General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: Rowlands Pharmacy, Chapelfield Medical Centre, Mayflower Way, Wombwell, BARNSLEY, South Yorkshire, S73 0AJ

Pharmacy reference: 1091432

Type of pharmacy: Community

Date of inspection: 26/02/2020

Pharmacy context

The pharmacy is in a medical centre in Wombwell. Pharmacy team members dispense NHS prescriptions and sell a range of over-the-counter medicines. They offer services including medicines use reviews (MURs) and the NHS New Medicines Service (NMS). They supply medicines to people in multi-compartment compliance packs. And deliver medicines to people's homes.

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 has procedures to identify and manage risks to its services. And pharmacy team members follow them to complete the required tasks safely and effectively. Pharmacy team members know how to safeguard the welfare of children and vulnerable adults. They protect people's confidential information. And they respond to feedback and make improvements where possible. Pharmacy team members discuss mistakes that happen. And they record most information about each mistake. They use this information to learn and reduce the risk of further errors.

Inspector's evidence

The pharmacy had a set of standard operating procedures (SOPs) in place. These were available electronically. And the superintendent pharmacist's (SI's) office reviewed them regularly every two years on a rolling cycle. Pharmacy team members read and signed the SOPs in March and April 2019. And, they confirmed their understanding by signing a paper record kept in the pharmacy. Pharmacy team members were required to answer questions after reading certain key SOPs to confirm their understanding. One example was the procedure for information governance. They were required to answer a certain number of questions correctly to pass the assessment. If they did not reach the pass mark, they discussed their responses with the pharmacist and colleagues and revisited the training material. Then they reattempted the assessment. The pharmacy defined the roles of the pharmacy team members in a role matrix kept with the SOP sign-off records. The matrix defined which procedures were relevant to each level of staff qualification. Pharmacy team members said they also assigned tasks by having regular discussions throughout the day. The pharmacy had a daily and weekly checklist of tasks that needed to be completed. These included making sure the responsible pharmacist (RP) log had been completed, near-miss errors were being recorded and medicines expiry dates were being checked. Pharmacy team members recorded they had completed these checks in examples of records available.

The pharmacist highlighted near miss errors made by the pharmacy team when dispensing. Pharmacy team members recorded their own mistakes. Their records sometimes included information about the causes of their mistakes. They discussed the errors made. And they discussed causes and the changes they could make to prevent a recurrence. Pharmacy team members explained that the pharmacist analysed the data collected about mistakes every month. But they could not find any records of analysis during the inspection in the regular pharmacist's absence. Pharmacy team members discussed the patterns identified. They also reflected on the changes they had made to establish if they had made the intended improvements. One example was a pattern they had identified with errors involving different formulations of ramipril. Their first step had been to attach stickers to the shelf where ramipril was stored to highlight the risks when dispensing. When they analysed the data of their errors over the following months, they discovered there had been no significant reduction in errors with ramipril. So, in addition to the shelf stickers, they started highlighting the formulation of ramipril on prescriptions to further highlight the risks of errors. In the following month's analysis, they found a marked reduction in the number of errors involving ramipril. And they explained that the improvement had generally been sustained since. Pharmacy team members had highlighted other look-alike and sound-alike (LASA) medicines involved in errors, either in the pharmacy or elsewhere in the company. Some examples were highlighting and separating zolpidem and zolmitriptan and omeprazole and olanzapine. The pharmacy had a clear process for dealing with dispensing errors that had been given out to people. It

recorded incidents using an electronic system that submitted the report to the superintendent pharmacist's office. The sample of the records seen provided little detail about why the errors had happened. And, little information about any changes made by pharmacy team members in response. This was discussed. And it was clear that causes were identified after pharmacy team members discussed errors. And they made changes to prevent mistakes happing again.

The pharmacy had a procedure to deal with complaints handling and reporting. It had a poster available for customers in the retail area which clearly explained the company's complaints procedure. It collected feedback from people by using questionnaires. And by verbal feedback from people. One example was feedback from the adjoining GP practice about the pharmacist having a lunch break in the late afternoon. This coincided with the GP's afternoon surgery session. And people had complained to the GP practice about having to wait too long for their prescriptions. The issue was discussed. And the pharmacist changed their lunch break, so they were unavailable for half an hour between 11am and 1pm. This coincided with the GPs carrying out home visits. And a quieter period in the surgery and pharmacy.

The pharmacy had up-to-date professional indemnity insurance in place. The pharmacy kept controlled drug (CD) registers complete and in order. It kept running balances in all registers. And these were audited against the physical stock quantity weekly, including methadone. The pharmacy kept and maintained a register of CDs returned by people for destruction. And it was complete and up to date. The pharmacy maintained a responsible pharmacist record electronically. And it was complete and up to date. The pharmacist displayed their responsible pharmacist notice to people. The pharmacy team members monitored and recorded fridge temperatures daily. They kept private prescription records in a paper register, which was complete and in order. And, they recorded emergency supplies of medicines in the private prescription register. They recorded any unlicensed medicines supplied, which included the necessary information in the samples seen.

The pharmacy kept sensitive information and materials in restricted areas. It shredded confidential waste. Pharmacy team members had been trained to protect privacy and confidentiality. They completed training every year via the company's online training platform, called 'Moodle'. Pharmacy team members were clear about how important it was to protect confidentiality. And there was a procedure in place detailing requirements under the General Data Protection Regulations (GDPR).

Pharmacy team members were asked about safeguarding. A dispenser gave some examples of symptoms that would raise their concerns in both children and vulnerable adults. And, they explained how they would refer to the pharmacist. The pharmacist said they would assess the concern. And, would refer to local safeguarding teams or the SI's office for advice if necessary. The pharmacy had contact details available for the local safeguarding service. And pharmacy team members displayed these and some guidance flowcharts in the area where prescriptions were prepared. Pharmacy team members trained every two years. The company provided training via their Moodle online platform for all pharmacy team members. And registered pharmacists completed additional training every two years.

Principle 2 - Staffing ✔ Standards met

Summary findings

Pharmacy team members are suitably qualified and have the right skills for their roles and the services they provide. They feel comfortable discussing their ideas and concerns about the pharmacy's ways of working. And they work well together to improve ways of working. They undertake training regularly. And they discuss any training needs with the pharmacist and other team members. They support each other to reach their goals.

Inspector's evidence

At the time of the inspection, the pharmacy team members present were two locum pharmacists, A pharmacy technician, three dispensers, two trainee dispenser and a delivery driver. Pharmacy team members explained their pharmacist manager had recently left. And they were in the process of appointing a non-pharmacist manager. In the meantime, pharmacy team members were sharing the management responsibilities. Pharmacy team members completed online training modules at least every two to three months via the company's Moodle training system. And, they explained the topics were often related to seasonal health conditions, such as hay fever and flu. The pharmacy had a performance review process. But some pharmacy team members said they had not received an appraisal for several years. They explained they would raise any learning needs with the pharmacist and colleagues informally. And they would teach them or signpost them to the most appropriate resources.

A pharmacy team member explained she would raise professional concerns with the reginal support pharmacist or head office, in the absence of a pharmacy manager. She felt comfortable raising a concern. And confident that her concerns would be considered, and changes would be made where they were needed. The pharmacy had a whistleblowing policy. And the procedure was displayed in the staff area. Pharmacy team members communicated with an open working dialogue during the inspection. They explained some changes they had made after identifying and discussing area for improvement. They had changed the way prescriptions returned from the pharmacy's dispensing hub were managed. Previously, when the totes arrived containing the prescription bags, their approach to sorting and booking in the bags had been disorganised. And this meant it took most of the day to process the prescriptions and place them in the retrieval area, making them difficult to find when people arrived to collect their medicines. They had discussed the issues. And changed the system so different pharmacy team members had responsibilities for different parts of the process. For example, one person scanned and book the prescriptions in to the pharmacy. Another person processed any items that needed to be dispensed locally. And a final person placed the bags and prescriptions in the retrieval area ready for collection. Pharmacy team members explained their new way of working had greatly improved the system and meant prescriptions were found quickly and easily when people came to collect them. And they were able to manage the pharmacy's other workload at the same time.

The pharmacy owners asked the team to achieve targets in several areas of the business. These included the number of medicines use review and new medicines service consultations being completed. And the number of prescriptions being dispensed. Pharmacy team members explained they took a team approach to achieving their targets. For example, they all took responsibility for identifying people to the pharmacist who would benefit from an MUR or NMS consultation while dispensing. They were supported to reach their targets by the regional support pharmacist.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean and properly maintained. It provides a suitable space for the services provided. And, it has a room where people can speak to pharmacy team members privately.

Inspector's evidence

The pharmacy was clean and well maintained. All areas of the pharmacy were tidy and well organised. And the floors and passage ways were free from clutter and obstruction. There was a safe and effective workflow in operation. And clearly defined dispensing and checking areas. Pharmacy team members kept equipment and stock on shelves throughout the premises. The pharmacy had a private consultation room available. Pharmacy team members used the room to have private conversations with people. The room was signposted by a sign on the door.

There was a clean, well maintained sink in the dispensary used for medicines preparation. There was a toilet, which provided a sink with hot and cold running water and other facilities for hand washing. Heat and light in the pharmacy was maintained to acceptable levels. The overall appearance of the premises was professional, including the exterior which portrayed a professional healthcare setting. The professional areas of the premises were well defined by the layout and well signposted from the retail area.

Principle 4 - Services ✔ Standards met

Summary findings

The pharmacy's services are easily accessible to people, including people using wheelchairs. And the pharmacy provides its services safely and effectively. The pharmacy advertises its services clearly. And pharmacy team members promote health and wellbeing to the people who use the pharmacy. They dispense medicines into devices to help people remember to take them correctly. And they manage this service well. They take steps to identify people taking high-risk medicines. And they give these people appropriate advice and support to help them take their medicines safely. They store, source and manage medicines safely.

Inspector's evidence

The pharmacy had level access from the street and the surgery car park. It advertised services in various areas throughout the retail area. Pharmacy team members explained they could provide large-print labels to help people with a visual impairment. And they would use written communication to help someone with a hearing impairment. The pharmacy was an accredited Healthy Living Pharmacy (HLP). Pharmacy team members ran a health promotion campaign about a different topic every month. They displayed information about the current topic in a "Healthy Living Zone" in the pharmacy's retail area for people to see. They used a variety of different materials, such as posters, wall displays and leaflets. A pharmacy team member explained the topics chosen were aligned with national health promotions campaigns. Recent examples were children's oral health, Stoptober, and Dry January. Pharmacy team members kept records and photographs of each campaign they ran. Pharmacy team members completed training on each topic before the campaign was launched. The training was provided in different forms. Sometimes pharmacy team members read a briefing pack. Other times they completed online training. They explained this helped them to talk to people about the subjects. And helped them to provide people with the right advice.

The pharmacy sent a proportion of its prescriptions to the company's off-site dispensing hub, where most medicines were picked and assembled by a dispensing robot. Pharmacy team members explained that prescriptions sent to the hub were usually for regular repeat medication. The pharmacy computer system determined which prescriptions could be sent to the hub. And, whether the whole prescription or only part could be dispensed at the hub. Prescriptions were then placed in a queue and a dispenser inputted the information from the prescription for each one. The pharmacist clinically checked prescriptions that were to be sent to the hub. And they signed each prescription token to confirm they had performed the clinical check. The data from the prescription added by the dispenser was checked for accuracy by the pharmacist and sent to the hub, with an electronic copy of the prescriptions. The prescriptions were picked and labelled at the hub pharmacy using automation. Pharmacy team members filed the prescriptions to wait for the medicines to be returned from the hub two days later. Prescriptions dispensed at the hub were returned to the pharmacy in dedicated totes. Pharmacy team members scanned all returned bags. The computer system recorded how many items had been dispensed at the hub. Pharmacy team members checked each sealed bag, using a transparent window in the bag, to confirm it contained the correct number of items. They dispensed any outstanding items not dispensed at the hub and attached the bags together. They then placed the bags in the retrieval area ready for collection or delivery. Pharmacy team members explained they were continuing to communicate with people about the timescales involved from ordering their prescriptions with their GP to them being ready to collect at the pharmacy.

Pharmacy team members signed the dispensed by and checked by boxes on dispensing labels. This was to maintain an audit trail of staff involved in the dispensing process. They used dispensing baskets throughout the dispensing process to help prevent prescriptions being mixed up. They routinely printed warnings generated by the computer system during labelling to pass to the pharmacist. And the pharmacist considered the warnings during their final check of the prescriptions. Pharmacy team members also made the pharmacist aware if a person was receiving a medicine for the first time, to help them provide people with the necessary information. The pharmacist counselled people receiving prescriptions for valproate if appropriate. He described how he would check if the person was aware of the risks if they became pregnant while taking the medicine. He also checked if they were on a pregnancy prevention programme. And would refer people back to their GP if he had any issues or concerns. The pharmacy had a stock of printed information material to give to people to help them manage the risks. The pharmacy supplied medicines in multi-compartment compliance packs when requested. It attached backing sheets to the packs, so people had written instructions of how to take their medicines. Pharmacy team members included descriptions of what the medicines looked like, so they could be identified in the packs. They picked the required medicines from the shelves before they generated the backing sheets. This meant they had the opportunity to make sure the medicines picked were described accurately on the backing sheet. Pharmacy team members provided people with patient information leaflets about their medicines each month. They documented any changes to medicines provided in packs on the patient's electronic medication record. And in a communications diary. Each time a medicine was changed, pharmacy team members generated a new master record sheet. This meant they kept the sheets clear and accurate. The pharmacy delivered medicines to people's homes. It recorded the deliveries made and asked people to sign for their deliveries. The delivery driver left a card through the letterbox if someone was not at home when they delivered. The card asked people to contact the pharmacy. The team highlighted bags containing controlled drugs (CDs) with a sticker on the bag and on the driver's delivery sheet.

The pharmacy obtained medicines from three licensed wholesalers. It stored medicines tidily on shelves. And all stock was kept in restricted areas of the premises where necessary. Pharmacy team members were aware of the new requirements under the Falsified Medicines Directive (FMD). They had received training and procedures were in place to incorporate the necessary checks in to the dispensing process. Each compliant medicine pack was scanned during dispensing to check for falsified medicines. And pharmacy team members scanned an aggregated barcode on each bag as they were collected by people or sent out for delivery to decommission the medicines from the supply chain. The pharmacy had adequate disposal facilities available for unwanted medicines, including CDs. Pharmacy team members kept the CD cabinets tidy and well organised. And out-of-date and patient returned CDs were segregated. The inspector checked the physical stock against the register running balance for three products. And they were found to be correct.

Pharmacy team members checked medicine expiry dates every 12 weeks. And records were seen. They highlighted any short-dated items on the pack up to six months in advance of its expiry. And they removed any medicines that expired before the next scheduled date-check. The pharmacy responded to drug alerts and recalls. And, any affected stock found was quarantined for destruction or return to the wholesaler. It recorded any action taken. And, records included details of any affected products removed. Pharmacy team members kept the contents of the pharmacy fridge tidy and well organised. They monitored minimum and maximum temperatures in the fridge every day. And they recorded their findings. The temperature records seen were within acceptable limits. Pharmacy team members packaged CDs and fridge items, such as insulin, in clear bags. They used the bags to perform a final visual check of the medicines against the prescriptions before sending them out. And they asked people to check they had received the expected items so any issues or queries could be quickly resolved before

the person left the pharmacy.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the necessary equipment available, which it properly maintains. And it manages and uses the equipment in ways that protect people's confidentiality.

Inspector's evidence

The pharmacy had the equipment it needed to provide the services offered. The resources available included the British National Formulary (BNF), the BNF for Children, various pharmacy reference texts and use of the internet. The pharmacy obtained equipment from reputable suppliers. It had a set of clean, well maintained measures available for medicines preparation. The pharmacy positioned computer terminals away from public view. And, it protected the computers with passwords. It stored medicines waiting to be collected in the dispensary, also away from public view. It had a dispensary fridge, which was in good working order. And pharmacy team members used it to store medicines only. They restricted access to all equipment and all items were stored securely.

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.