were provided on request. The team members had access to the internet. Which they used to signpost people requiring a service that the team did not offer. A wide range of healthcare related leaflets were available for people to select and take away. A television screen was positioned for people to see in the retail area. The screen promoted various healthcare related products. A Calpol promotion was seen.

The team members used stickers attached to prescriptions to alert them to complete various actions or provide advice when handing out people's medication. For example to highlight interactions between medicines or the presence of a fridge or a controlled drug that needed to be added to the bag. An audit trail was in place for dispensed medication using dispensed by and checked by signatures on labels. The dispensary had a manageable workflow with separate areas for the team members to undertake the dispensing and checking parts of the dispensing process. Baskets were used to keep prescriptions and medicines together. This helped prevent people's prescriptions from getting mixed up. The team used different coloured baskets to indicate urgency and which prescriptions required delivery.

The pharmacy had a procedure in place to highlight dispensed controlled drugs, that did not require safe custody. This helped the team ensure that the medicine was not supplied to people after the prescription had expired. The pharmacy used clear bags to store dispensed fridge and CD items. Which allowed the team to do a further check of the item against the prescription with the patient during the hand out process.

The team members said that they occasionally identified people who were prescribed high-risk medication such as warfarin. And they were given additional verbal counselling by the pharmacist, if the pharmacist felt there was a need to do so. But details of these conversations were not recorded on people's medication records. So, the pharmacy could not demonstrate how often these checks took place. INR levels were not always assessed. The team were aware of the pregnancy prevention programme for people who were prescribed valproate. The team said that they were aware of the risks. And they demonstrated the advice they would give people in a hypothetical situation. The team did not have access to any literature about the programme that they could provide to people.

People could request for their medicines to be dispensed in multi-compartmental compliance packs. And these were supplied to people on either a weekly or monthly basis. The team members were responsible for ordering the person's prescription. And they did this around a week in advance, so they



had ample time to manage any queries. And then the prescription was cross-referenced with a master sheet to ensure it was accurate. The team queried any discrepancies with the person's prescriber. The team always checked with people if they required any items that they didn't supply in the packs before ordering. The team recorded details of any changes, such as dosage increases/decreases, on the master sheets. The team supplied the packs with backing sheets which contained dispensing labels. And it provided descriptions of the medicines in the pack on the backing sheet to help people visually identify the medicines. The team supplied patient information leaflets with the packs each month.

The pharmacy kept records of the delivery of medicines from the pharmacy to people. The records included a signature of receipt. A separate delivery sheet was used for controlled drugs. A note was posted to people when a delivery could not be completed. The note advised them to contact the pharmacy.

Owing slips were given to people when the pharmacy could not supply the full quantity prescribed. One slip was given to the person and one kept with the original prescription for reference when dispensing and checking the remaining quantity. The team attempted to complete the dispensing of the owing medication the next day.

The pharmacy stored pharmacy (P) medicines behind the retail counter. The storage arrangement prevented people from self-selecting these medicines.

The team checked the expiry dates of the stock every three months. And the team kept records of the activity. The team used stickers to highlight medicines that were expiring in the next six months. The team recorded the date the pack was opened on liquid medicines. This allowed them to identify medicines that had a short-shelf life once they had been opened. And check that they were fit for purpose and safe to supply to people.

The team were not currently scanning products or undertaking manual checks of tamper evident seals on packs, as required under the Falsified Medicines Directive (FMD). No software, scanners or a SOP were available to assist the team to comply with the directive. The team had not received any training on how to follow the directive.

Fridge temperatures were recorded daily using digital thermometers. A sample of the records were looked at. And the temperatures were always within the correct range.

The pharmacy obtained medicines from several reputable sources. Drug alerts were received via email to the pharmacy and actioned immediately. The team said that alerts were printed and stored in a folder. But the team could not locate it.

## Principle 5 - Equipment and facilities ✓ Standards met

### Summary findings

The equipment the pharmacy uses in the delivery of its services is clean, safe and protects people's confidentiality.

### Inspector's evidence

References sources were in place. And the team had access to the internet as an additional resource. The resources included hard copies of the current issues of the British National Formulary (BNF) and the BNF for Children.

The pharmacy used a range of CE quality marked measuring cylinders. Tweezers and rollers were available to assist in the dispensing of multi-compartmental compliance packs. Medical fridges used to store medicines were of appropriate sizes. Medicines were organised in an orderly manner. A blood pressure monitor was used. It was calibrated each year.

Electrical equipment was safety tested each year. The next test was scheduled for January 2020. The computers were password protected and access to people's records were restricted by the NHS smart card system. Cordless phones assisted in undertaking confidential 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.